COMPLIANCE UPDATE 2015

Presented by Sharon M. Litwin, RN, BSHS, MHA, HCS-D
Senior Managing Partner
5 Star Consultants, LLC

Compliance is key to a success for homecare and hospice agencies!

Yet, it is increasingly difficult to understand and comply with the continual new and changing laws and regulations in the homecare industry.

Today's Objectives

- Understand the many compliance regulations and laws that Homecare Agencies must comply with, and know how to ensure that they are indeed compliant.
- A look at the various legal and regulatory orgs that have laws for homecare to follow or are there to enforce those laws: CMS, MACs, State, Accrediting bodies, OIG, 3rd party auditors

Today's Objectives

- Understand the current survey process and CMS enforcement of the COPs
- Introduction to the new laws for Sanctions
- Importance of preventing repeat standard level and conditional deficiencies
- Tips to lessen vulnerability to deficiencies that will result in sanctions

Today's Objectives

Final Rule issues:

- Review current CMS directives on FTF and understand the changes
- Denials seen for FTF
- Therapy Reassessments
- Insulin Injections
- Pay for Reporting – Quality Assessments

Today's Objectives

- Understand compliance issues leading to denials and/or deficiencies:
- ABNs, Homebound and skilled need
- Time points to complete ABNs
- Qualifiers for Medicare HH – Homebound, Under care of physician and skilled need
- Common reasons for denials

Start with the COPs

- Condition of Participations (COPs)for a homecare agency to be Medicare Certified-
- This is our Rule Book!
- Frequently deficiencies just because Management doesn't know or understand a standard

Start with the COPs

- What is the difference between a Condition and a Standard?
- Conditions are the main topics such as Pt Rights or Plan of care
- Standards are specific rules you must follow to meet that condition to participate in the Medicare homecare program

Standard Level Deficiency

- Means you were not compliant with one of the standards under a condition
  - You must then write a plan of correction
  - You may or may not have a follow up survey to check the compliance and completion of the action plan
    - Follow up depends on your state or accrediting body and the scope and severity of the deficiency

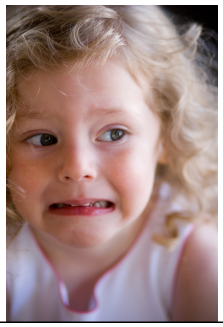
Condition Level Deficiency

- Means you either are:
  - Non compliant with the entire condition
  - Or non compliant with several of the standards associated under the Condition
  - Or Scope and Severity warranted a condition level deficiency.

Condition "Out"

- When you get a condition out, the state or accrediting body notifies Medicare that you have a condition level deficiency
- You are at risk of losing your Medicare Certification if you do not abate the Condition quickly, usually 10 days
- Surveyor typically in 45 days from survey
- Plan of correction must be very specific
- Must show great improvement to have lifted
- Cannot competency your Aides for 2 years

SANCTIONS



Be Afraid…….. Be Very Afraid

Sanctions given for REPEAT STANDARD LEVEL DEFICIENCY OR CONDITION LEVEL DEFICIENCY!

What are the Sanctions for homecare agencies ?

- Directed education
- Directed plan of care
- Interim management provided by CMS designee
- Beginning this past July 1, **Monetary Penalties paid BY THE DAY until plan of correction approved following repeat survey(s)**
- Can also include ***suspension of payments*** for all new admissions

Sanction -Monetary Penalties $500-$10,000 per day per citation!

- Daily Monetary Penalties in the range of $500 to $4,000 per day -
  - for repeat and/or condition-level deficiencies "related predominately to structure or process-oriented conditions"
- Penalties in the range of $1,500 to $8,500 a day for deficiencies related to poor quality patient care outcomes that don't involve "immediate jeopardy" situations.

Sanction -Monetary Penalties

- 8,500 – 10,000 for Immediate jeopardy
- Immediate jeopardy is a situation where the home health agency's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient

GUIDING PRINCIPLES OF IMMEDIATE JEOPARDY (IJ)

- Harm does not have to occur, it could just be a potential for harm
- It could be a potential for either physical or psychological harm
- Harm can result from abuse or neglect
- Only one patient needs to be at risk
- A potential IJ is a situation that is likely to occur in the near future, if no action is taken
- The surveyor's goal is to identify, & prevent serious injury, harm, impairment or death
- When an agency has an IJ, immediate corrective action is needed

If the surveyor can answer yes to the following 3 questions, an IJ exists:

1. Is there actual or potential serious injury, harm, impairment, or death?
2. Are one or more patients at risk of immediate serious injury, harm, impairment, or death?
3. Was the agency culpable in that they knew of the situation and did not ensure safeguards or should have known about the situation?

