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This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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Agenda

• Root Cause Analysis
• Length of Stay Statistics
• Signs, Symptoms, and Ill-Defined Conditions
• Going Beyond Diagnosis
• Documentation to Support Homebound Status
• Medical Necessity
  • The Nursing Process
  • Therapy Medical Necessity
• Face to Face Encounter
• Change Management
Root Cause Analysis
It is a new day!
Times are Changing

I didn’t have any accurate numbers so I just made up this one.

Studies have shown that accurate numbers aren’t any more useful than the ones you make up.

How many studies showed that?

Eighty-seven.

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Health Information Supply Chain

The Health Information Supply Chain consists of three steps.

Step 1: Medicare beneficiary and provider encounter

Step 2: Coding and billing of claim

Step 3: Processing of claim by Palmetto GBA and use of information by CMS
Health Information Supply Chain

• The HISC begins with a healthcare encounter between a Medicare beneficiary and a provider.
• This encounter generates a record that is then used by a coder to translate the encounter into a form that a biller can use to communicate the reason for the encounter to Medicare.
• The biller does so through the submission of a Medicare claim that is then processed by Palmetto GBA.
Health Information Supply Chain

• CMS then uses the information to inform policy aimed at continuously improving the beneficiary-provider encounter.

• Having complete and accurate information in healthcare records is therefore the first step in the development of a HISC that will help Medicare providers continuously improve their services while supporting the Medicare Program.

Feliciano, Harry. The Importance of a Strong Health Information Supply Chain (HISC). May 29, 2012
Continuous Improvement Process

- An ongoing effort to improve products, services, or processes
- These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once

http://asq.org/learn-about-quality/continuous-improvement/overview/overview.html
Tracing a Problem to its Origins

• In medicine, it's easy to understand the difference between treating symptoms and curing a medical condition.

• When you're in pain because you've broken your wrist, you WANT to have your symptoms treated – now!

• Taking painkillers won't heal your wrist, and true healing is needed before the symptoms can disappear for good.

http://www.mindtools.com/pages/article/newTMC_80.htm
This Isn’t Jeopardy!

Figure 1: Jeopardy Game Show Host

Figure 2: Creating an innovative solution without having identified a problem.
Tracing a Problem to its Origins

• But when you have a problem at work, how do you approach it?
• Do you jump in and start treating the symptoms?
• Or, do you stop to consider whether there's actually a deeper problem that needs your attention?

http://www.mindtools.com/pages/article/newTMC_80.htm
Tracing a Problem to its Origins

• If you only fix the symptoms – what you see on the surface – the problem will almost certainly happen again... which will lead you to fix it, again, and again, and again.

• If, instead, you look deeper to figure out why the problem is occurring, you can fix the underlying systems and processes that cause the problem.

http://www.mindtools.com/pages/article/newTMC_80.htm
What Do You Do Now?

I don't get it...
I've been in this thing
for 20 years and still
haven't gotten anywhere.
What Do You Do Now?

• Determine what happened
• Determine why it happened
• Figure out what to do to reduce the likelihood that it will happen again
Root Cause Analysis

Root cause analysis (RCA) is a method of problem solving that tries to identify the root causes of faults or problems.

http://en.wikipedia.org/wiki/Root_cause_analysis
Primary Aim of Root Cause Analysis

To identify the factors that resulted in the nature, magnitude, location, and timing of consequences of past events in order to identify what behaviors, actions, inactions, or conditions need to be changed to prevent recurrence of similar harmful outcomes and to identify the lessons to be learned to promote the achievement of better consequences.

http://en.wikipedia.org/wiki/Root_cause_analysis
Three Basic Types of Causes

• Physical causes – Tangible, material items failed in some way (for example, a car's brakes stopped working).

• Human causes – People did something wrong, or did not do something that was needed. Human causes typically lead to physical causes (for example, no one filled the brake fluid, which led to the brakes failing).

• Organizational causes – A system, process, or policy that people use to make decisions or do their work is faulty (for example, no one person was responsible for vehicle maintenance, and everyone assumed someone else had filled the brake fluid).

http://www.mindtools.com/pages/article/newTMC_80.htm
DMAIC
DMAIC Step 1 – Define

The “D” in the DMAIC process focuses on selecting high-impact projects and understanding which underlying metric(s) will reflect project success.
Define

- The purpose of this step is to clearly articulate the business problem, goal, potential resources, project scope and high-level project timeline.
- Seek to clarify facts.
- Set objectives.
Define

• Define which metrics are most important

• Define:
  • The system
  • The voice of the customer
  • The project goals
Palmetto GBA Actions

• Research the CMS design requirements for addressing the potential or observed vulnerabilities

• Design requirements are typically contained in Medicare statute, regulation, manual/NCD instruction, or LCD

• Communicate them to providers
DMAIC Step 2 – Measure

The “M” in DMAIC is about documenting the current process, validating how it is measured, and assessing baseline performance.
Measure

• The purpose of this step is to objectively establish current baselines as the basis for improvement.

