Documentation and the Additional Development Request

February 2016

Today's Presenters

- Shelly Bernardini RN, BSN, CPHM
  - Medicare JK Lead Home Health Clinical Consultant
- Lauri Domingo RN
  - Medicare JK/J6 Home Health Clinical Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website at http://www.cms.gov.

JK/J6 Territories

Jurisdiction K	Jurisdiction 6	
Maine	New York	California
New Hampshire	New Jersey	Arizona
Vermont	Michigan	Alaska
Rhode Island	Wisconsin	Hawaii
Massachusetts	Minnesota	Puerto Rico
Connecticut	Idaho	Mariana Islands
	Nevada	American Samoa
	Washington	Virgin Islands
	Oregon	Guam

No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Acronyms

- Acronyms used in this presentation can be viewed on the **NGSMedicare.com** website. On the **Welcome** page, click on **Provider Resources > Acronyms**.

Today's Presentation

- Presentation is available on our website
  - Go to http://www.NGSMedicare.com
  - In the **About Me** drop down box, select your provider type and applicable state, click on **Next**, **accept** the **Attestation**. On the Welcome page, click the **Education** tab, then **Webinars, Teleconferences & Events**
  - Under the **Register** button for this event, you will see the **Presentation** link
- Materials from prior webinars are available
  - Click the **Education** tab, then **Past Events**

Objective

- To provide clear direction to HHAs and providers referring Medicare beneficiaries to eligible HH services, as per CMS regulations.

Agenda

- Pre-test
- Medicare HH eligibility
- Ordering HH services
- Eligibility criteria
  - Homebound status
  - Need for skilled service
  - Under the care of a physician
  - Plan of pare
  - Face-to-Face encounters
- Certification
- Recertification
- Documentation collaboration
- Resources
- Post-test
- Test answers

Pre-Test

- True or false?

1. Medical record documentation must support five eligibility criteria.
2. The referring physician must identify the name of the community physician who will be monitoring the patient's HH services.
3. When an HHA receives an ADR from National Government Services, Inc., they must submit the medical record within 45 days.
4. An ADR identifies all of the documentation that must be submitted.
5. It is imperative that the HHA validate all physician enrollment in PECOS.

Medicare HH Eligibility

- HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare HH benefit to review entities and/or CMS.
  - If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided.

Ordering HH Services

- Documentation provided to HHA when HH services are ordered/patient is referred to HH include:
- Order/Referral for HH Services
  - Written and signed by the certifying and/or referring physician
  - For the patient's current diagnosis (as witnessed during the time of the FTF encounter visit with the doctor)
- Documentation that supports that the Medicare beneficiary meets all five eligibility criteria
- Reminder: This information should also be forwarded to the physician that has agreed to provide oversight of HH services and monitor the HH POC

Medicare HH Eligibility Criteria

- Medicare regulations state that to qualify for the HH benefit, the patient must:
  - Be confined to the home
  - Need skilled services
  - Be under the care of a physician
  - Receive services under a POC established and reviewed by a physician
  - Have had a FTF encounter with a physician or allowed NPP
- There must be documentation in the medical record to support that all five of these eligibility criteria have been met.

Eligibility Criteria

- Homebound status
  - One of five eligibility criteria
  - No mandatory form requirement
  - Documented anywhere in the medical record from the certifying and/or referring physician
  - Maintained throughout the HHA medical record

Eligibility Criteria

- Need for skilled service
  - One of five eligibility criteria
  - No mandatory form requirement
  - Documented anywhere in the medical record from the certifying and/or referring physician
  - Maintained throughout the HHA medical record

Eligibility Criteria

- Plan of care
  - One of five eligibility criteria
  - No mandatory form requirement
    - CMS-485 form is no longer an up-to-date or endorsed form
    - Certification statement on the CMS-485 form does not encompass the FTF encounter
  - May utilize:
    - Discharge plan written by a referring certifying physician from an acute or post-acute facility at the time of patient discharge prompting referral to HH
    - Initial POC written by the referring certifying physician at the time of his/her office visit with the patient that prompted the referral to HH

Eligibility Criteria

- Under the care of a physician (physician oversight)
  - One of five eligibility criteria
  - The physician providing oversight may or may not be the referring physician
  - The physician providing oversight may or may not be the certifying physician
    - Referring physician provides the name of the physician who has agreed to monitor HH services in the community at the time of referral when he/she will not be providing oversight of HH services (hospital, SNF, inpatient rehabilitation center or outpatient surgery center referrals)

