Compliance in Home Care

Presented by:

Sarah Spry, CPC and Ken Hooper, CPA, CHC

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- This presentation is intended to provide basic information regarding coding and billing principles and guidelines. While every effort has been made to provide accurate information, payor guidelines will determine the proper coding and billing criteria.

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AGENDA

- Coverage of Home Health
- Orders
- Plan of Care
- Start of Care
- Skilled Services
- Therapy
- Wound Care
- Diagnosis Coding
- MSP/ABN
- Compliance
- Reimbursement

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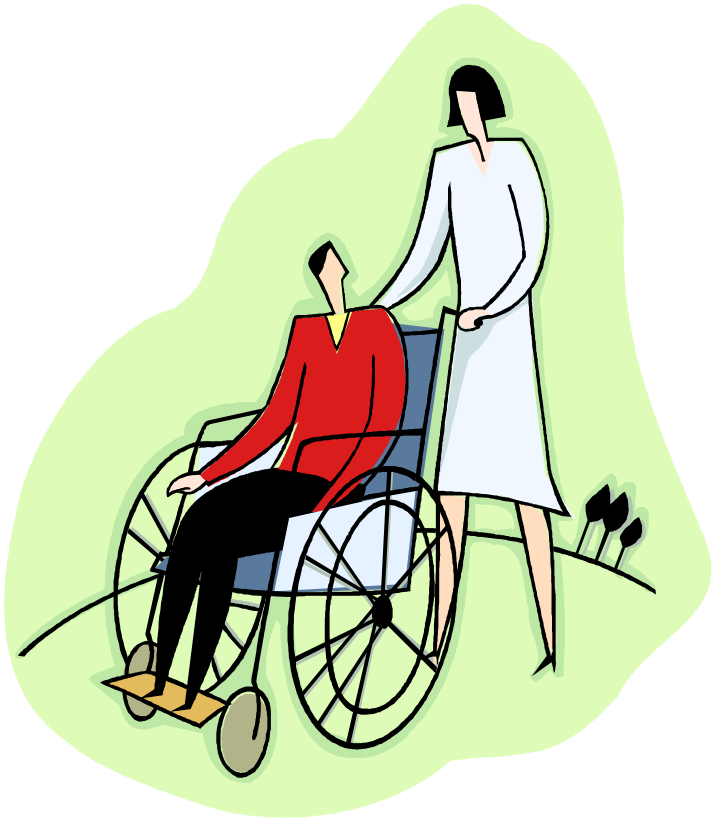
COVERAGE OF HOME HEALTH



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HOMEBOUND CRITERIA

- A physician must certify that the patient is confined to his/her home in order for an agency to receive payment under the home health benefit.
  - Individual **does not** have to be bedridden to be considered confined to the home.
  - Condition of these patients should be such that there exists a normal inability to leave home.
  - Leaving the home would require a considerable and taxing effort.

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HOMEBOUND CRITERIA

- Examples of homebound patients
  - A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.
  - A patient who is blind or senile and requires the assistance of another person to leave his/her residence.
  - A patient with arteriosclerotic heart disease of such severity that he/she must avoid all stress and physical activity.
  - A patient in the late stages of ALS or a neurodegenerative disability.
  - A patient who has lost the use of his/her upper extremities and is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave his/her residence.

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HOMEBOUND CRITERIA

- Determining home bound status
  - Generally speaking, a patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with:
    1. The aid of supportive devices such as crutches, canes, wheelchairs, and walkers;
    2. The use of special transportation;
    3. The assistance of another person or if leaving home is medically contraindicated.

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HOMEBOUND CRITERIA

- Documentation
  - In order to establish and support homebound criteria, each absence from the home must be documented.
  - Documentation of absences should include:
    - ✓ Length of absence
    - ✓ Destination (MD office, church, etc.)
    - ✓ Assistive devices, equipment, etc., utilized to leave the home
  - **If the home health agency (HHA) determines during an episode that a patient is no longer homebound, the agency should discharge the patient from home health care.**

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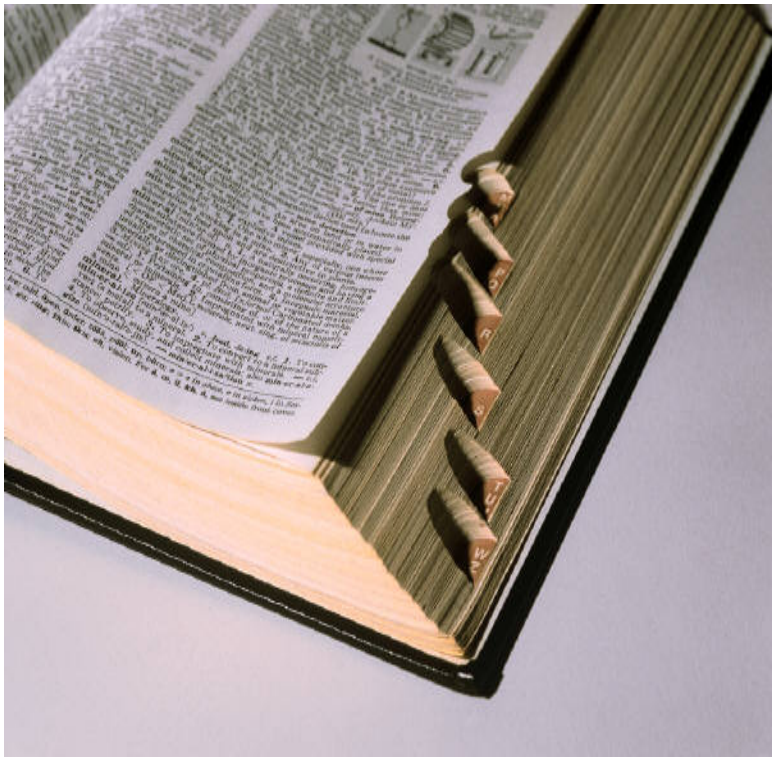
MEDICAL NECESSITY

- Definition of Medical Necessity
  - The CMS definition may not be the same one the physician, therapist or patient uses.
  - “Services must be reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the functioning of a malformed body member.”



