Tuesday, October 15, 2019  3:45 PM
805  Getting it Right: Improved Intake Under PDGM
Setting Sail with Start of Care:
Getting it Right From Intake to Admission

There are so many factors to consider when taking on a new patient. From the intake process, MD certification, face to face documentation, staffing...all of the parts and pieces have to mesh in order to have a proper referral and admission. If one, or more, of the parts are missing or are incorrect, agencies set themselves up for complaints, denials, ADRs and a host of other things we'd all rather avoid. By understanding the factors and documentation necessary for a proper referral and admission, agencies can better manage their patients and revenue flow from intake through discharge.

At the conclusion of the presentation, the participant will be able to:

• Identify the components of the home health eligibility criteria and required physician documentation.
• Cite Medicare compliant Face to Face documentation.
• Recognize what constitutes effective intake and referral information.
In the beginning: Improved Intake Processes

- Imperative that accurate information be obtained at time of intake.
  - Appropriate referral? Is patient eligible for home care?
  - Demographics and referral documents
  - CoPs
  - Payment
  - Diagnosis
Eligibility for Home health

- Be confined to the home with clearly documented home bound status
- Be under the care of an MD who will establish and periodically review the POC
  - NPI must match the MD signing the POC
- Be in need of skilled nursing &/or therapy which is both reasonable and medically necessary
  - Documentation must show care is necessary to:
    - Improve patient’s current condition or,
    - Maintain current condition or,
    - Slow further decline in condition
- Accurate F2F documentation
### CGS Jan-Mar 2019

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<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># of Claims Denied</th>
<th>% of Claims Denied</th>
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<td>The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.</td>
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### Palmetto Oct-Dec 2018

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<th>Denial Code</th>
<th>Denial Description</th>
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<td>3</td>
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<td>4</td>
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<td>Unable to Determine Medical Necessity of HIPPY Code if Applicable as Appropriate as Not Submitted</td>
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<td>5.8</td>
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### Face to Face

```
MD/NPP: __________________________ Date of visit: ________
Visit note appropriate & attached?: ______ Visit within timeframe?: ________
F2F visit pending with: __________________________
Scheduled F2F date: _______________ Within 30 days of SOC? __________
```
No more than 90 days prior
Within 30 days of

Who May Complete the F2F?

- Certifying physician
- Physician/NPP who cared for patient in acute/post-acute facility
- Nurse practitioner
- Clinical Nurse Specialist
- Certified nurse-midwife
- Physician Assistant

***But remember only an MD (doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license) can **order home health, write ongoing orders for home health, and sign the Plan of Care***
FAQ on SOM manual released Jan. 23, 2019

• Q. Can mid-level providers, such as nurse practitioners and physician assistants, write orders for home health services?

• A. No, only a physician can write orders for home health services. Section 1861(m) of the Social Security Act requires that the home health plan of care be established and maintained by a physician and does not include other licensed practitioners, such as nurse practitioners and physician assistants. Only physicians may establish and maintain the home health plan of care, including reviewing, signing, and ordering home health services.

What will complete your F2F circle?

- NPP
- Supervising MD (PCC?)
- PCP signing the POC
Required Components of the F2F

- ***Documentation of the name of the MD or NPP who saw the patient and the date of the encounter.
- Clinical condition that supports homebound status
- Need for skilled services
  - Supports primary reason the patient required home health
- ***Reason for home health referral
- ***MD name, signature and date

*** items must come directly from MD
Additional items may be located throughout the medical record but must be clearly identifiable
F2F Documentation

APPROPRIATE

- Discharge summary
- MD office visit note
- Progress note from acute/post-acute facility
- Note on MD letterhead summarizing the required information. Must include the date of the actual encounter.
- Clinical summary
- Admission summary
- History & Physical

INAPPROPRIATE

- Diagnosis list alone
- Recent procedures alone
- Recent injuries alone
- Generic statement without specific clinical finding to indicate what makes the patient homebound:
  - “taxing effort to leave home”
  - “gait abnormality”
  - “weakness/muscle weakness”

Word Up on F2F

- Address the F2F proactively
- Have a process for monitoring pending F2F visits
- Who will monitor & maintain the F2F log? Add to the job description and HAVE A BACKUP!!!
- Know what barriers the patient may have when making the MD F2F visit and address ASAP.
- Must have the actual visit or encounter note
- F2F is a condition of payment
The Basics

Demographics

- Referral date:
  - When was the referral received?
  - This will be your M0104 date of referral unless updated or MD ordered SOC received.
  - UPDATE with additional information if patient SOC to be delayed.
  - 48 hr. window for initial assessment starts with this date

So what?