Eligibility Criteria

- Face-to-face encounter
  - One of five eligibility criteria
  - No mandatory form requirement
  - NPP may complete and sign the FTF encounter without a counter physician signature
  - No mandatory narrative regarding the need for skilled service and homebound status in the encounter documentation
  - Mandatory narrative regarding skilled oversight of unskilled care (when ordered)
  - May utilize:
    - Discharge Summary from the acute or post-acute care facility written at the time of patient discharge prompting referral to HH
    - Progress Note from the Physician office written at the time of the patient one on one visit with the physician in the office prompting referral to HH

Certification of Eligibility Criteria

- Required statement from a physician acknowledging all five eligibility criteria have been met
  - The certifying physician may or may not be the referring physician
- Required for all HH care claims
- No mandatory form or format
- Requires a dated signature below the statement from a Medicare enrolled physician
- Certification can not be completed/signed by a NPP

Recertification of Eligibility Criteria

- Required statement from the community physician that has been overseeing HH services acknowledging that all five eligibility criteria continue to be met
- Includes documentation of all initial eligibility criteria (review previous slides)
- Date of FTF encounter at the time of initial certification
- Physician estimate regarding how much longer skilled services may be required
- Dated signature below the certification statement from a Medicare enrolled physician
- Mandatory narrative regarding skilled oversight of unskilled care (when ordered)
- Recertification can not be signed by a NPP

ADR

- ADR: request for documentation to support the claim
- It is imperative that a HHA maintain a process or policy that ensures requested medical record documentation is collected efficiently and appropriately for review.
- Methods or techniques often utilized to ensure proper documentation is collected include:
  - Mock chart
  - Check list
  - Staff members assigned to collect documentation
  - Staff members assigned to review documentation prior to submission

ADR

- Incorporating the methods and techniques mentioned into the policies/procedures of the HHA will assist in ensuring:
  - Appropriate documentation is obtained from outside entities
  - Records are reviewed for accuracy by multiple people prior to submission
  - All eligibility criteria have been met
  - All proper documentation is included in the medical record prior to submission
  - Proper payment for HH claims

Sample ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart.

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS VIA PAPER, FAX, CD/DVD AND ESMD OMB #0938-0969

PLEASE NOTE:

MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 45 CALENDAR DAYS.

NON-MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 14 CALENDAR DAYS.

Records DUE:
45 Days

Sample ADR

- The ADR provides helpful hints to help appropriate claims payment.

MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED.

MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN SIGNATURES, HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD.

NO STAMPED SIGNAURES

Sample ADR

PATIENT IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER SIGNATURE IS NOT CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE, AND THE INITIALS FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT AN ATTESTATION STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE THAT THE MEDICAL NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

PLEASE SUBMIT THE SUPPORTING DOCUMENTATION WITHIN 45 DAYS FROM THE DATE OF THIS NOTICE. THIS DOCUMENTATION MUST BE CLEAR AND LEGIBLE.

Date

Signature

Legibility

ADR

- The ADR does not provide an all-inclusive list of what should/should not be included for medical record submission.
- Documented eligibility criteria, certification and recertification statements must be forwarded with the medical record.
- **Reminder:** It is important to review the records prior to submission to ensure documentation supports eligibility criteria.

ADR

- Other sources of documentation that may assist in supporting eligibility criteria include:
  - Discharge summary from the referring facility (may support the FTF encounter eligibility criteria)
  - Progress notes from 1:1 physician visit (may support the FTF encounter eligibility criteria)
  - Inpatient history & physical (may support homebound status or need for skilled service eligibility criteria)
  - Inpatient POC (may support homebound status or need for skilled service eligibility criteria)
  - Case Management and Discharge Planning documentation from the referring facility (may support homebound status or need for skilled service eligibility criteria)
  - PT/TO/SLP documentation (may support homebound status or need for skilled service eligibility criteria)

ADR

- Prior to submission of documentation, it is imperative that all paperwork is completely reviewed to ensure:
  - All pages are for the appropriate patient
  - PECOS - validation for all physicians involved in the patient's care for all DOS in the episode
  - Appropriate OASIS submission
  - Any and all therapy evaluations and reevaluations where applicable
  - The patient's name is on each page (front and back where appropriate)
  - The correct DOS for the claimed episode
  - Dates and signatures are clear and appropriate
  - Legibility of all handwritten documentation

