Home Health Prospective Pay System

- Payment methodology for certified home health implemented October 2000
- Affects Part A payment only
- Consolidated billing
  - Services, supplies, wound care treatments
- 60-Day Episodic Reimbursement System
- Requires OASIS (Outcomes & Assessment Information Set)
- Proposed PPS Reform Rule 4/27/07
  - Rule is labeled “SIGNIFICANT”

PPS BILLING BASICS

- Payment includes all services and supplies under a home health plan of care
  - DME excluded from home health bundling
  - 178 non-routine medical supply codes
  - Diabetic supplies excluded
  - Osteoarthritis drug excluded from payment but bundled

Episodic Reimbursement System

- Episode set at 60 day intervals
- Unlimited episodes
- Definition of episode
  - An episode begins with the first billable visit and ends with the 60th day from start of care
  - Subsequent episodes will begin on day: 61, 121, 181, etc.
  - Prospective Payment covers one individual regardless of number of days of care within the episode unless the following exceptions occur:
Special Payment Circumstances

- **LUPA (Low Utilization Payment Adjustment)**
  - Less than 5 visits occur during the episode
- **PEP (Partial Episode Payment)**
  - If a patient transfers to another agency or is discharged and readmitted during the same episode
- **Outliers**
  - Loss-sharing ratio
  - 5% of national total episode payment
- **SCI C (Significant Change in Condition)**
  - there is an unexpected major decline or improvement in the patient's condition,
  - the payment is affected, and POC changes
  - Optional; requires case by case evaluation

OASIS Assessment

- Required at start of episode, resumption of care, significant change in condition, and end of episode
  - Specific time frames required for each assessment
- 93* items make up current version
- Medicare payment is determined by
  - 80 HHRG (Home Health Resource Group) Items
    - Going to 153
- Assessment items grouped by
  - Clinical (C), Functional (F), and Service (S) Domains

HHRG OASIS Reimbursement

- **Clinical Domain (C)**
  - MO230/245 Primary DX, MO240(b) Secondary DX
    - Orthopedic, neurological, diabetes, trauma codes
  - Wounds
    - MO450/460 pressure ulcers
    - MO476 stasis ulcers
    - MO488 wounds
- **Functional Domain (F)**
  - MO650, MO660, MO670, MO680, MO690, MO700
    - Dressing, Bathing, Toileting, Transfers, and Locomotion
- **Service (S)**
  - MO175 Inpatient discharges in the past 14 days
    - (Inpatient rehabilitation, skilled nursing facility)
  - MO825 - 10 or more therapy visits
    - Therapy Thresholds at 6, 14, and 20 visits

HHRG - HIPPS - RAP - FINAL

- HHRG translated to HIPPS code for billing purposes
- Payments are case-mix and wage adjusted
- Reimbursement split into Request for Anticipated Payment (RAP) and Final Claim
  - Initial RAP payment 60% of reimbursement
  - RAP payment 50% with subsequent episodes
  - RAP not considered claim except for purposes of False Claims Act

HHRG TO HIPPS

- First position: always "H"
- 2-4 position

<table>
<thead>
<tr>
<th>Domain Level</th>
<th>Position 2</th>
<th>Position 3</th>
<th>Position 4</th>
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<tr>
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<td>C0 = A</td>
<td>F0 = E</td>
<td>S0 = J</td>
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<tr>
<td>Low</td>
<td>C1 = B</td>
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<td>S1 = K</td>
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<tr>
<td>Moderate</td>
<td>C2 = C</td>
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<tr>
<td>High</td>
<td>C3 = D</td>
<td>F3 = H</td>
<td>S3 = M</td>
</tr>
<tr>
<td>Maximum</td>
<td>F4 = I</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C0F0S0J = Lowest Case-Mix Adjustment (0.52560)
C3F4S3M = Highest Case-Mix Adjustment (2.81130)
HHRG Calculation Example
Clinical Severity Score: 11 - Low
Functional Status Score: 0 - Min
Service Utilization Score: 0 - Min
HHRG Group: C1F0S0
Case Mix Weight: 0.6131
MSA or Rural Area: 5600
Wage Index Rate: 1.4461
PPS Total: $1681.63

Clinical Severity Score: 10 - Low
Functional Status Score: 26 - High
Service Utilization Score: 4 - Mod
HHRG Group: C1F3S2
Case Mix Weight: 1.7677
MSA or Rural Area: 5600
Wage Index Rate: 1.4461
PPS Total: $4848.50