Home Health Compare

<table>
<thead>
<tr>
<th>Process of care measures</th>
<th>As listed on Home Health Compare</th>
<th>Date source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely initiation of care</td>
<td>How often the home health team began their patients’ care in a timely manner</td>
<td>OASIS</td>
</tr>
<tr>
<td>Indicators of sub-acute care</td>
<td>How often the home health team used care that</td>
<td>PHSB</td>
</tr>
</tbody>
</table>
Insurance

- Who will be paying the bill for home care?
- If an MCR Advantage plan, is your agency a provider for the plan?
- Does this payor require auth?
  - Is this insurer quick to give auth or does it take a week or longer?
  - Make sure your clinicians are aware of auth.
- Does the plan pay per visit or episodic?
  - Need to have a budget for your payor mix and make sure your intake department is aware

Episode Timing: PPS vs. PDGM

PPS: First 2 continuous, adjacent 60-day episodes are early (120 days)

First 30-day period = Early

Second 30-day period = Late

30 Day Episode

PDGM

Must have greater than 60-day break to restart count
**Referral source**

- Where did the referral originate from?
- Primary MD
  - Who will be signing your POC? Intake should call to verify MD will sign orders.
- Was it an institutional source?
  - ACH, LTACH, SNF, IRF
- Community source?
  - MD office, outpatient source (i.e. same day surgery, etc.), emergency room, urgent care

  ~45% drop in CMW from institutional early to community late

**Other information**

- Emergency contact
  - What is their relationship to the patient? Are they the primary CG?
  - §484.55(c)(6): (must identify) The patient’s primary caregiver(s), if any, and other available supports
- Legal representative
  - §484.55(c)(7): The patient’s representative (if any): (can be legal or patient determined)
- Advance directive:
  - §484.60(a)(2) The individualized plan of care must include the following: (xv) Information related to any advanced directives;
- Primary language:
  - Multiple instances in CoPs that discuss meeting the needs for patients with limited English proficiency and accessibility for those with disabilities
Referral Documentation

Requirements

• Must support homebound status

• Show medical necessity

• Support need for requested skilled services
  – Does the documentation support the ordered disciplines?
  – “Therapy diagnosis”

• Match the agency’s focus of care
### 77yo, hospital referral, RN/PT/OT

**- Primary Discharge Diagnosis**

**Active and Suspected Problems** (Last Reviewed 05/03/19 @ 03:03 by [Signature])

Acute exacerbation of systolic CHF (congestive heart failure) (Acute)

**- Secondary Discharge Diagnosis**

**Chronic Problems** (Last Reviewed 05/03/19 @ 03:03 by [Signature])

- COPD (chronic obstructive pulmonary disease) (Chronic)
- History of successful cardiopulmonary resuscitation (Chronic)
- CAD (coronary artery disease) (Chronic)
- History of stroke (Chronic)
- Left bundle branch block (Chronic)
- Carotid artery disease (Chronic)
- HLD (hyperlipidemia) (Chronic)
- HTN (hypertension) (Chronic)
The patient is a 77 year old M with a PMH of CAD and ischemic cardiomyopathy s/p ICD, HFrEF (EF of 30%), COPD and CKD 3, who was admitted with a complaint of 1 month history of progressively worsening shortness of breath with a severe flare on the day of presentation. He had associated PND and orthopnea as well as increased LE swelling. Family though he had gained ~ 8 pounds in the last 10 days. BNP was >5000 on admission, and patient had not been on any lasix at home. EKG shwoed no acute ST changes. He was admitted and managed for acute exacerbation of Heart failure with reduced EF. He was started on IV lasix 40mg bid, with monitoring of input and output, Fluid restriction 2500 mg daily. He had a repeat echo which showed EF of 15 to 20% with severe global hypokinesia which was similar to previous echo. Patient shortness of breath currently and lower extremity edema resolved. He was saturating well on room air. He remained stable and was discharged home on 5/5/2019 with a prescription for p.o. Lasix 40 mg twice daily as well as p.o. potassium 20 mg daily. He is to continue his metoprolol and Entresto. He is follow-up with his primary care doctor and cardiologist within 1 week.

69yo male, MD office referral, SN/PT/MSW

| Diagnosis | Muscle weakness  
| ICD-10: M62.81: Muscle weakness (generalized) |
| Order Name | Orders included: 1  
| | Muscle weakness  
| ICD-10: M62.81: Muscle weakness (generalized)  
| | HOME HEALTH REFERRAL / FACE-TO-FACE ENCOUNTER  
| | Schedule Within: provider’s discretion  
| | Additional Services: HH RN, PT, MSW for community resources, specifically transportation  
| | Medical necessity (describe condition) which requires the above skilled services: Muscle weakness, CHF, unsteady gait  
| | This patient is homebound due to: Muscle weakness, CHF, unsteady gait |

Electronically Signed by: [Signature]
PA, PASUP
Communication Order
05/14/19 15:32:00 CDT, Consult for Home Health OT PT and Nursing to eval and treat. Home Aide to assist with bathing and adl’s, Constant Indicator

ASSESSMENT AND PLAN
1. This is a 76-year-old female with general weakness, decondition, most likely multifactorial. The patient is going to continue daily physical therapy, occupational therapy, and skilled nursing facility.
2. Recent sepsis due to methicillin-resistant Staphylococcus aureus wound infection, resolved.
3. Methicillin-resistant Staphylococcus aureus right foot wound infection with cellulitis, dorsal abscess status post debridement. Blood culture negative. Magnetic resonance imaging consistent with cellulitis, gas gangrene. The patient on intravenous antibiotics therapy per follow up with
5. Polymyelitis with post-polio syndrome.
6. Constipation.
8. Hypertension with occasionally low normal BP. The patient is going to continue her home regimen.