Immediate Jeopardy Numbers

- 41 since 2009 BUT….
- 37 of those have been SINCE 2012!

- 19 have come from Complaint Surveys
- 22 have come from a Survey

Avoid Repeat Standard or Condition Level Deficiencies !!!!!

- MOCK SURVEYS!!!! Annually
- Identify your vulnerabilities and prioritize
- Spend most of your time working on issues that will get you repeat or condition level deficiencies
- Have a GREAT QI program to work the problems and see improvement
- Home Visits made by supervisors quarterly
- Ongoing Clinical Record Reviews – Concurrent!

State Laws and Regulations

- Most states have specific state regulations and laws.
- Be Sure you Know them- they may be statutes for a particular area, such as criminal background checks. (Florida: CBC, HIV, Domestic Violence, etc)
- Or they may be almost as comprehensive as the COPs.

Accreditation Standards

Three Organizations for Deeming Homecare and Hospice to Medicare (and Some State Licensing- Florida and Missouri):

- ACHC (Accreditation Commission for Healthcare)
- CHAP (Community Health Accreditation Program)
- (TJC) The Joint Commission

Accreditation Standards

Main categories that are elevated from state and Medicare regulations:

Policies
In-services
Competencies
Quality Improvement

PRO of ACCREDITATION TODAY

- Accrediting Bodies cannot give SANCTIONS!
- SO …..if you are accredited and get a repeat standard or a condition level deficiency you May Not Get Sanctions
- UNLESS: CMS does a follow up or validation survey OR the State (rather than Accrediting Body) does a complaint survey
- Less chance of Sanctions when Accredited

Medicare Eligibility Criteria for Homecare

- There are still ONLY 3! And they have Not changed
- But they are not always black and white!

All must be present and documented

- Homebound
- Skilled Need
- Under care of a physician

Homebound

- Documentation has to be specific!
- The guide to billing says:
  - Considerable and taxing effort for the patient to leave the home
  - Brief and infrequent absences are acceptable
  - Leaving home for medical treatment is okay

Avoid Homebound Denials

- Denials seen for generic documentation
- Make your Homebound statement at SOC AND Ongoing as specific as possible- documented in clear, specific, and measurable terms.
- Homebound status is to be documented frequently enough to reflect the patient's current functional status.
- Documentation of the homebound status needs to be clear throughout care.
- Whether stated or implied, the homebound status must be obvious from a reviewer's standpoint.

Homebound Examples

- Example: Patient can only walk 10 feet before becoming extremely SOB and diaphoretic and must rest for 15 minutes prior to walking again.
- Example: Patient must use a quad cane while ambulating even short distances in the home, and even then has a very slow, unsteady gait. At times, the patient requires the assistance of another to get up and moving safely.

Homebound

- What you document for homebound status must be supported in the clinical record, in:
- The OASIS comprehensive assessment
- All visit notes
- Face to Face
- As it changes be sure to update with documentation
- DISCHARGE WHEN NO LONGER HOMEBOUND!

Skilled Need

- Medically reasonable and necessary
- How to determine a skilled need:
  What are the patient's medical problems?
  What are my interventions?
  What are the goals?
- ALL disciplines need skilled need for all visits!
  (exception Aide)

Skilled Need Rarely Black & White

- Teaching - is typically a skilled need UNLESS:
- Teaching the same med or diet for many visits when there are no problems or reason documented.
- Repeat teaching said to be a skill when pt cannot cognitively understand the teaching
- Teaching is done on a diagnosis or medication that the patient has had for 10 years. If you teach that as a skill, document why the patient needs teaching on an old dx or med.

Skilled Need

- Must coordinate care with other clinicians so that the teaching plan is appropriate for the patient.
- Document skilled need on every visit note
- DO not think that skilled need of a nurse is to assess the pt without physician orders or changes in status for lengthy period, esp recert
- DO not think skilled need is to "check on the pt because he will get worse when we dc"!

Under the care of a Physician

- ***On referral***, use caution if hospitalist or resident as MD. They often do not follow pt when discharged, and will not sign 485
- In state physician (unless bordering state allowed)
- DO physician verification on all new physicians and annually

Under the care of a Physician

- DO NOT admit the pt or keep the pt on service if does not have a current physician!
- Ex: Pt hasn't been to his physician so physician will not order homecare. Pt is going to get another physician shortly so homecare admits pt.
- Your agency and clinicians are working without physician orders!