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MEDICAL NECESSITY

- To be considered medically necessary, items and services must have been established as safe and effective. This means the items and services must be:
  - ✓ Consistent with the symptoms or diagnosis of the illness or injury under treatment.
  - ✓ Necessary and consistent with generally accepted professional medical standards.
  - ✓ Furnished at the most appropriate level that can be provided safely and effectively to the patient.
- **The fact that a physician ordered it or the patient requested it does not make it medically necessary.**

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MEDICAL NECESSITY

- Treatment must be consistent with the nature/severity of the illness or injury.
- Intensity, frequency and duration of services meet but do not exceed the patient's unique medical needs.
- Treatments are specific and effective for the patient's condition.
- Treatments restore or improve function affected by illness or injury.
- Treatment to facilitate maintenance of function of the involved body part.

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MEDICAL NECESSITY

- Treatments promote recovery.
- Treatments are within the accepted standards of medical practice.
- Significant, practical improvement can be objectively demonstrated.
- There is an expectation based on skilled assessment, that material improvement of the patient's condition will occur in a reasonable and generally predictable period of time ***or*** a safe and effective maintenance program is established.

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ORDERS

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ORDERS

- Order Criteria
  - Home health agencies must obtain an order for home health services prior to rendering care.
  - Orders may be verbal or written.

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ORDERS

- Verbal Orders
  - Must be documented by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies.
  - The orders must be signed and dated with the date of the receipt by the registered nurse (RN) or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services.

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ORDERS

- The orders may be signed by the supervising RN or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist.
- Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

There is not a required form or format for documentation or confirmation of verbal orders.

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ORDERS

- Specificity of Orders
  - The order must specify the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency (the number of visits per discipline to be rendered, stated in days, weeks or months) and duration (identifies the length of time the services are to be rendered and may be expressed in days, weeks or months) of the services.
  - A range of visits may be reflected in the frequency (e.g., 2 to 4 visits per week). When a range is used, consider the upper limit of the range as the specific frequency. An agency may use ranges if acceptable to the physician without regard to diagnosis or other limits.

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ORDERS

- Examples of Acceptable Format
  - ✓ SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; three times per week for 4 weeks; and two times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).
  - ✓ SN x 2-4/wk x 4 wk; 1-2/wk x 4 wk for skilled observation and evaluation of the surgical site…
- Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

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ORDERS

- ***Acceptable*** - Therapist to work with pt on transfers, gait, mobility, assist with ALF with working with brace 2x3xwkx3wks
- ***Unacceptable*** - Therapy for 3 wks

- ***Acceptable*** - Physical therapy 3xwkx3wks, 2xwkx3wks, 1xwkx1 wk for evaluation and treatment for gait training, transfer training, ex for RLE
- ***Unacceptable*** - Physical therapy 3xwkx3wks, 2xwkx3wks, 1xwkx1 wk

- ***Acceptable*** - Physical therapy 2xwkx3wks for strength training
- ***Unacceptable*** - Physical therapy for strengthening

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ORDERS

- ***Acceptable*** - Physical therapy 2xwkx1wk, 2-3xwkx2wks, 2xwkx2wks to evaluate, therapeutic ex, transfer training, gait training, HEP, family ed/training, balance/coordination, w/c mobility training and acquisition of adaptive equipment for functional independence
- ***Unacceptable*** - Physical therapy 2xwkx1wk

- ***Acceptable*** - OT evaluation, ADL training, fine motor coordination 3xwkx6wks
- ***Unacceptable*** – OT training

- ***Acceptable*** - ST evaluation, speech articulation disorder treatment 3xwkx4wks
- ***Unacceptable*** – ST speech disorder

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ORDERS

- ***Acceptable*** - SN observation and assessment of C/P and neuro status instruct meds and diet/hydration, instruct 3xwkx2wks
- ***Unacceptable –*** SN assessment and instruction meds 2 wks

- ***Acceptable*** - MSS assessment of emotional and social factors 1xmox2mos
- ***Unacceptable*** – Assess emotional status

- ***Acceptable*** - AIDE assist with personal care, catheter care 3xwkx9wks
- ***Unacceptable*** – AIDE assistance 9 wks

- ***Acceptable*** - PT to apply hot packs to the C5-C6 x 10 minutes 3xwkx2wks
- ***Unacceptable*** – PT to apply hot packs 3xwk

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PLAN OF CARE

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PLAN OF CARE

- Home health services must be provided under a plan of care established and approved by a physician.
- The plan of care must be established by the patient's treating physician with the assistance of the home health agency. A treating physician is defined as the physician who is responsible for the management and care of the patient. For example, the treating physician could be the patient's attending physician, his or her primary care physician, psychiatrist, or other specialist.
- The plan of care must be signed before submitting the final claim to your fiscal intermediary.
- Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

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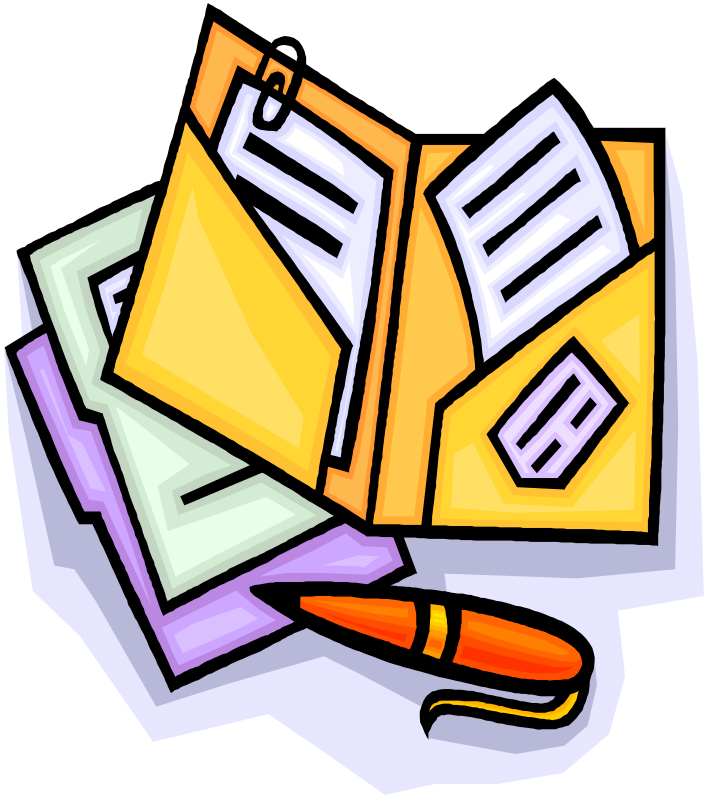
PLAN OF CARE

- The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of the review.
- The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.