INFECTION DISEASE PROGRESS NOTE

ASSESSMENT/PLAN
1. Right foot wound infection MRSA, CRP almost normal
2. H/o Polio
Plan: Cont abx until next week then d/c

Post Hospital Wound Care Order Set
Location of wound(s): Right dorsel foot
Cleanse wound and peri-wound skin with Normal Saline
Apply _ to peri-wound skin to protect.
Dress wound with _ bandage plus 4X4, cover with a dry gauze, wrap with Kling and secure.
Change dressing: BID
Every other Day
97yo male, MD office referral, PT

Reason for Visit

Old-age

ICD-10: R54: Age-related physical debility
PHYSICAL THERAPY REFERRAL

Reviewed Problems
- Malignant tumor of colon
- Anemia
- Mitral valve regurgitation - Onset: 09/28/2018
- Gastroesophageal reflux disease
- Hiatal hernia
- Diverticular disease
- Benign prostatic hyperplasia
- Cramp in lower limb - Onset: 07/26/2018
- Osteoporosis
- Kyphosis of thoracic spine
- Abnormal glucose level
- Old-age - Onset: 07/26/2018

He presents today for feeling of fullness in his right ear canal. He denies any pain associated with this. He states he recently did have a sinus issue however it is resolving at this point. He denies any sore throat nasal congestion or ear pain. Denies any cough fevers or chills. On examination the right tympanic membrane is completely occluded with cerumen on the left is also however not as severe. Blood pressure today is 114/60 pulse rate of 73 denies any headaches dizziness visual disturbances.

Intake Diagnosis
Clinical Grouping (From Principal Diagnosis Reported on Claim)

- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- MS Rehab
- Behavioral Health
- MMTA - Other
- MMTA - Surgical Aftercare
- MMTA - Cardiac and Circulatory
- MMTA - Endocrine
- MMTA - GI/GU
- MMTA - Infectious Disease
- MMTA - Respiratory

Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)

- None
- Low
- High

- M62.81 Muscle weakness
- R26.81 Unsteadiness on feet
- R29.6 Repeated falls
- M19.91 Primary OA, unspecified
- M54.5 Low back pain
- M06.9 RA, unspecified
- M25.5 Joint pain
- All R codes
- Superficial injury codes

List not all inclusive

Use the Grouper Tool
AVOID diagnosis that will result in claim being returned to provider (RTP)

Points to Ponder
• Invest in education and training for your intake/marketing departments and liaisons on the updated requirements for referrals
  – Have your CM (or other clinical staff) verify necessary information has been obtained.

• Provide up to date tools
  – PDGM grouper is free and easy to use.

• Consider a certified coder/coders on your intake/marketing team to cut down time spent running around to clarify and correct.

• Determine YOUR agency’s questionable diagnosis
  – Review your EMR reports for the most frequently used primary diagnosis within your agency.
  – Identify trends with physicians
  – An all-inclusive list would be cumbersome
  – Educate, educate, educate!!!
• Avoid upcoding referral diagnosis without proper documentation
  – The physician must be the one to say right knee pain is really osteoarthritis of the right knee, not the clinician or coder!

• Develop a physician query process to ensure coding specificity
  – Provide information that would make it easier for the MD
  – CHF > weight gain, edema, BNP, etc.

• Begin to educate your physicians on PDGM.
  – Accelerated billing periods requiring timeliness of signing orders
  – Increased emphasis on coding specificity
  – F2F requirements

• Review your current process for intake flow in the agency
  – Is it fragmented?
  – Where can you streamline?
  – Define the roles in your job descriptions

• Have a process for authorization management beginning at intake.

• Disease management protocols
  – Possible frequencies
  – Suggested disciplines
  – Evidence based practice measures to promote consistency in care and improve outcomes
  – Market your programs

• Increase clinical competency
  – Consider specialty programs
Links

- [https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html) <PDGM grouper tool version date July 2019>

From CMS site

- CMS-1711-P
  - CY 2020 HH PPS Wage Index
  - CY 2019 HH PPS Case Mix Weights for 60 day episodes into CY 2020
  - CY 2015-CY 2022 Rural Add-On Payment Designations
  - CY 2020 PDGM Case Mix Weights and LUPA Thresholds (Updated 07/12/2019)
  - CY 2020 PDGM Grouper Tool
  - CY 2020 PDGM Agency Level Impacts
  - CY 2019 Home Infusion Therapy - Geographical Adjustment Factors (GAFs)

Grouper Tool (Excel file)

<table>
<thead>
<tr>
<th>Grouping</th>
<th>HIPPS Code Structure</th>
<th>OASIS items</th>
<th>ICD10 DXs</th>
<th>Comorbidities</th>
<th>Comorbidity - High</th>
<th>Comorbidity - Low</th>
</tr>
</thead>
</table>

Links

Apryl Swafford RN, BSN, COS-C, HCS-D, HCS-H
888-418-6970
aprylswofford@homehealthsolutionsllc.com
www.homehealthsolutionsllc.com