ADR

- Prior to submission of documentation, it is imperative that all paperwork is completely reviewed to ensure:
  - Identifiable credentials for each clinician signature
    - Signature sheets as appropriate from agency and referring facility/office
  - Accuracy of documentation
  - All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
  - Pages are not folded over, cut off or crinkled during copying/printing/faxing
  - Highlighter is not utilized
  - ADR is placed on the top of the medical record
  - Reminder: Black ink copies best
  - Provider contact name and telephone number

Resources

- Change Request 9119: “Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services”
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf
  - In accordance with its references to Transmittal 92 & 208 in the CMS IOM Publications 100-01 and 100-02

Collaboration of Documentation

- As per CR 9189:
  - The HHAs generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare HH services.
  - It is the patient's medical record held by the referring certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for HH services.

Collaboration of Documentation

- Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - Information from the HHA can be incorporated into the certifying referring physician's and/or the community physician's medical record for the patient.
  - The certifying physician must review and sign any documentation incorporated into the patient's medical record that is used to support the certification.
  - If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim.

Post-test

- True or False?

1. Medical record documentation must support five eligibility criteria.
2. The referring physician must identify the name of the community physician who will be monitoring the patient's HH services.
3. When an HHA receives an ADR from National Government Services, they must submit the medical record within 45 days.
4. An ADR identifies all of the documentation that must be submitted.
5. It is imperative that the HHA validate all physician enrollment in PECOS.

Test Answers

1. Medical record documentation must support five eligibility criteria. **TRUE**
2. The referring physician must identify the name of the community physician who will be monitoring the patient's HH services. **TRUE**
3. When an HHA receives an ADR from National Government Services, they must submit the medical record within 45 days. **TRUE**
4. An ADR identifies all of the documentation that must be submitted. **FALSE**
5. It is imperative that the HHA validate all physician enrollment in PECOS. **TRUE**

Resources

- Change Request 9189, Transmittal 602
  - The purpose of this CR is to manualize policies in the calendar year 2015 Home Health Prospective Payment System Final Rule published on November 6, 2014, in which the CMS finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare HH services.
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R602PI.pdf

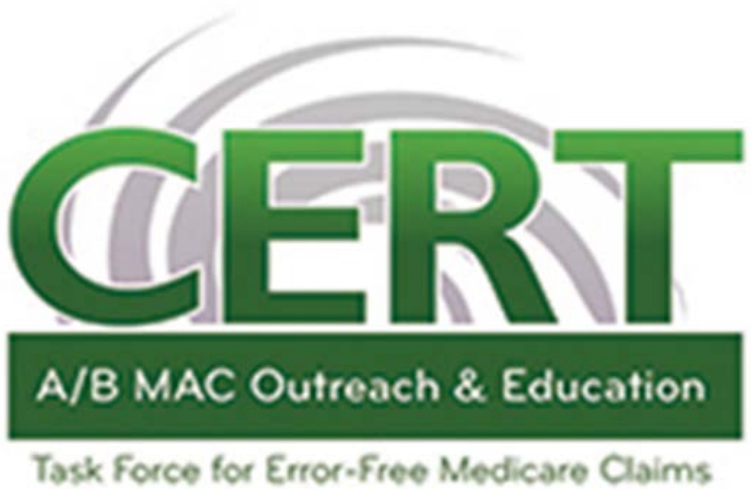
Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 7
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 10
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 6
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

Questions

- Please type in any questions you may have to the question box at this time and they will be addressed momentarily…

CERT A/B MAC Outreach & Education Task Force



CERT A/B MAC Outreach & Education Task Force

- A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
- Shared goal of reducing the national improper payment rate as measured by the CERT program
- Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- **Disclaimer:** The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

Participating Contractors

- Cahaba Government Benefit Administrators, LLC/J10
- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./JN
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

CERT A/B MAC Outreach & Education Task Force

- The CERT Task Force educates on common billing errors and contributes educational Fast Facts to the CMS website
  - CMS MLN Provider Compliance Fast Facts web page
    - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html
  - In addition, the CERT Task Force section on the NGSMedicare.com website provides a link to the CMS MLN Provider Compliance Fast Facts