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PLAN OF CARE

- The Plan of Care must include the following:
  - All pertinent diagnoses
  - Patient's mental status
  - Types of services, supplies and equipment required
  - Frequency of visits to be made
  - Prognosis
  - Rehab potential
  - Functional limitations
  - Activities permitted
  - Nutritional requirements
  - Medications and treatments
  - Safety measures
  - Instruction for discharge
  - Additional items

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START OF CARE

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START OF CARE

- The start of care date is determined based on the date of the first skilled service performed.
- Agencies are required to perform a start of care assessment including evaluation of:
  - Patient's place of residence
  - Homebound status
  - Family support
- **The cost of evaluation visits are administrative and are not chargeable as a visit. However, if a skilled service is furnished, as ordered, in addition to the evaluation, the encounter would become the 1st billable visit of the 60 day episode.**

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START OF CARE

- ***Billable*** – OASIS with documentation of wound debridement, cleansing and dressing change
- ***Not billable*** - OASIS with documentation of wound location and general appearance

- ***Billable*** – PT assessment, established HEP, stand by assist transfers from bed to chair, gait training with walker using stand by assist 20'
- ***Not billable*** – Multi-system assessment, patient and wife educated on reason for home health, skilled nursing goals, other disciplines: PT, PT, MSS, HHA

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OASIS ASSESSMENT

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OASIS ASSESSMENT

- **Key Areas Affected by the OASIS assessment include:**
  - Plan of Care
  - Reimbursement
  - Patient outcome data (OBQI)
- **Errors in OASIS scoring can lead to**:
  - Medical record discrepancies
  - Lost revenue
  - Compliance risk due to overpayments
  - Inaccurate patient outcome data
- **Issues that lead to incorrect/suboptimal responses:**
  - Assessments performed by different disciplines (i.e. skilled nursing vs. PT)
  - Completing OASIS questions simply by reading questions to patients

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OASIS ASSESSMENT

- Completing the OASIS assessment correctly requires:
  - Standard policies and procedures regarding the performance of the OASIS assessment.
  - Patient demonstration of activities instead of “interviewing” the patient.
- Examples:
  - M0390-Vision

    Ask the patient about vision problems and whether or not the patient uses glasses. Observe the patient’s ability to locate the signature line on your consent form, to count fingers at arms length and ability to differentiate between medications, particularly if medications are self administered.
  - M0490-Dyspnea

    Request to see the bathroom, allowing the assessor the opportunity to observe and evaluate the occurrence of shortness of breath with a walk of distance that you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath?

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OASIS ASSESSMENT

- M0670-Bathing

  Observe the patient actually stepping into the shower or tub to perform the activity safely.
- M0650- Upper Body Dressing

  Ask the patient to open and remove garments during the physical assessment of the heart and lungs which allows the assessor to evaluate upper extremity range of motion, coordination and manual dexterity needed for dressing. Assess the patient's ability to put on clothing that is routinely worn.

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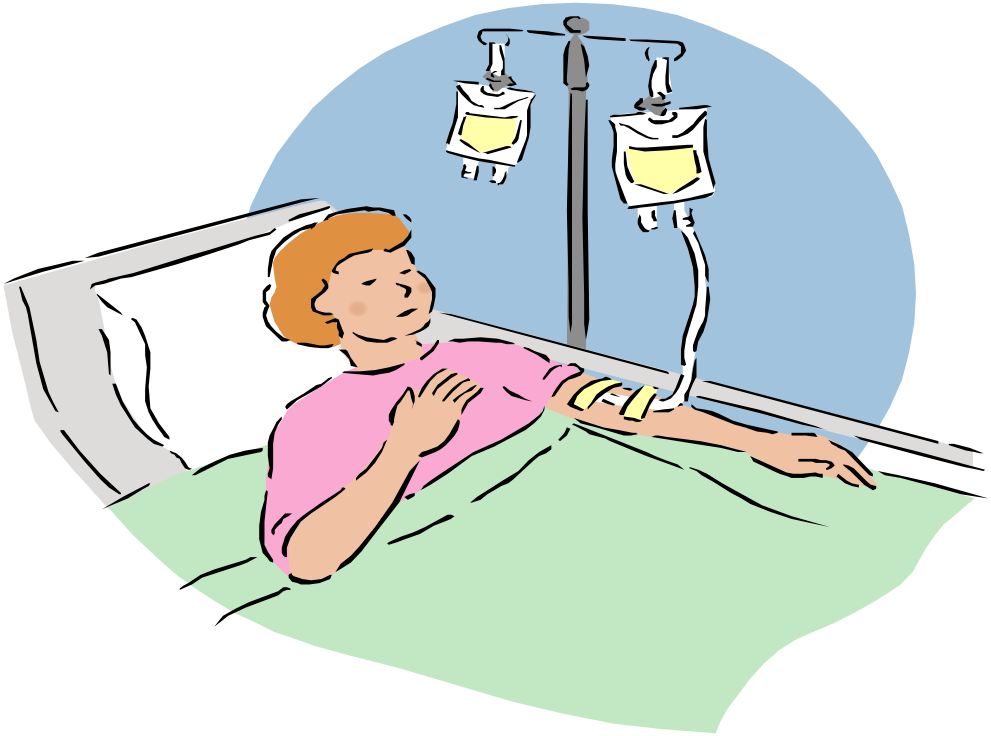
SKILLED SERVICES



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SKILLED SERVICES

Patients must require at least one skilled service for home health to be covered and the patient's condition must support the need for skilled services.

- **Skilled Nursing**
  - A skilled nursing service is a service that must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skill of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.
  - Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. However, in some cases the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

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SKILLED SERVICES

- ***Skilled Therapy***
  - The service of a physical, speech-language pathologist or occupational therapist 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. To be covered, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration of maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed although many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist.

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SKILLED SERVICES

- Examples of skilled services
  - A patient was discharged from the hospital with an open draining wound that requires irrigation, packing and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for wound care that is needed during the time that the family is not available to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as it is required by the patient.
  - A physician has ordered skilled nursing visits for injections of insulin and teaching of self-administration and self-management of the medication regimen for a patient with diabetes mellitus. Insulin has been shown to be a safe and effective treatment for diabetes mellitus, and therefore, the skilled nursing visits for the injections and teaching self-administration and management of the treatment regimen would be reasonable and necessary.
  - Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse.