Auditors!

- MAC – Medicare Administrative Contractors (FI's)
- RAC – Recovery Audit Contractor
- ZPIC – Zone Program Integrity Contractor
- SMRC – Supplemental Medical review Contractor

RACs- Recovery Audit Contractor

- CMS recently awarded new contracts
- New RAC requirements:

1. ADR rate adjustment – rate of denials influences rate of ADRs (higher denials = higher ADRs)
2. Wait 30 days to allow providers to discuss claims being sent to MACs for adjustment.
3. Confirm they received the discussion request within three days
4. Wait until the second level of appeal from the QIC (Qualified Independent Contractor) is exhausted before they can receive their fees.
5. MACs and ZPICs are still allowed to issue ADRs.

RACs- Recovery Audit Contractor

- Effective 3/6/14, RACs, MACs, and ZPICs can deny more claims which are not under review but are "related to" claims on which non-coverage or non-payment decisions have been made.
- Documentation on one claim can be associated with another.
- They will not be required to request ADRs before denying associated claims. (Extrapolation!)

ZPIC- Zone Program Integrity Contractor

Functions

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System (Center for Program Integrity;
- Performing medical review, as appropriate;
- Performing data analysis in coordination with CPI's Fraud Prevention System;
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

ZPIC- Zone Program Integrity Contractor

- In performing these functions, ZPICs may, as appropriate:
- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.
- ZPICs also support victims of Medicare identity theft. A provider provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case.

SMRC - Supplemental Medical review Contractor

- New in 2013 to home health
- Directed by CMS to focus on face-to-face, pre- and post-payment ADRs.
- Reviews may include vulnerabilities identified by CMS internal data analysis, the CERT (Comprehensive Error Rate Testing) Program, professional organizations, and federal oversight agencies.

Avoiding Denials

Frequent Denials:

- Homebound documentation inappropriate
- No physician orders & Missing/incomplete/ untimely orders
  - Catch on Pre- Bill Audits!
- Downcode due to incorrect primary diagnosis
- Therapy visits not medically necessary so not allowed
  - Have very detailed Goals
  - Show on Reassessments WHY therapy is needed
  - What to do to reach goals and/or new goals

Avoiding Denials

Frequent Denials:

- Medical necessity not supported in the record
  - Make sure record flows from oasis/485 to the rest of the notes and orders
  - Document why you are in the home! Skilled need
- Skilled observation –
  - initial approval, but then pt is stable and not dc'd
- ADR information not received
  - Check for ADRs in billing system at least weekly!
  - Check timeframe to send record in

Avoiding Denials

- Use ADR review to identify:
- What you have been targeted for
- How your documentation holds up to an outside reviewer
- Use this for teaching to prevent further ADRs, and/or denials.

Avoiding Denials

- Be careful with recertifying pts unless there are changes in condition with physician orders
- Recerts are often denied due to lack of skilled need
- Chronic illness does not mean skilled need and auditors deny for this
- Good Case Conference should determine if pt has continued skilled need!

Final Rule for 2015 Medicare– Clinical

Face to Face - Effective for episodes beginning on/after 1/1/2015

✓Eliminates the physician narrative except for when the qualifying service is Skilled Nursing for the Management and Evaluation of a Care Plan

✓All episodes beginning 12/31/14 and before still need narrative and expect that all pre1/1/15 dates ADR requests will continue to target insufficient physician narratives.

CMS says Home Health administrative burden is reduced by new F2F rule but…

- Documentation in the certifying physician's medical records **and/or** the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility.

Documentation?

- Supporting Information Like
  - The Skilled Need addressed by the HHA POC
  - Homebound Status
  - Patient is under the care of the physician
  - Timely Face-to-face encounter
  - F2F encounter was for same reason as the homecare stay
- CMS says they will educate the physicians on this. Provider - Webinar Dec 18, 2015 on the subject agencies was the first and only education so far which was also open to home health,

Incomplete Documentation

- If the documentation used as the basis for the certification of homecare eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- The physician claim for oversight will then also be denied.

5 Things Needed for F2F

1. The certifying physician's and/or the acute/ post-acute care facility's medical record must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's: Need for the skilled services; and
2. Homebound status

5 Things Needed Continued

3. The certifying physician's and/or the acute/ post-acute care facility's medical record must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter: Occurred within the required timeframe,
4. Was related to the primary reason the patient requires home health services; and
5. Was performed by an allowed provider type.

Where is the needed documentation?