CERT A/B MAC Outreach & Education Task Force

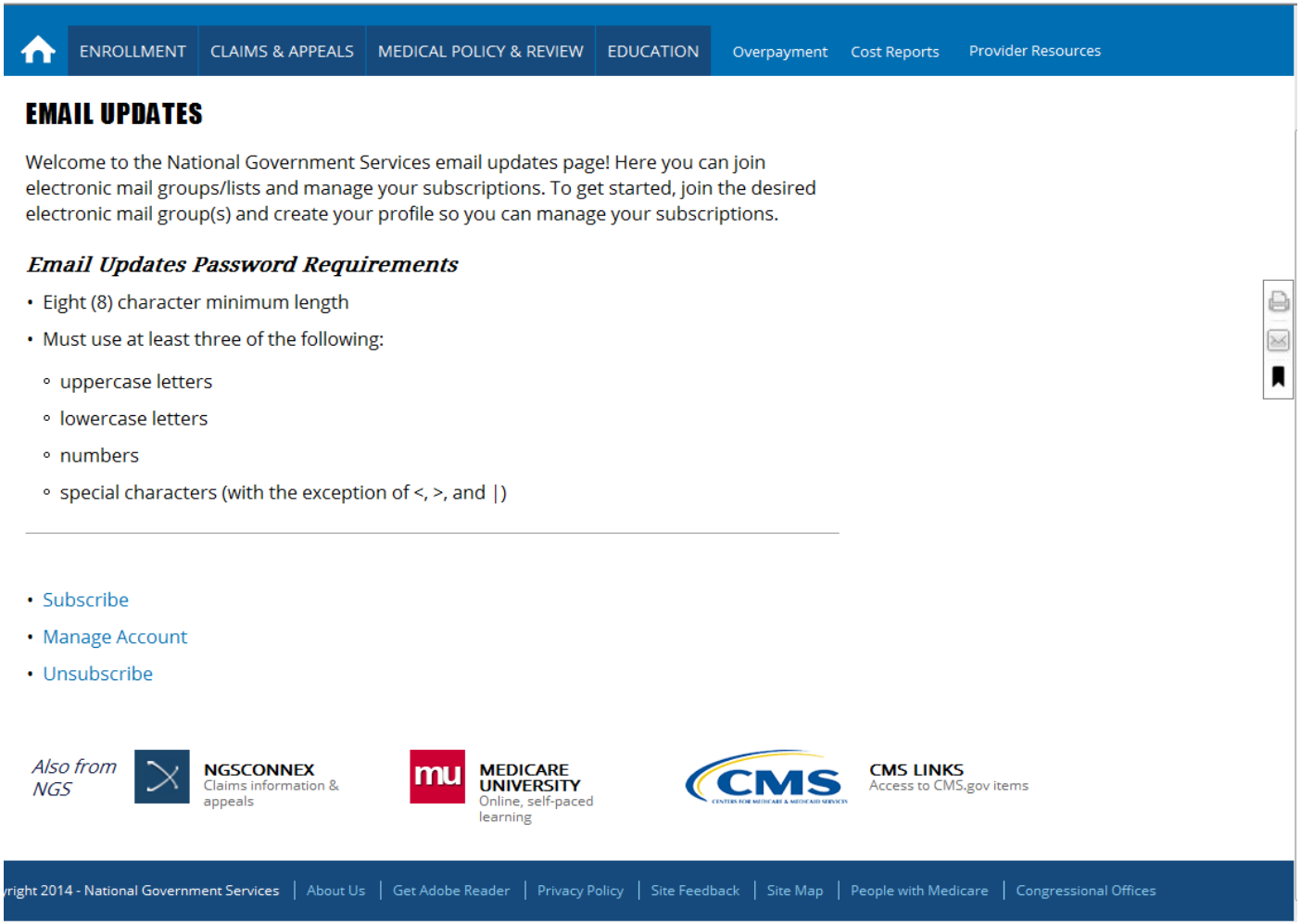
- CERT Task Force Web Page
  - Go to our website, http://www.NGSMedicare.com; in the **About Me** drop down box, select your provider type and applicable state, click on **Next**, **accept** the **Attestation**. Choose the **Medical Policy & Review** tab, then choose **CERT**, the **CERT Task Force** link is located to the right of the web page.
- Task Force Scenarios
  - Complying with medical record documentation requirements
  - Documenting therapy and rehabilitation services
  - Look for new articles added to this page and provided in your Email Updates

CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
    - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html

Email Updates

- Subscribe to receive the latest Medicare information.



Website Survey

- This is your chance to have your voice heard—Say “yes” when you see this pop-up so National Government Services can make your job easier!

Thank You!