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SKILLED SERVICES

- A patient has a second-degree burn with full thickness skin damage on his back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services.
- A patient who has had a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to safely climb and descend stairs.

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THERAPY

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THERAPY

- Therapy (physical and occupational) is covered when:
  - The services are provided with the expectation, based on the assessment made by the physician of the patient's rehab potential, that:
    - ✓ The condition of the patient will improve materially in a reasonable and generally predictable period of time; or
    - ✓ The services are necessary to the establishment of a safe and effective maintenance program.
- Services involving activities for the general welfare of any patient e.g. general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy.
- Once the patient reaches the therapy goals specified in the physician's care plan and/or the patient is no longer homebound, the patient should be discharged from home health.

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THERAPY

- Documentation for therapy must include the following:
  - Therapy administered
  - Response to therapy
  - **Patient status with respect to treatment plan**
  - **Changes in objective findings**
  - Subjective assessment of patient
  - Adverse reactions to treatment
  - *Duration of treatment(s) (total face-to-face time including start and stop time of each timed modality)*
  - Education provided
  - Alterations in treatment plan
  - Appropriate maintenance criteria met, if applicable

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THERAPY

- Examples

A patient who has a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to safely climb and descend stairs.

Orders – Pt 2-3xwkx4wks for strength training, education and safety

Objectives – To ambulate safely without assistance, safely climb stairs, return strength to normal

Acceptable Documentation – The patient walked with assistive device 20'; 2nd wk – walk with assisted device 50'; 3rd wk – walk unassisted 20', education and safety on stairs; wk 4-walk unassisted 50'

Unacceptable Documentation –Patient progressing well, continue with plan of care

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THERAPY

A patient who has received gait training has reached his maximum restoration potential and the physical therapist is teaching the patient and family how to perform safely the activities that are a part of a maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) would be covered since they are needed to establish the program.

Orders – Pt 2xwkx2wks for teaching patient and family gait training exercises and safety

Objectives – To teach the patient and family gait maintenance and safety

Acceptable Documentation - Taught family safe use of DME equipment, including proper technique with walker, cane, and walking with oxygen. Reviewed the following gait training exercises: 2x25' using walker with minimal assistance, assist with stair training and uneven surfaces.

Unacceptable Documentation– Patient and family understand safety and gait training exercises.

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THERAPY

A patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting and bathing. The occupational therapist will establish goals for the patient's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment.

Orders – Pt 3xwkx5wks for education and safety for lower extremity dressing, hygiene, toileting and bathing

Objectives – To safely dress, bath and toilet and have proper hygiene

Acceptable Documentation – Patient properly demonstrates, lower body dressing with min. assist and using self help devices, patient demonstrates proper safety technique for transfers to toilet and bath tub with min. assist.

Unacceptable Documentation – Patient making progress towards goals, continue OT.

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WOUND CARE

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WOUND CARE

- **What is Included**
  - Care of wounds, (including, but not limited to ulcers, burns, pressure sores open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury is considered to be a skilled nursing service.
- **When is it Covered?**
  - For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency and quantity), condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a nurse are usually reasonable and necessary.

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WOUND CARE

- **Examples**
  - Pressure sores where there is partial tissue loss with signs of infection like foul odor or purulent drainage.
  - Recently debrided ulcers.
  - Complications from post-op wounds such as, infection, allergic reaction, or underlying disease (e.g. diabetes) that has a reasonable potential to affect healing.
  - Wounds that require irrigation into several layers of tissue and skin and/or packing w/sterile gauze.

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DIAGNOSIS CODING

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DIAGNOSIS CODING

- **Primary Diagnosis (M0230)**
  - The primary diagnosis is based on the condition that **is most related to the current plan of care**.
  - The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA.
  - If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.
  - V codes are acceptable as both primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, do not use the V code when the acute diagnosis code is more specific to the exact nature of the patient's condition – if reporting V code in place of case mix see M0245.
  - Do not use unspecified codes, **unless a specific code does not exist.**
  - May not use E codes
  - Use only skilled services (skilled nursing, physical, occupational and speech therapy), in determining relevancy of a diagnosis to the plan of care.

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DIAGNOSIS CODING

- **V Codes**
  - According to national official coding guidelines (which are approved by CMS), the ICD-9-CM codes in the "V code" section are often the most appropriate primary diagnosis codes in the home health setting. For example, the official coding guidelines stipulate that the acute fracture codes are not to be reported in the home health setting because the fracture has already received restorative treatment.
  - ***Aftercare*** – means the initial treatment of disease or injury has been completed but patient requires continued care during healing or recovery phase or long-term consequences of the disease. There are V codes for aftercare following treatment of traumatic and pathological fractures and joint replacements, and following surgery on specified body systems (without complications).

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DIAGNOSIS CODING

- ***Status-post category*** - (V42-49 most often refers to an earlier surgery, injury or previous injury and usually has no significance for the episode of care)
  - V54.10-V54.29 - deals with aftercare for healing fractures
  - V54.81-V54.89 - covers aftercare for orthopedic joint replacement and other orthopedic aftercare
  - V57.1 - “other physical therapy” may be technically accurate and allow you to claim Medicare reimbursement but a more specific code might better describe the patient’s condition.
  - V58.42 – aftercare following surgery for neoplasm
  - V58.43 – aftercare following surgery for injury and trauma
  - V58.71-V58.78 aftercare for surgery on various systems

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DIAGNOSIS CODING

- **Secondary Diagnosis Codes (M0240)**
  - Enter all pertinent diagnoses…relevant to the care rendered
  - Other Pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or which developed subsequently.
  - Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care.
  - In general, include not only conditions actively addressed in the plan of care, but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

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DIAGNOSIS CODING

- **Payment Diagnosis Codes (M0245)**
  - M0245 used only when V code in M0230 replaces case mix
  - If a V code is reported in place of a case mix diagnosis, then M0245 (payment diagnosis) should be completed
  - M0245(b) is used when a manifestation code is listed with the primary underlying condition code

    For example, patient is receiving home health services for wound care/dressing changes. The patient has received surgical debridement of a diabetic ulcer of the calf.
    - ✓ M0230 – V58.3 (Aftercare-attention to surgical dressing and sutures)
    - ✓ M0245a – 250.80 (Diabetes w/specified manifestations)
    - ✓ M0245b – 707.12 (Ulcer of calf)

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DIAGNOSIS CODING

- ***Late Effects***. Category code 438, late effects of cardiovascular disease, is an extremely common home care diagnosis among elderly patients. When a patient is receiving home care following hospitalization for an acute cerebrovascular accident (CVA), a code from category 438 is the correct code assignment for the primary home care diagnosis, but is not a case-mix diagnosis.

- ***Acute CVA***. Under home health PPS, the acute CVA code should be reported as primary after the initial hospital treatment.
  - At this time, it is not clear how long an active CVA code should be reported before moving to a late effect code (438.xx)
  - When goals have been met and the patient is readmitted to home care subsequent to initial HH treatment for acute CVA – then move to a late effect code for residuals.

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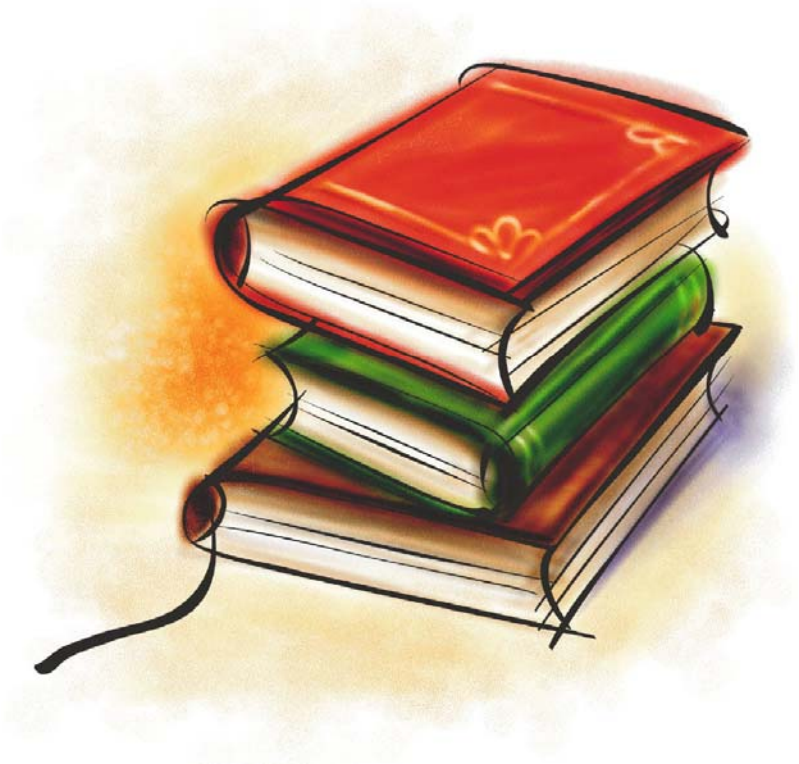
DIAGNOSIS CODING

- ***Late Effects Coding Examples***
- Subdural hemorrhage, two years ago, with residual aphasia, admitted to hospital with acute cerebral thrombosis = 434.00 and 438.11
- Cerebrovascular accident two years ago with residual hemiplegia of the dominant side = 438.21
- Cicatricial contracture of left hand due to burn 709.2, 906.6
- Posttraumatic, painful arthritis, left hand = 716.14, 908.9
- Flaccid hemiplegia due to old cerebrovascular accident = 438.20



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MEDICARE SECONDARY PAYER

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MEDICARE SECONDARY PAYER

- Medicare Secondary Payer (MSP)
  - Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first.
  - The term “Medicare Secondary Payer” is sometimes confused with Medicare supplement. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the “gaps” in Medicare’s coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay for because of deductible or coinsurance amounts or other limits under the Medicare program.
- Responsibilities of Providers Under MSP
  - Medicare requires providers to determine prior to submitting Claims for reimbursement if another insurer is primarily responsible for payment.
  - Complete the MSP prior to rendering services to every Medicare patient, at the start of each episode.
  - Blank or partially completed MSP forms are not acceptable.

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ADVANCE BENEFICIARY NOTICE

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ADVANCE BENEFICIARY NOTICE

Q. What is an "ABN" and what does it mean to a Medicare beneficiary who signs it?

A. An Advance Beneficiary Notice (ABN) is a written notice given by a supplier, physician or provider to a Medicare beneficiary BEFORE a service is provided, which indicates that the service likely will not be paid for by Medicare, indicates why Medicare denial is expected, and asks the beneficiary to sign an agreement to pay personally for the service. A beneficiary who signs an ABN agreement will likely be held responsible for payment of the bill, if Medicare denies the payment.

Q. What information must be included in an ABN for a Part B service?

A. The ABN must clearly identify the service(s) for which denial is being predicted, and it must clearly state the reason(s) for that prediction. It must include a section for the beneficiary's agreement to pay, specifying that the beneficiary has been notified that Medicare probably will not pay for the service(s) and that the beneficiary agrees to be personally or fully responsible for payment. The beneficiary may sign the agreement to pay or choose not to receive the service.

Q. What does it mean to be "personally and fully responsible" for payment?

A. This means that the beneficiary will have to pay for the service(s) either out-of-pocket or by some other insurance coverage which he/she has in addition to Medicare.

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Q. In what circumstances should an ABN be given to a beneficiary?

A. ABN's should be given to beneficiaries whenever the supplier, physician, or provider believes that a claim for the service(s) is likely to be denied payment by Medicare for medical necessity denials- denials of otherwise covered services that were found to be not "reasonable and necessary," that is, so-called "medical necessity denials" under section 1862(a)(1).

Q. In what circumstances are ABN's not needed?

A. ABN's to beneficiaries do not have to be given whenever a service is believed likely to be denied payment by Medicare for statutory exclusions (statutorily excluded services, sometimes referred to as "categorically non-covered services," such as cosmetic surgery,hearing aids, and routine physicals and screening tests).

Q. Should a physician or laboratory give an ABN to a beneficiary in the case of screening test?

A. No, as indicated above, screening tests are statutorily excluded and Medicare never pays for them. Therefore, no ABN is necessary for screening tests, and no Medicare charge limits apply to such tests.
EXCEPTIONS: For those few screening tests included in 1862(a)(1) of the act, Medicare coverage and payment is possible, so ABN's should be given if denial is expected. These tests include mammograms, Pap smears and pelvic exams and colorectal tests.

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Q. When a beneficiary is liable for payment because of receiving an ABN, how much can the beneficiary be charged for the services?

A. When a service is non-covered by Medicare and the beneficiary is liable for payment, as in the case where an ABN was properly given, there are no Medicare charge limits which apply to the supplier's, physician's, or provider's charges to the beneficiary. Medicare balance billing limits do not apply. The amount of the bill in such cases therefore, is a matter between the supplier, physician, or provider and the beneficiary.

Q. What is the difference between an ABN and a Private Contract?

A. An ABN is furnished by a physician who has not opted out of the Medicare program. An ABN pertains to non-coverage of services; that is, services for which the physician or practitioner believes Medicare likely will not make payment. An ABN affects only those services listed on the ABN and allows the physician to charge the beneficiary only if Medicare actually denies payment for those particular services.

A Private Contract is used by a physician or practitioner who has opted out of Medicare. Private contracts are pertinent to services that usually are covered by Medicare, that is, services for which Medicare likely would have made payment. When a physician enters into a private contract, it affects all of his or her services to Medicare beneficiaries for a period of two years.

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ADVANCE BENEFICIARY NOTICE

Q. What is a "defective ABN" and what implications does it have for beneficiaries and for suppliers, physicians, and providers?

A. A "defective ABN" is one which fails to meet Medicare standards in a material way, such as the beneficiary does not receive proper notice of why a particular claim is likely to be denied, or does not receive it in a manner allowing the beneficiary to make an informed consumer decision.

Q. **May a supplier, physician, or provider routinely give ABN's to all beneficiaries?**

A. Generally, NO. Such routine ABN's are considered defective notices since they do not provide adequate notice as to why that particular claim is likely to be denied and since they do not allow the beneficiary to make an informed consumer decision. Such a defective notice leaves the supplier, physician, or provider liable for denied charges.

EXCEPTIONS: For screening tests with statutory frequency limits, ABN's may be routinely given to beneficiaries due to the supplier's, physician's, or provider's great difficulty in establishing when a beneficiary's last test actually occurred.

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ADVANCE BENEFICIARY NOTICE

Q. **Are there circumstances where one ABN will serve for a series of services?**

A. Yes. When there is an extended course of treatment for which the likelihood of denial of payment by Medicare can be predicted in advance, a single ABN for the whole course of treatment will suffice. An ABN for an extended course of treatment must make it clear that it applies to the whole course of treatment (include beginning and reasonable ending dates, not to exceed six months). If the course of treatment is changed substantively, it is necessary to give a new ABN to the beneficiary which specifies the changes in the course of treatment and the likelihood of denial for those services.

Q. If an ABN was given to a beneficiary, must a claim be submitted to Medicare?

A. Yes, a claim must be submitted whenever there is **<u>any</u>** possibility that the claim may be paid. For Part B services, the mandatory claims submission provision of the Act (1848(g)(4)) requires submission of a claim for a "service for which payment may be made under this part" and provides sanctions for failure to submit claims. For all services for which payment generally may be made, but a medical necessity denial is expected, a claim must be submitted so that a Medicare determination can be made. When and if the claims are denied as not reasonable and necessary (and an ABN has been signed), the beneficiary is liable to pay for the service(s). Failing to submit such claims is a violation of the mandatory claims submission provision and is an abuse because it disenfranchises beneficiaries by denying them a Medicare coverage determination and subsequent appeals rights.

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COMPLIANCE

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COMPLIANCE

- Compliance Nationwide
  - 1,024 Home Health Agency providers are currently excluded
  - These include business managers, aides, nurses, owners, operators and agencies themselves

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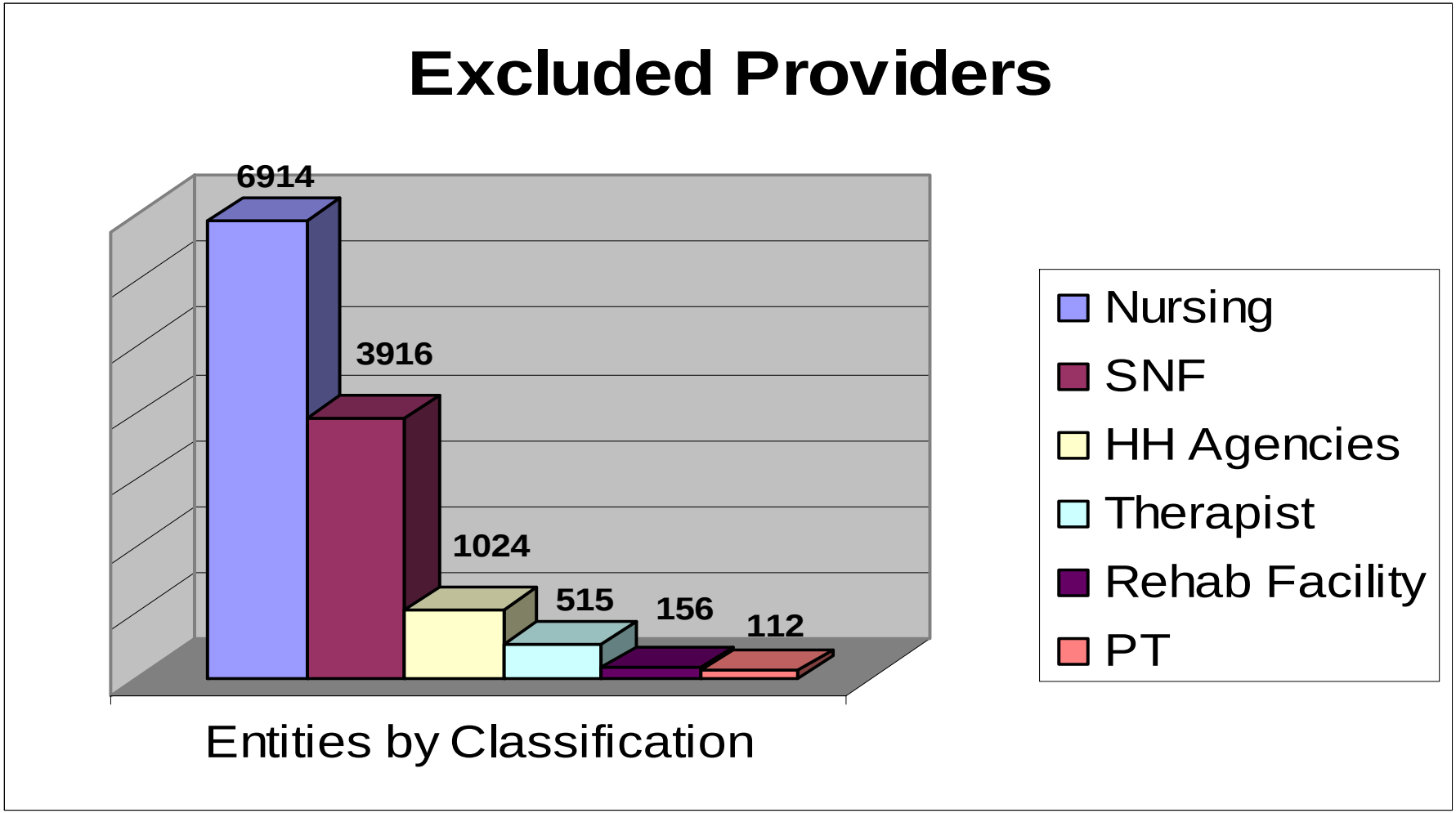
COMPLIANCE



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COMPLIANCE

- What does exclusion mean?
  - Any person who is excluded may not participate in any activity that causes a claim for reimbursement to be submitted to the federal government. (This includes Medicare, Medicaid, Champus, Mail Handlers Benefit and any Federal Employee Health Benefit Plan).
  - Excluded individuals may not order services, care for patients or submit claims for payment.
  - Anyone can be excluded for a variety of reasons including; fraudulent billing, patient abuse and failure to repay student loans.
  - You must verify the exclusion status of employees and referring providers, preferably every 6 months, but no less than annually.
  - If you submit a claim for a service that involved an excluded individual, you must re-pay the money.

http://exclusions.oig.hhs.gov

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COMPLIANCE

- Common Errors
- Physician order not current or not for therapy provided.
- Verbal orders not appropriately documented.
- Physician order is not complete.
- Therapy initiated before the POT is established and approved by the physician.
- POT has pre-printed date for physician signature.
- No documentation that the physician has seen the patient at least every 30 days.
- The POT exceeds 30 days with no documentation of reassessment by the therapist and revalidation by the physician.
- Reports are dictated and transcribed well after the period in question.
- Improper medical record amendments/corrections.

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COMPLIANCE

- Non-standard abbreviations.
- Start and stop times not documented for timed services.
- Evaluation, POT, reassessment and/or therapy notes do not meet documentation guidelines.
- Patient assessment not measurable and objective.
- Student notes are not properly supported by therapist documentation.
- POT is not signed by the physician and returned in a timely manner.
- The reason for a delayed POT certification not documented.

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COMPLIANCE

- The Office of Inspector General's Compliance Program Guidance identifies compliance risk areas which should be evaluated at least annually.
  - Billing for items or services not rendered
  - Billing for medically unnecessary services
  - Duplicate billing
  - False cost reports
  - Failure to refund credit balances
  - Billing for services provided to patients who are not homebound
  - Over and under utilization
  - Insufficient documentation to evidence that services were performed and to support reimbursement
  - Billing for services provided by unqualified or unlicensed personnel
  - Falsified plans of care
  - Inappropriate medical record addendums
  - Untimely physician certifications on plans of care
  - Improper beneficiary signatures on visit slips and consent forms

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COMPLIANCE

- **2006 OIG Work Plan**

  - **Outlier Payments**: The OIG will evaluate the frequency of outliers and if they cluster in certain HHRGs or geographical areas. They will also determine if payments were in compliance with Medicare regulations and plan to evaluate the current outlier methodology.
  - **Enhanced Payments for Therapy**: The OIG will determine whether home health agencies' physical therapy services met the threshold for higher payments. The number and duration of therapy visits provided per episode will be analyzed.
  - **Survey and Certification Deficiencies**: The OIG is will examine trends and patterns in HHA survey and certification deficiencies and identify whether any HHAs show patterns of cyclical noncompliance with certification standards.
  - **Home Health Compare Website**: The OIG will look at the accuracy and completeness of the information on Medicare-certified HHAs that CMS maintains on the website.

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COMPLIANCE

- Auditing and Monitoring
  - Performed by a qualified individual with expertise
  - Performed at least annually
  - Auditing should include, but is not limited to, the following actions:
    - ✓ Testing clinical and billing staff on their knowledge of reimbursement coverage criteria and official coding guidelines
    - ✓ Review of documentation and coding utilizing a standard, reproducible methodology, to ensure compliance with government guidelines (including review of the plan of care, orders, nursing and therapy notes)
    - ✓ Analysis of utilization patterns
    - ✓ Re-evaluation of deficiencies cited in past surveys and audits
    - ✓ Examination of complaint logs

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COMPLIANCE

- Investigating problems or concerns
  - Compare statistics to national averages
  - Use trend analysis to “drill down” and understand what is going on
    - Interview staff
    - Look at selected episodes on a random or statistical basis

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COMPLIANCE

- Episode trends – tracking trends as a tool in monitoring compliance
  - **Episode Growth** – do all of these patients qualify ? This is particularly true for patients previously receiving only personal care, homemaker or aide type services.

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COMPLIANCE

- Episode trends – continued
  - **Average visits per episode** – does the trend indicate that the amount of care is consistent with the average case mix weight?
  - **Outliers** – Does the trended outlier percentage indicate inappropriate services are being provided?

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COMPLIANCE

- Episode trends – continued
  - **LUPA's** – Is the percentage of LUPA's consistent with historical trends, referral sources and the industry?
  - **Episodes with 5-10 visits** – are these full episodes justified or indicative of an effort to pass the LUPA threshold?

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COMPLIANCE

- Episode trends – continued
  - **Episodes that barely exceed the Therapy Threshold** – Is the therapy justified?
  - **Cancelled RAP's** – If RAP's are regularly cancelled and re-submitted, what is the reason?
  - **Diagnosis coding** – has the diagnosis code profile changed over time?

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COMPLIANCE

- Episode trends – continued
  - **Average episode revenues** – are episode revenue increases (and related case mix weights) justified?
  - **Gross episode profits** (episode payments minus direct costs)– If episodes profits are climbing, is this indicative of greater efficiencies or reduced care ?

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COMPLIANCE

- Cost reporting
  - Areas of risk include:
    - Incorrect answers on the form 339 questionnaire
    - Proper disclosure and adjustment for related party transactions
    - Exclusion of non-reimbursable costs
    - Non-reimbursable cost centers
    - Methods of allocating administrative and general costs

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COMPLIANCE

- Cost reporting - care should be taken in answering form 339 questions
  - If a discrepancy is found in the cost report, incorrect 339 answers may elevate provider exposure and the exposure of the agency administrator.

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COMPLIANCE

- Cost Reports - related party transactions
  - General -Any service, product or rent paid to a related entity or person (other than through payroll) must be disclosed including ownership %, charge to agency and cost to provide service, product or space by the related party
  - Related party charges are generally reduced to cost (with exceptions)

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COMPLIANCE

Cost reports – non-reimbursable costs must be excluded. Examples include but are not limited to:

- Advertising to attract patients
- Marketing salaries or cost related to marketing time spent by employees spent in the effort to attract patients.

COMPLIANCE

Cost reporting – examples of non – reimbursable costs - continued

- Adjustment to straight line depreciation
- Non reimbursable interest expense
- Late fees and penalties
- Political and lobbying costs
- Etc.

COMPLIANCE

Cost reports - non- reimbursable cost centers

- Any activity or service that is not similar to home health services (skilled services tracked via visits) such as:
  - Hospice
  - Private duty nursing
  - Personal care services
  - Residential care facilities
  - Etc.

COMPLIANCE

Cost reports – non-reimbursable cost Centers should be accounted for as separate business lines on the cost report, Schedule A and not treated as non Medicare visits on form S-1.

COMPLIANCE

Cost reports - administrative and general cost allocation methods

- Must use “Step Down” unless another more accurate method is pre-approved

COMPLIANCE

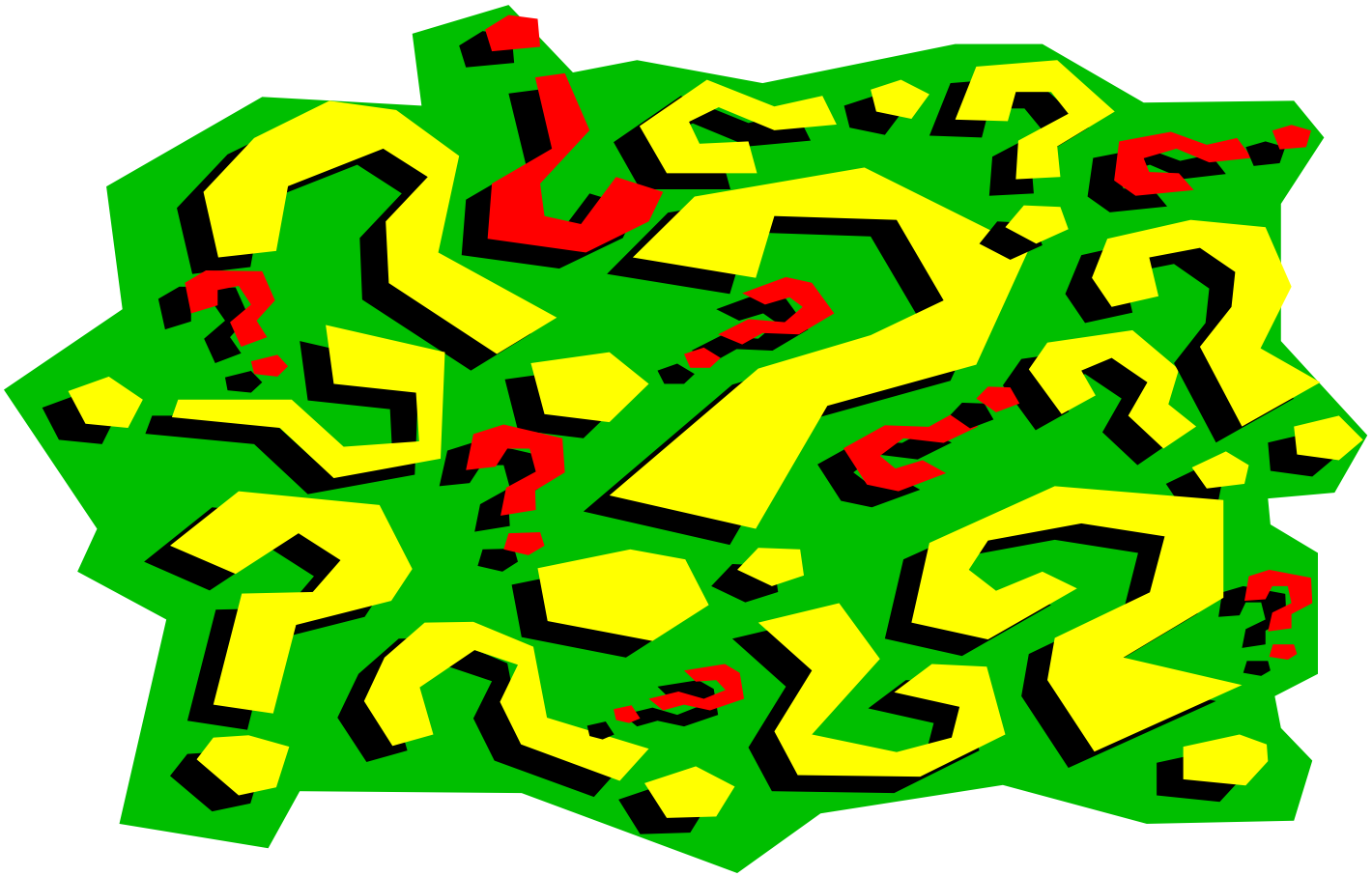
Other things to worry about

- Kick backs – anything of value in exchange for a referral
- STARK – ownership and relations with referral sources

COMPLIANCE

- You know the risk areas, now what?
  - Develop an effective compliance plan!
  - Policies and procedures
  - Designate a compliance officer
  - Training and education
  - Effective lines of communication
  - Disciplinary guidelines
  - Internal auditing and monitoring
  - Respond promptly to detected offenses

QUESTIONS



THANK YOU

Hooper Cornell, P.L.L.C.
250 Bobwhite Court
Suite 300
Boise, Idaho 83706
Phone: (208) 344-2527
Fax: (208) 342-0030
hcare@hoopercornell.com
www.hoopercornell.com