Missouri Alliance for HOME CARE

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Melony,

In This Edition:

Action Alert: Contact Your Members of Congress to Cosponsor the Home Health Care Planning Improvement Act of 2015

Neither of Missouri's Senators have cosponsored the bill. Only three Missouri Congressmen have signed: Sam Graves, Blaine Luetkemeyer and Lacy Clay. We have our work cut out for us in MO. Please use NAHC's Legislative Action Center to contact them to cosponsor the bill right away. *Summary of the Home Health Care Planning Improvement Act of 2015 (S. 578/H.R. 1342). This only takes a minute or two. Call and follow up if possible. We need both Senators and all 8 Congressmen from MO to sign on.*

From NAHC Report: Currently, 34 members of the U.S. Senate and 126 members of the U.S. House of Representatives have indicated their support for the Home Health Care Planning Improvement Act of 2015 (S. 578/H.R. 1342). Most recently, on July 13 eight members of the U.S. House of Representatives joined the bill as cosponsors.

The National Association for Home Care & Hospice (NAHC) is continuing to visit members of the Senate to build support, including meetings this week with the offices of Senators Pat Toomey (R-PA), John Hoeven (R-ND), Rand Paul (R-KY), and John McCain (R-AZ). Last week, NAHC's government affairs staff met with the offices of Senators Tim Scott (R-SC), Deb Fischer (R-NE), and Tom Cotton (R-AR).

NAHC in coordination with other organizations supporting the bill continues to pursue the goal of 40 cosponsors for the Senate bill and as many as possible for the House bill. NAHC is working with key champions in Congress to receive a Congressional Budget Office score of the legislation and technical assistance from the Centers for Medicare & Medicaid Services so that the bill can move forward in the Committee process. More Congressional cosponsors would increase the likelihood of the bill being included in a future Committee markup so NAHC has set the attainable goal of 40 supporters in the Senate.

Nurse practitioners and physician assistants are currently authorized to work in states either independently or in coordination with physicians to treat, diagnose, and prescribe medicine. However, they are unable to order home health care services.

The fact that non-physician health professionals are unable to certify home health services is increasingly a problem because more and more people are receiving home-based care from non-physician health professionals. As a result, patients face the burden of first visiting an unknown physician in order to receive home health care.

NAHC strongly supports this legislation, which will reduce expensive hospitalizations and nursing home stays. "Outside experts assessed the impact of the bill earlier last year and projected a Medicare savings of $7.1 million in 2015 and up to a ten-year savings of $252.6 million," stated a letter in support of the legislation from leading senior and disability advocacy groups including NAHC. "This analysis also notes the potential to reduce beneficiary admissions to and lengths of stay in institutional settings under the policy change."

KEPRO Phone Change

Over the last year, in compliance with the CMS contract, KEPRO has accepted forwarded calls from each state based QIO's beneficiary appeal/quality of care (QOC) toll free number. CMS requested that we implement this during the first year of the contract to help with the transition.

As of August 1, 2015 the calls to the state based QIOs toll free number for ***appeals and QOC*** concerns will no longer be forwarded to KEPRO. Additionally, the toll free numbers that were in effect prior to August 1, 2014, the state based QIOs appeals/QOC concerns, will no longer work starting August 1, 2015.

Please keep in mind that this change only affects the state based QIO toll-free number that was *used for beneficiary appeals, such as discharge, and Quality of Care concerns.* Some Area 4 states still work with the same state based QIO as they were awarded the QIN contract. You need to touch base with your QIN concerning questions associated with other numbers they have in place. QIN-QIO in Missouri: TMF sub-contracted to Primaris.

With this change it is imperative all providers have KEPRO information on their forms.

KEPRO Area 4 toll-free number: 855-408-8557

If you have any questions please contact me. You can also visit our website, www.keproqio.com, for additional information.

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CMS Releases Star Ratings on Home Health Compare

On Thursday, July 16, the Centers for Medicare & Medicaid Services (CMS) published the first round of star ratings on the Home Health Compare web site.

"Adding star ratings to Home Health Compare is another step forward in our continuing efforts to empower consumers by providing more information to help them make health care decisions, while also encouraging providers to strive for higher levels of quality," said Dr. Patrick Conway, Acting Principal Deputy Administrator for CMS and Deputy Administrator for Innovation and Quality.