• This is data collection.
Measure

Good data is at the heart of the DMAIC process:

• Identify the gap between current and required performance.

• Collect data to create a process performance capability baseline for the project metric.

• Assess the measurement system for adequate accuracy and precision.

• Establish a high level process flow baseline. Additional detail can be filled in later.
Measure

• Measure historical performance.
• Measure key aspects of the current process and collect relevant data.
Palmetto GBA Actions

• Determine the relevant metrics that will be used to track improvement for providers selected for medical review.

• All error classes undergoing medical record audits will have impact severity risk maps constructed.
Communicating Risk

• Palmetto GBA uses a procedure that determines the inherent level of risk of an error-class based on a combination of financial risk and National or local audit experience.
• “Dollars at risk.”
• “Estimated error dollars” – the product of dollars at risk and either the locally corresponding Charge Denial Rate (CDR) measured by Palmetto GBA’s PCA process or the corresponding Claims Payment Error Rate (CPER) measured and reported Nationally by the CERT Contractor – are subjected to a weighting procedure that determines an “a priori risk score”.

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Impact Severity Priority

- High (Red)
- Medium (Yellow)
- Low (Green)
- Determined by mapping the risk category and the observed probability of denial in the sampled claims

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<th>Minor Risk</th>
<th>Moderate Risk</th>
<th>Major Risk</th>
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<td>0.81 – 1.0</td>
<td>Yellow</td>
<td>Red</td>
<td>Red</td>
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<tr>
<td>0.61 – 0.8</td>
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<td>Red</td>
<td>Red</td>
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<tr>
<td>0.41 – 0.6</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Red</td>
</tr>
<tr>
<td>0.21 – 0.4</td>
<td>Green</td>
<td>Yellow</td>
<td>Red</td>
</tr>
<tr>
<td>0.01 – 0.2</td>
<td>Green</td>
<td>Yellow</td>
<td>Yellow</td>
</tr>
</tbody>
</table>

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DMAIC Step 3 – Analyze

• The Analyze phase isolates the top causes behind the metric that the team is tackling.
• The Analyze phase deploys a number of tools for collecting team input and conducting objective experiments to identify or confirm top causes.
Analyze

• List and prioritize potential causes of the problem.
• Prioritize the root causes to pursue in the Improve step.
• Identify how the process inputs affect the process outputs.
Palmetto GBA Actions

• Conduct medical review to validate problem(s).
• Prioritize classes and subclasses of errors, and target interventions.
• Notify providers of results.
DMAIC Step 4 – Improve

The Improve phase focuses on fully understanding the top causes identified in the Analyze phase, with the intent of either controlling or eliminating those causes to achieve breakthrough performance.
Improve

• The purpose of this step is to identify, test and implement a solution to the problem; in part or in whole.
• Identify creative solutions to eliminate the key root causes in order to fix and prevent process problems.
• Create innovative solutions.
• Focus on the simplest and easiest solutions.
Improve

• Test solutions using Plan-Do-Check-Act (PDCA) cycle.
• Based on PDCA results, attempt to anticipate any avoidable risks associated with the “improvement”.
• Create a detailed implementation plan.
• Deploy improvements.
J. Edward Deming

- Dr. Deming, the famous quality guru, provided a simple yet highly effective technique that serves as a practical tool to carry out continuous improvement in the workplace.
- This technique is called PDCA Cycle or simply Deming Cycle.

J. Edward Deming

In the 1970s, Deming's philosophy was summarized by some of his Japanese proponents with the following 'a'-versus-'b' comparison.
J. Edward Deming

a) When people and organizations focus primarily on quality, defined by the following ratio, quality tends to increase and costs fall over time.

b) However, when people and organizations focus primarily on costs, costs tend to rise and quality declines over time.

Quality = Results of work efforts

Total costs

The Steps in PDCA Cycle

Plan
• Establish the objectives and processes necessary to deliver results in accordance with the expected output (the target or goals).

Do
• Implement the plan, execute the process, make the product. Collect data for charting and analysis in the following "CHECK" and "ACT" steps.