- The document(s) do not have to say "F2F"
- This information can be found most often in physicians' clinical and progress notes, problem lists and discharge summaries.
- We all know information may be missing - the HHA can assist by sending information to the physician for review, signature, *Review, Signature, Filing* in their record and *Return* to the HHA.

What to send to Physician?

- Consider automatically sending the certifying physician, portions of the OASIS ADL/IADL's that support why homebound.
- Consider a narrative to the certifying physician with the plan of care to support need and homebound status.
- No not rely only on boxes on POC for assistive devices because lots of people with assistive devices are not homebound.
- Remember the physician must Review, Sign, File and Return what you sent for it to be considered by CMS as supporting documentation.

Management & Evaluation Narrative

- If a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential **non-skilled care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.**

Management & Evaluation Narrative

- If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature.
- If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

F2F Review by the HHA

- The HHA will need to review the documentation supplied by the physician to make sure the 5 Items are present.
- The HHA will need to request the narrative if Management & Evaluation is the qualifying service
- The HHA will need to send missing information to the physician for his/her record to *Review, Sign, File and Return!*

Can you see the issues with this?

- **ADR process will request physician documentation for which the agency has little control and inadequate documentation will lead to homecare denials.**
  - **How can the HHA help - Follow/up on Face-to-Face scheduling**
  - **Request the physician documentation from their record to send with the ADR if you don't already have it**
  - **Always sent the initial certification F2F documentation for any period ADR as it is now considered a requirement for eligibility for the homecare benefit**

FTF - Physician payment for certification / recertification

- CMS will reject physician claims where HH certification determined to be noncompliant!
- No formal rule; will be done through guidance
- FTF only done for Certifications (SOC), not Recertifications though?

NAHC's Lawsuit against CMS Continues related to FTF

- Alleges:
- Excess documentation required in relation to all ACA requirements
- Failure to provide adequate and clear guidance on acceptable documentation
- Failure to review whole record (on denials)
- Lawsuit will continue to address past claims denials and continuing audits!

Therapy Reassessment is Truly Good News!

- Effective for episodes beginning on/after 1/1/2015
- CMS eliminated the 13/19th and every 30 day visit threshold for therapy reassessments
- Final Rule – Each therapy provided to a patient requires a therapist re-assessment every 30 days.
- The 30 day clock starts with the last therapist visit - Example PT visits on day 27, then PT needs to visit by day 57. OT visits on day 29 then OT needs to visit by day 59.

Insulin Injections

- CMS will provide a list of diagnoses that support inability to self inject
- But regardless of these diagnosis, insulin injections are a covered benefit.
- The Diagnosis code alone does not ensure the payment.
- So …Just make sure the written documentation supports the skilled need - the inability to self-inject, the lack of willing/able caregiver and of course the homebound status.

Advance Beneficiary Notice (ABN) has been replaced by the Home Health Change of Care Notice (HHCCN)

- The HHCCN replaces 2 notice formats of the Home Health Advance Beneficiary Notice of Noncoverage (HHABN). The HHABN will be discontinued.
- Mandatory Date of Use: December 9, 2013
- The HHCCN, Form CMS-10280, and the ABN, Form CMS-R-131 must be used.

HHAs must provide notice:	Instead of:	Use:
prior to providing an item or service that is usually paid for by Medicare but may not be paid for in this particular case because: • it is not considered medically reasonable and necessary; • the care is custodial; • the individual is not confined to the home; or • the individual does not need intermittent skilled nursing care.	HHABN Option Box 1	ABN (CMS-R-131)
prior to the HHA reducing or discontinuing care listed in the beneficiary's plan of care (POC) for reasons specific to the HHA on that occasion.	HHABN Option Box 2	HHCCN (CMS-10 280)
prior to the HHA reducing or discontinuing Medicare covered care listed in the POC because of a physician ordered change in the plan of care or a lack of orders to continue the care.	HHABN Option Box 3	HHCCN (CMS-10 280)

Today we talked about:

- Medicare COPs – difference between standard and condition level deficiencies
- Sanctions for repeat and condition level
- Immediate Jeopardy
- How to avoid "bad surveys"
- Deemed status with Accrediting Bodies – differences and sanctions

Today we talked about:

- Medicare eligibility criteria
- Homebound
- Skilled Need
- Under Care of Physician
- Auditors: MACs, RACs, ZPICs, SMRCs
- Avoiding Denials
- Final Rule – FTF, Therapy, Pay for Reporting
- ABN's

Compliance 2014

Thank You!

Sharon Litwin
5 Star Consultants
slitwin@5starconsultants.net