Ratings are based on agencies' relative performance on 9 of the 29 quality measures including:

- How often the home health team began their patients' care in a timely manner.
- How often the home health team made sure that their patients have received a flu shot for the current flu season.
- How often the home health team taught patients (or their family caregivers) about their prescribed drugs.
- How often home health patients got better at walking or moving around.
- How often home health patients got better at getting in and out of bed.
- How often home health patients had less pain when moving around.
- How often home health patients got better at bathing.
- How often home health patients' breathing improved.
- How often home health patients had to be admitted to the hospital.

CMS recently released information on corrections to the second round of star ratings scheduled to be published on October 8, 2015. The National Association for Home Care & Hospice has expressed concern about the Star Ratings and the methodology used.

More information about the CMS announcement is available here.

Further information about the Home Health Quality of Patient Care Star Ratings is available on the CMS Home Health Star Ratings web site.

Senators Seek to Reform Home Health Face-to-Face Physician Documentation Requirement

Senators Robert Menendez (D-NJ) and Pat Roberts (R-KS) are working on legislation to reform the home health face-to-face physician encounter documentation requirement. The Senators demonstrated their commitment to addressing the issue in June by introducing a bill (S. 1650), and they are continuing their efforts to improve the bill in order to ensure it

resolves serious concerns with the existing face-to-face requirement and its impact on patient care.

Both Senators have expressed the need for legislation in order to reform the existing requirement. “The existing home health face-to-face requirement is simple in theory, but has proven unworkable in practice,” said Senator Menendez in a statement regarding his efforts to reform the face-to-face requirement.

“I’ve been concerned the face-to-face encounter requirement would be particularly difficult for our most vulnerable beneficiaries, especially those in rural areas, and could limit access to care,” said Senator Roberts.

The current face-to-face encounter requirement to certify eligibility for home health services has resulted in substantial increases in home health claim denials and a backlog of appeals. Under a provision of the Affordable Care Act, a home health provider cannot bill Medicare for services to a home health patient unless the certifying physician has a face-to-face encounter with the beneficiary 90 days prior to the start of home health or 30 days after the start of home health. As part of this certification, CMS required physicians to document several detailed clinical findings in a narrative in order to support the need for home health services. CMS has since dropped the narrative requirement but replaced it with a physician documentation requirement that can be equally problematic.

As a result of the previous narrative requirement, Medicare has denied payment for thousands of home health services. Agencies and certifying physicians are now struggling to comply with the new physician documentation requirement. According to a nationwide home health provider survey, 52% of face-to-face claim denials resulted mainly from Medicare determining that the physician documentation was insufficient, even though medically necessary care was provided. The federal Office of the Inspector General (OIG) has recommended a more uniform method for physicians to document face-to-face encounters, based on the fact that physicians are experiencing difficulty complying with the cumbersome requirements. Seventy-five bipartisan members of Congress stated that the “complicated, confusing and overlapping documentation requirements … exceed the intent of the law passed by Congress.”

In June, Senators Menendez and Roberts introduced the Home Health Documentation and Program Improvement Act of 2015 (S. 1650) in an attempt to address the problem by reforming the documentation requirement. The legislation would require CMS to develop a standardized form for collecting evidence of a beneficiary’s eligibility for home health services. It allows a home health agency to complete the form that is then reviewed and signed by the referring physician. The bill exempts home health agencies from collecting documentation for beneficiaries who have been discharged from a hospital or skilled nursing facility within 14 days prior to the initiation of home health services. It also seeks relief from past claim denials.

Although the legislation allows the home health agency to fill out the form, it requires that a statement justifying eligibility for home health services must be included in the form. This sounds similar to the previous narrative requirement that CMS abandoned. The home health agency would be allowed to compose the statement for the physician, but NAHC is concerned that claims could still be denied based on a subjective determination that the statement is insufficient even when a review of the whole record would establish eligibility. This could result in technical denials of valid claims.

NAHC is working with the sponsors of the legislation to delete the bill's requirement of a statement and simply require that the physician document that the face-to-face encounter occurred. Stay tuned to NAHC Report for more developments in the ongoing campaign to obtain relief from the F2F documentation requirements.

In addition to seeking a legislative remedy, NAHC continues its legal challenge to the claim denials resulting from the Medicare home health services physician face-to-face narrative requirement.

CMS Issues Instructions for Medical Review on Home Health Certifications

The Centers for Medicare & Medicaid Services (CMS) released Transmittal 602; Change Request (CR) 9189, which provides medical review instructions on the certification and recertification requirements for home health services.

The CR instructs reviewers that the physician's entire medical record should be reviewed to determine if the eligibility criteria for home health services have been met. The physician's record must include information that supports all the required elements for certification including the need for skilled service, reason for homebound, and a valid face to face (F2F) encounter. The CR affirms that documentation from the home health agency (HHA) can be incorporated into the physician's record and is to be considered when determining eligibility for home health services:

> "….. *the patient's medical record must support the certification of eligibility. Documentation in the patient's medical record shall be used as a basis for certification of home health eligibility. Therefore, reviewers will consider HHA documentation if it is incorporated into the patient's medical record held by the certifying physician and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) and signed off by the certifying physician. The documentation does not need to be on a special form."*

Any documentation from the HHA that is incorporated into the physician's record must corroborate the physician's medical record for the patient and be "signed off" by the physician in a timely manner.

> *"The reviewer shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission."*

The CR contains an inconsistent definition for "incorporated timely." Business Section-9189.4 of the CR states that timely incorporation is when the documentation is "signed off" prior to or at the time of certification. However, in the body of the CR under section 6.2.3, it reads that "incorporated timely" is when the documentation is "signed off" prior to or at the time of claim submission. CMS has clarified for the National Association for Home Care & Hospice (NAHC) that timely incorporation is prior to or at the time of claim submission. CMS will revise the Business Requirement section to reflect section 6.2.3.

CMS will require that the initial certification requirements be met in order for subsequent episodes to be covered, regardless of whether the requirements for recertification are met. Therefore, agencies will be required to submit documentation from physician's record for the initial certification for home health services for any claim that is reviewed.

According to the CR, if the review contractor finds that the documentation in the certifying physician's medical record, including the HHAs incorporated documentation, is insufficient to demonstrate the patient is or was eligible to receive services under the Medicare home health benefit, payment on the home health claim will be denied.

CMS, in the CR, also states the requirements for recertification and reiterates that a recertification for home health services must include a statement by the certifying physician which indicates a continuing need for services and estimate how much longer the services will be required. NAHC was hopeful that CMS would allow the duration for services as ordered by the physician to meet this requirement. However, it is apparent from the CR that CMS intends to require a statement from the physician in addition to orders for visit frequency and duration.

Several of the Medicare contractors have instructed agencies that the physician should estimate how much longer services will be needed for the entire spell of illness for the patient. Therefore, the estimated time frame could be stated longer than the 60 day recertification period. Since this is a physician's estimate, the agency must obtain the information from the physician, but it can be an oral communication. CMS does not provide instructions to reviewers on how or where this statement needs to be located. The CR only states that "The contractor shall review for the certifying physician statement which must indicate the continuing need for services and estimate how much longer the services will be required." NAHC recommends that agencies either incorporate a statement within the certification statement for recertification or include a separate statement in the medical documentation where it is obvious to the reviewer, such as on the plan of care.

However the agency chooses to address this, it should be clear that it is part of the certification for continued services. If using a statement separate from the certification statement, NAHC recommends that agencies phrase the physician's estimation for services as a certification statement. For example: "I certify that in my estimation continued services will be required for _____." A statement for the estimation of services is required for each recertification regardless of how long the physician expects home health services will be needed.

NAHC also recommends that agencies provide as much information as possible to the certifying physician to be incorporated into his/her medical record. At a minimum, agencies should provide the certifying physician with the POC and pertinent sections from the comprehensive assessment, along with an admission summary of the why the patient is in need of skilled services and is homebound. Agencies should also confirm that a face-to-face encounter has occurred within the required time frame.

NAHC is concerned that CMS will be making initial coverage determinations based solely on the certification requirements contained in the physician's record, similar to when the narrative was required for the F2F encounter requirement. CMS will not likely make determinations for reasonable and necessary care based on the agency's medical record unless the certification requirements have been met.

Click hereto view the CR.

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