Questions from JK TPE Sessions - April 2018

Q. TPE Payment Error Rate (PER) – is it the adjusted rate?

A. It is the rate of dollars denied/the dollars Medicare would have reimbursed if the claim was paid. The error rate used to determine continuation to the next round or release is the one on the TPE Results Letter based on the decision made in Medical Review. Any Appeals decisions are not taken into consideration because the provider has the ability to submit additional documentation with the appeal, and given the multiple levels of appeals available to the provider, a final decision on a single claim could take years. This is not new for the TPE, but has been the policy for past reviews as well.

Q. Does the F2F have to be done prior to the RAP billing?

A. No, the HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met:

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the national assessment system;
- Once a physician's verbal orders for home care have been received and documented;
- A plan of care has been established and sent to the physician; and
- The first service visit under that plan has been delivered.

An episode will be opened on CWF with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

The face-to-face encounter must occur 90 days prior or 30 days after the SOC, be related to the same reason that HH is ordered, and be provided by an allowed provider type, MD, DO, DPM, NP, PA, CNM, CNS.

Q. Can a NP not associated with the Certifying physician or acute/post-acute care facility perform the F2F?

A. No, the regulations from the Medicare Benefit Policy Manual, Chapter 7 state:

NPPs who are allowed to perform the encounter are:

- A nurse practitioner or a clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health;
- A certified nurse midwife, as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the

patient in the acute or post-acute care facility from which the patient was directly admitted to home health;

• A physician assistant under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

Q. Can a NP or PA order HH if a MD countersigns the order?

A. No, a physician must order home health services.

Q. Where is telehealth allowed?

A. The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

The originating sites authorized by law are:

• The office of a physician or practitioner;

• Hospitals;

• Critical Access Hospitals (CAH);

• Rural Health Clinics (RHC);

• Federally Qualified Health Centers (FQHC);

• Hospital-based or CAH-based Renal Dialysis Centers (including satellites);

• Skilled Nursing Facilities (SNF); and

• Community Mental Health Centers (CMHC).

Q. Is there confirmation of receipt for response to ADRs when using NGSConnex?

A. When a provider responds to a MR ADR using NGSConnex, once the response has been completed and submitted a message will display notifying the provider that their MR ADR has been submitted successfully. In addition, they will receive an email from No.Reply@NGSMedicare.com which will be sent to the email address associated with their User Profile, informing them that the response was received.

A history of previous ADR submissions and documentation can also be found in the My History mega tab.

Q. Can we pull Homebound/Need for skilled services documentation from the OASIS into the POC and consider it "incorporated in the POC" to support the certification?

A. If the information is present on the POC which is signed by the certifying physician, it would be given consideration as supporting documentation that has been incorporated into the certifying physician's record. This information should be patient specific and provide detailed information to support eligibility. From the regs:

Information from the HHA, such as the plan of care required per 42 CFR §409.43 and the initial and/or comprehensive assessment of the patient required per 42 CFR §484.55, can be incorporated into the certifying physician's medical record for the patient and used to support the patient's homebound status and need for skilled care. However, this information must be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient. This means that the appropriately incorporated HHA information, along with the certifying physician's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services.

Q. Can the hospital documentation be used to support eligibility when the patient goes to a SNF before being discharged with HH?

A. Yes, we will look at the acute care facility documentation to support eligibility even if the beneficiary went to a SNF prior to discharge with Home Health Services.

Additional issues emphasized by Lauri during TPE education:

- Please don't utilize the phone number of the MR Reviewer who contacts you intra-probe during a TPE review as a method for contact for appeals or any other claims determination rebuttals. This is a courtesy call to let you know if there is something missing that can be easily corrected.
- When responding to an ADR for an episode that includes therapy, don't forget to send the assessments and 30 day reassessments along with the POC for review. This reminder is also in the ADR language.
- The OASIS regulations called for stricter enforcement of submission of the OASIS not timeliness to ensure a matching OASIS is on file in the QIES system by the time the final claim appears in the Medicare system. Be sure to check the final validation report to fix any errors. This is RTPing now if there is a mismatch, but will go back to a denial in the future.
- Importance of responding to ADRs timely to avoid 56900 denials
- NGSConnex as an option for free claims submission and the wide array of self-service functions, reference to YouTube as a teaching tool for it
- Accepting a HH Referral – Consider intake process when accepting a referral to ensure HHA has documentation to support eligibility to "to assure that the patient eligibility criteria have been met and must be able to provide it to CMS and its review entities upon request", per the Medicare Program Integrity Manual, Chapter 6.
- Reminder about the Face-to-Face Encounter needing to be related to the same reason HH is being ordered, per the regs: In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to

start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

References:

Medicare Benefit Policy Manual, Chapter 7 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Medicare Claims Processing Manual, Chapter 10 – https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf

Medicare Program Integrity Manual, Chapter 6 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf