Compliance in Home Health & Hospice – It’s in Everyone’s Best Interest

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HCCA 2013 Hawai‘i Regional Conference

Aloha kakou!

Compliance in Home Health & Hospice – It’s in Everyone’s Best Interest

Who’s in the room...
Objectives

1. Understand some of the key compliance risks for Home Health and Hospice Agencies
2. Understand which of these risks are impacted by other providers
3. Learn how to assist Home Health and Hospice Agencies prevent certain compliance risks

Hot Topics
- OIG
- NGS
- TCG

On-Notice: OIG 2013 Work Plan

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October 2013

Overview: Hawai’i
Hawaii Utilization Lags National Levels

% Deaths on Hospice

% HH Utilization

Proposed Flow
1. Getting Started/Context
2. Home Health
   • Hot Topics for Interfacing Providers
   • Tips
3. Hospice
   • Hot Topics for Interfacing Providers
   • Tips
4. Q&A

What is the home health benefit?
Patient must be:
• Under the care of a doctor and have order for HH services
• In need of skilled care
• Homebound
On-Notice: OIG- Home Health

- Home Health Face-to-Face Requirement *(2)*
- Homebound Requirements *
- Provider Compliance and Beneficiary Eligibility *
- Duplicate Payments by Medicare and Medicaid
- Employment of Home Health Aides With Criminal Convictions
- Missing or Incorrect Patient Outcome and Assessment Data
- Home Health Prospective Payment System Requirements
- States' Survey and Certification
- Medicare Administrative Contractors' Oversight
- Trends in Revenues and Expenses

On-Notice: NGS CERT Reporting

Home Health (September 2013)

#1 denial reason: documentation of Face-to-Face requirements*

State error rates: 35% to 62%

- Does not explain homebound status or clinical need for nursing or therapy services adequately
- Preprinted statement about homebound status

On-Notice: Other TCG Findings

Home Health and Hospice

Physician signatures: illegible, missing, undated *

Home Health

Home Health Therapy compliance with 13th/19th functional reassessment visit
**Hot Topics at HH Interface**

- Home Health Face-to-Face Requirement
  - Timing
  - Need for skilled services
  - Homebound Requirements
- Physician signatures: illegible, missing, undated

**HH Face-to-Face Requirement**

**Timing**

Encounters must occur either:

- within the 90 days before beneficiary starts home health care
- up to 30 days after care begins

(42 CFR § 424.22.)

**Insufficient documentation of clinical findings by the physician/non-physician practitioner to show:**

- The encounter was related to the primary reason for home care
- How the patient’s condition supports the patient’s homebound status; AND
- How the patient’s condition supports the need for skilled services
**HH Need for Skilled Services**

**CONDITION**

**INSUFFICIENT**
- "Family is asking for help"
- "Continues to have problems"
- List of tasks for nurse to do
- "Patient unable to do wound care"
- "Diabetes"

**SUFFICIENT**
- Skilled nurse visits to perform wound care and assess wound status.
- Nurse to assess respiratory status for s/s of recurring infection/changes in respiratory status.

**INSUFFICIENT**
- "Functional decline"
- "Dementia" or "confusion"
- "Difficult to travel to doctor's office"
- "Unable to leave home"
- "Unable to drive"

**SUFFICIENT**
- "Patient on bed to chair activities only."
- "Short of breath with talking and ambulation of 1-2 feet."

**HH Homebound Requirement**

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**HH Physician Signatures**

**Signatures**
Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.

**Date**
the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ordered.

**Attestations**
Reviewers shall not consider attestation statements where there is NO associated medical record entry.
In those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date, an attestation can be used to clarify the identity associated with an illegible signature but cannot be used to "backdate" the plan of care.
### HH Physician Signatures

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legible full signature</td>
<td>Initials NOT over a typed/printed name</td>
</tr>
<tr>
<td>Legible first initial and last name</td>
<td>Unaccompanied by:</td>
</tr>
<tr>
<td>Legible signature over a typed or printed name</td>
<td>a) a signature log, or</td>
</tr>
<tr>
<td>Legible signature where the other information on the page indicates the identity of the signator</td>
<td>b) an attestation statement</td>
</tr>
<tr>
<td>Illegible signature NOT over a typed/printed name and NOT on letterhead, but accompanied by:</td>
<td>Unsigned typed note with or without provider’s typed name</td>
</tr>
<tr>
<td>1) a signature log, or</td>
<td>Signed handwritten note, the only entry on the page</td>
</tr>
<tr>
<td>2) an attestation statement</td>
<td>Signature stamp</td>
</tr>
<tr>
<td>“signature on file”</td>
<td></td>
</tr>
</tbody>
</table>

### Hot Topics at HH Interface

- **Home Health** Face-to-Face Requirement
  - Timing
  - Need for skilled services
  - Homebound Requirements
  - **Physician signatures:** illegible, missing, undated

### Proposed Flow

1. Getting Started/Context
2. Home Health
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3. Hospice
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4. Q&A
What is the hospice benefit?

Patient must be:
- must be entitled to Part A of Medicare
- be certified as being terminally ill (life expectancy is 6 months or less if the illness runs its normal course)
- waive all rights to Medicare for treatment related to the terminal condition

On-Notice: OIG- Hospice

- Acute-Care Transfers to Inpatient Hospice Care *
- Marketing Practices and Financial Relationships with Nursing Facilities *
- Compliance With Reimbursement Requirements (Certification Documents, Eligibility – Physicians)*
- General Inpatient Care (SNFs, Hospitals)*

On-Notice: Other TCG Findings

Home Health and Hospice
Physician signatures: illegible, missing, undated *

Hospice
Hospice certification of terminal illness (physicians) *
Hospice IDT meetings to review the plan of care – core team, documented dates
Clinical documentation supports terminal prognosis: failure to utilize records from outside sources to support dx and prognosis, such as hospital/SNF H&Ps, lab tests, etc. *
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**Hot Topics at Hospice Interface**
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- General Inpatient Care (SNFs, Hospitals)*
- Physician signatures: illegible, missing, undated *

**Hospice-NF Relationships**

**AVOID**
- “A hospice offering free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice”
- “A hospice referring its patients to a nursing home to induce the nursing home to refer its patients to the hospice”
- “A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home”

**SAFE**
- “Relationship building activities with Hospice & NF leadership and staff”
- “Integrating hospice staff and volunteers into the NF team and culture”
- “A hospice provide education to the NF staff on subjects, such as, pain and symptom management, death and dying, advance directives, cultural aspects of death and dying, spiritual care”

**Reimbursement Requirements**

Be certified as being terminally ill (life expectancy is 6 months or less if the illness runs its normal course)
- Attending
- Timing – within 2 calendar days

Face to Face requirement starting 3rd benefit period

Documentation provides support for the terminal illness
Terminal Illness

**CRITERIA +**

**INSUFFICIENT**
- "Alzheimer’s, elderly – needs assistance with all ADLs"
- "Prostate cancer, still independent and traveling"
- "End stage CHF, ejection fraction 40%, independent in all ADLs"

**SUFFICIENT**
- "Alzheimer’s, no meaningful communication, needs help with all ADLs & 10% weight loss in last 6 months"
- "Prostate cancer with mets, unable to perform ADLs, mostly bedbound"
- "End stage CHF, ejection fraction < 20%, dependent, Hx of cardiac arrest"

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General Inpatient Care

- General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings
- Expect to see medication adjustments or other treatment interventions

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General Inpatient Care - Initial

- Document what was done in home setting to address problems before transfer to GIP LOC
- Document involvement in decision to transfer to GIP
  - IDT
  - Hospice physician
  - Attending physician
- Document discharge planning from the start of GIP LOC

**Tip:** Develop admission criteria/algorithm for GIP for use with hospice staff and referrals sources
**General Inpatient Care - Ongoing**

- Describe comprehensive assessments and uncontrolled symptoms that can only be addressed at a GIP LOC
- Document monitoring and response to interventions
- Update POC to reflect changing care needs
- Document justification for continuing need for GIP LOC daily (changing needs, uncontrolled symptoms, monitoring, interventions)

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- Marketing Practices and Financial Relationships with Nursing Facilities *
- Compliance With Reimbursement Requirements (Certification Documents, Eligibility – Physicians)*
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Questions/discussion...

Aloha kakou!

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