Conditions of Participation - COPs
► Skilled Care (RN, PT, SLP)
► Reasonable and Medically Necessary Care
► Intermittent Services
  ▪ No 1-time only visits
  ▪ Can be daily for short duration
► Homebound
► Services provided in a place of residence
► Plan of Care (Form 485)

PLAN OF CARE (POC)
► POC must be completed prior to provision of care
► Must indicate:
  ☑ Type of Services
  ☑ Duration and Frequency of all services
  ☑ Treatment orders
► May be verbal order initially
► With subsequent episodes of care, new or updated POC required, along with new orders
► Intermittent and other verbal orders received during episode of care modify the POC
► Physician MUST sign the Plan of Care and all verbal orders prior to final claim submission

Enrollment in Hospice
Any patient who is eligible for Medicare (Part A) is eligible to elect the hospice benefit.

Beneficiary must have:
► A prognosis of less than 6 months or less if the disease runs its normal course.
► Certification of the terminal illness by two physicians (attending physician and medical director of hospice)
► A Statement of choice by the beneficiary choosing hospice rather than a curative treatment.

Hospice Reimbursement
Veterans Affairs covers hospice through a contracted rate. Managed care also covers hospice typically at the same reimbursement level. Most commercial health plans have some type of hospice coverage or will negotiate on a case-by-case basis. Covered by Medicaid in 43 states and the District of Columbia. Enacted in 1982 under the Tax Equity and Fiscal Responsibility Act (TEFRA).

### Services Covered

- **Core Services**
  - Nursing
  - Medical Social Work
  - Counseling (bereavement, dietary, spiritual)
  - Physician
- **Other Services**
  - Home Health Aide
  - PT, OT, ST services
  - Medications related to the terminal diagnosis
  - Durable medical equipment including oxygen
  - All diagnostic and therapeutic services needed to manage the terminal diagnosis.
  - Transport
  - General inpatient hospital/ SNF care related to the terminal diagnosis
  - Volunteer

### Hospice Reimbursement

- Hospice Reimbursement is defined by Medicare.
- Continues to be the most comprehensive benefit for end-of-life care available.
- Covered by Medicaid in 43 states and the District of Columbia.
- Most commercial health plans have some type of hospice coverage or will negotiate on a case-by-case basis.
- Managed care also covers hospice typically at the same reimbursement level.
- Veterans Affairs covers hospice through a contracted rate.

### Reimbursement Requirements

- Establishment of Initial Plan of Care:
  - Verbal orders obtained within 48 hours of admission by attending physician and medical director.
  - Written signatures by attending physician and medical director within 8 days of admission.
- Notice of Election by Beneficiary Selecting Hospice.
- Consent for Hospice.
- Notice of Election by state (Medicaid).
- Establishment of Level of Care for each day provided.
- Specific payor authorizations may be needed.
- Invoices may be provided electronically to the Fiscal Intermediary.

### Limitations

- **Per Beneficiary Limit**
  - Calculated annually representing the total that may be reimbursed to a hospice for the total number of beneficiaries served.
  - 2006 PBL Cap: $20,585
- **GIP Cap**
  - No more than 20% of the days of care provided by the hospice in total may be billed as General Inpatient Care.

### Hospice Benefit Reimbursement

- The actual amount paid by Medicare is per diem established on a regional basis adjusted to the labor costs.
- Four Levels of Care:
  - **Routine Home Care**: Provided to patients at home (patient defines home).
    - Rate about $125 per day
  - **Continuous Care**: Covers care during crisis in the patients home for short durations. Rate hourly for 24 hours (no less than 8 hours of professional services up to 24 hours in a day).
    - Rate for 24 hours about $750
  - **General Inpatient Care**: Covers acute episode of care in hospital or SNF for pain and symptom management for short durations.
    - Rate about $600 per day
    - **Respite Care**: Cover a maximum of 5 days during a benefit period for family relief.
      - Rate about $130 per day

### Special Considerations

- Invoices will only be reimbursed in a chronological fashion.
- Additional documentation required for each benefit period (90-90-60-60-unlimited).
- Reviews of records may occur at any time known as Additional Request (ADRs).
Compliance - Impact on Reimbursement

- Informed Consent (unrelated to payment)
- Election of the Hospice Benefit
- Certification of Terminal Illness
- Interdisciplinary Team (IDT) Documentation

Informed Consent

- Unrelated to reimbursement for services
- Indicates that a person has been given relevant facts and has the capacity to understand the facts and the implications of giving consent
- Protective for healthcare providers

Election of the Hospice Medicare Benefit

- Signed by the beneficiary or his/her representative
- Specific elements are required
- Signed election must be completed BEFORE claim submission

Election Compliance Challenges

- No provisions for verbal elections
- Claims may be denied if the election statement does not include the required elements

Certification of Terminal Illness

- Hospice providers are required to:
  - Obtain written certification of terminal illness (COTI) for each benefit period
  - If a written COTI cannot be obtained within 2 calendar days after a period begins, a verbal COTI must be obtained and DOCUMENTED within these same 2 days
  - Obtain the written COTI before submitting a claim for payment

COTI Compliance Challenges

- Obtaining and documenting the verbal COTI
- Ensuring timeliness of MD signatures
- Sufficient IDT documentation to support eligibility throughout the course of care, including recert discussions
**IDT Documentation**

- Hospices are required to designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.
- Establish, review and update the plan of care.
- Supervise the care and services.
- RN must coordinate the plan of care.

**IDT Documentation Challenges**

- Documenting care planning...not care reporting.
- Documenting resolution of problems.
- Documenting individualized plans of care.
- Documenting input from all disciplines.
- If it isn’t documented, it didn’t happen!!!!

**Hot Topics in Hospice Compliance**

- General Inpatient (GIP) level of care—what is for and where can it be provided?
- Continuous Care—under utilization, documented medical necessity?
- Hospice in nursing facilities?

**Compliance Trends**

- Closer scrutiny of Medicare Hospice providers due to the tremendous growth in overall spending over the last few years.
- Increasing ADRs (Additional Development Request).
- Increasing frequency of Probe Audits.

**Know the Regulatory Trends**

- TECHNOLOGY
  - Probe Edits
  - Measurable data (OASIS)
  - Increase state survey scrutiny
  - Recovery Audit Contractors (RACs)
    - Strong incentive to recoup $$$
- QUALITY & ACCESS
  - Outcomes
  - Pay for Performance
**Watch Government Activities**

- What are hot topics for the Government
  - Centers for Medicare Services (CMS)
  - Office of Inspector General (OIG)
  - Department of Justice (DOJ)
  - State Attorney General
- OIG and DOJ recent investigations
  - Medical necessity of homecare therapy
  - Billing errors – MD Care Plan Oversight

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**2007 OIG WORK PLAN**

**Home Health**

- Home Health Outlier Payments
  - Frequency & cluster in HHRGs
- Enhanced Payments for Therapy
  - Analyze # and duration of visits/episode
- Cyclical Non-Compliance of Surveys
- Accuracy of Data on HH Compare
- Coding Accuracy for HHRGs
- Medical Necessity of Therapy

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**Fiscal Intermediary**

- Focus Areas
  - Analysis of ADRs, Denials, Down-codes
- Resources
  - Website & Publications
    - Clarification of Regulations
    - Tips on answering OASIS $$ questions
- Directives from CMS
  - “MedLearn Matters”
    - Free On-line Education

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**OIG Compliance Guidance**

- Implement 7 Fundamental Elements
- Need to coordinate your P & P with appropriate training & educational programs
- Emphasis on areas of risk identified by the OIG
  - 31 identified areas of concern - HH
  - 29 identified areas of concern - Hospice
**OIG Clinical Risk Areas - Home Health**

- Billing for services not provided
- Billing for medically unnecessary services or patients or not homebound
- Insufficient documentation to support reimbursement
  - OASIS
- False dating of amendments to nursing notes
- Falsified Plans of Care

**OIG Clinical Risk Areas - Hospice**

- Admitting non-terminally ill patients
- Falsified medical records or POC
- Untimely and/or forged physician certifications on POC
- Inadequate services by IDG
- Insufficient oversight of patients on service 6 months or more
- Overlap in services with nursing home
- Billing for higher level of service

**Use Your Compliance Plan**

- Establish Strong Corporate Culture
- Support the culture
- Provide Checks & Balances

**Corporate Culture**

- Code of Conduct
  - Verbal/Written expression of your organizational culture
- Education and Buy-in of Board & Top Management
  - Policies
  - Responsibilities
- The message needs to be clear:
  - “Do the Right Thing”
**Systems to Support Culture**

- **Adequate Staffing**
  - Oversight of case management
  - Avoid the desire to cut corners
- **TOOLS to do the job efficiently**
- **Documented Procedures**
  - Train to a procedure
  - Allows staff to “Say what they do & do what they say”
- **On-going Education**
  - Training on new regulations
  - Re-training on existing regulations

**Checks & Balances**

- **Data Analysis**
  - Monitor trends
  - Utilize accepted benchmarks for “early warning”
- **Internal Audits**
  - Clinical record review
  - Cross departmental audit
- **Employee Reporting**
  - Open lines of communication
  - Exit Interviews
    - Insist on completing as often as possible
  - Supervision

**Billing/ Claim Strategies**

**Electronic Billing**

- FISS is a process that allows remote users online connectivity to the Fiscal Intermediary Standard System (FISS), or mainframe, used by RHHI to process Medicare claims.

**Through FISS you can...**

- Enter UB92 claims
- Correct electronic claims
- Correct paper claims
- Track all claims through the processing system
- Access the Common Working File (CWF) through HIQH (Health Insurance Query for HHAs)
- View check number, date, & amount of your last 3 payments
- Review files for inquiry purposes, i.e. diagnosis codes, revenue codes, ANSI reason codes
- View claims selected for additional review & information requests

**Claims Summary Inquiry**

- Weekly check of the Claims Summary Inquiry screen
  - Displays specific claim history information for all pending and processed claims.
  - Check for claims in pending status:
    - Return to Provider (RTP)
    - Medicare Secondary Payer (MSP)
    - Medical Review claims
Additional Development Request (ADR)

- Definition: a billing transaction that fails a medical review edit while processing in FISS
- Bill suspends to S/LOC SB6001
- Documentation requested to support services billed
- Medicare medical review nurse will review documentation to make payment determination.
- Print ADR letter and forward to the clinical department per your agency procedures.
- Documentation must be submitted within 45 days or the bill is automatically denied.
- Check for ADR requests at least weekly

Most Common Denial Reasons - Home Health

- Medical Review Down-Code
- Lack of response to ADR
- Documentation does not support medical necessity
- Denials related to Physician Orders
  - POC/Verbal Orders not signed and/or dated timely
  - No physician orders for services provided
  - Incomplete Orders
    - Discipline, Frequency/Duration, Treatment, PRN
- Visits/Supplies/DME billed not documented

Most Common Denial Reasons - Hospice

- Not hospice appropriate based on documentation submitted
- Initial Certification not signed timely by both the Medical Director and Attending Physician
- Certification did not cover all dates billed
- Documentation submitted for review did not include Certification of Terminal Illness

OASIS: Compliance Pitfalls

- Most common areas identified with inconsistencies:
  - Facility Discharge MO175
  - Primary Diagnosis MO230
  - Pain MO420
  - Dyspnea MO490
  - Incontinence MO530
  - Wounds MO450/460, MO476, MO488

Basic Coding Guidelines

- Determine the principal diagnosis
  - Represents the most acute condition
  - Requires the most intensive services
- All services/treatments should be substantiated by a diagnosis
- Code all documented diagnoses that coexist and require or affect patient care
- Exclude secondary diagnoses that have no bearing on current episode POC
- Avoid listing diagnoses that are of mere historical interest
- No surgical codes
  - Medical diagnoses only if still applicable
  - V Code may be appropriate
THERAPY MO825
► High Risk Area
► Can affect reimbursement up to $2,000
► Automatic Down-Code for not meeting 10 visit threshold
► Agency responsible for adjusting MO825 if therapy threshold met
  ▪ Greatest potential for lost revenue
► Inaccurate Management Reports
  ▪ Overstated average case-mix weight

HOSPICE
Compliance Pitfalls
► Election date not specified by beneficiary or designee
► CTI not signed/dated timely
► Initial POC not established by other IDG members
► Documentation does not support terminal illness
  ▪ Local Coverage Determination (LCDs)
► Bereavement POC at admission – risk level
► Fulfillment of professional management
  ▪ Nursing Home & Inpatient Facilities

FOCUS AUDITS
► Government & FI Focus Areas:
  ▪ Probe Edits
  ▪ HH - Therapy, Coding
  ▪ Hospice - GIP, LOS, Soft DX, NH
Definitive Billing Risk
  ▪ Home Health
    ► MD Orders
    ► Visit Notes
  ▪ Hospice
    ► Certification of Terminal Illness (COTI)
    ► Benefit Election

Question and Answer Session
► Robin N. Seidman, RN, BSN, MSN, MBA, LNCC
  Director, Simione Consultants, LLC
► Betty Brennan
  CEO, Beacon Hospice Inc.
► Connie Woodworth
  CFO/Compliance Officer, Hospice of the North Shore, Inc.
► Larry Vernaglia, Moderator
  Partner, Health Care Industry Team, Foley & Lardner, LLP