Check
• Study the actual results.

Act
• Request corrective actions on significant differences between actual and planned results. Analyze the differences to determine their root causes. Determine where to apply changes that will include improvement of the process or product.

Moen, Ronald; Norman, Clifford. “Evolution of the PDCA Cycle” Associates in Process Improvement
PDSA

Figure 1 displays the elements of the Plan, Do, Study, Act (PDSA) Cycle

PDSA Cycle, 1994

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Figure 2 displays the Model for Improvement in the Plan, Do, Study, Act cycle

Model for Improvement, 1996, 2009
If employees want to improve, they should ask themselves about following questions during the Planning phase of this cycle:

• What are we trying to accomplish?
• What changes can we make that will result in improvement?
• How will we know that a change is an improvement?

Palmetto GBA Actions

• Continued medical review
• One-on-one education via telephone conferences
• Educational articles
• Webcasts
• LCDs
DMAIC Step 5 - Control

The Control phase is about sustaining the changes made in the Improve phase to guarantee lasting results.
Control

The purpose of this step is to:

• Sustain the gains.

• Monitor the improvements to ensure continued and sustainable success.

• Create a control plan.

• Update documents, business process and training records as required.
Palmetto GBA Actions

• Utilize statistical process control methods to identify recurrent problems with providers that have experienced denials via the Progressive Corrective Action (PCA) process.

• Prevent new problems by systematically sampling new providers for known error-classes within their specialty/service type.
Let’s Look at the Numbers
Length of Stay Statistics

Data Analysis
Home Health – Starting Point

The map above shows the statistics based on the reports from the OIG and MedPAC.

- OIG Report OEI-04-11-00240 *Inappropriate and Questionable Billing By Medicare Home Health Agencies*
- Home Health Spending Per Capita (2012)
- Jonathan Blum (CMS) presented to all AB MACs on May 1, 2013
The areas where the Medicare home health benefit is utilized per enrollee from low to high in the J11 region.
The areas where the Medicare disbursement was made for the home health benefit per enrollee from low to high in the J11 region.
Home Health Category of Errors for Focus

Top weighted Home Health HIPPS (Health Insurance Prospective Payment System) codes ranked as a major risk:

• Focus on all states for greatest global impact
• Targeted focus of all identified counties of the J11 high risk states for tighter control of aberrant providers – based on:
  • OIG Report OEI-04-11-00220 CMS and Contractor Oversight of Home Health Agencies Dated December 2012
  • OIG Report OEI-04-11-00240 Inappropriate and Questionable Billing By Medicare Home Health Agencies Dated August 2012
  • Medicare Payment Advisory Commission (MedPAC) Report to The Congress Medicare Payment Policy Dated March 2013
• Home Health Beneficiary Edit
Focus on All States for Greatest Global Impact

• 2BGL: Early episode, 16-17 therapy visits, moderate score on clinical domain, moderate score on functional domain.

• 2BGM: Early episode, 18-19 therapy visits, moderate score on clinical domain, moderate score on functional domain.

• 4BGL: 3rd or later episode, 16-17 therapy visits, moderate score on clinical domain, moderate score on functional domain.

• 2AGM: Early episode, 18-19 therapy visits, low score on clinical domain, moderate score on functional domain.
Targeted Focus of All Identified Counties of The J11 High Risk States For Tighter Control of Aberrant Providers – OIG Report Dated December 2012

This report identified six cities within the J11 region with a high percentage of questionable billing identified by the OIG.
Targeted Focus of All Identified Counties of The J11 High Risk States For Tighter Control Of Aberrant Providers – OIG Report Dated December 2012

These are the cities that were targeted by the Strike Force for questionable billing.
Targeted Focus of All Identified Counties of The J11 High Risk States For Tighter Control of Aberrant Providers – OIG Report Dated December 2012

- 2CGL: Early episode, 16-17 therapy visits, high score on clinical domain, moderate score on functional domain.
- 2CHK: Early episode, 14-15 therapy visits, high score on clinical domain, high score on functional domain.
- 2CHL: Early episode, 16-17 therapy visits, high score on clinical domain, high score on functional domain.
- 4CGK: 3rd or later episode, 14-15 therapy visits, high score on clinical domain, moderate score on functional domain.
- 2CGM: Early episode, 18-19 therapy visits, high score on clinical domain, moderate score on functional domain.
- 4CGL: 3rd or later episode, 16-17 therapy visits, high score on clinical domain, moderate score on functional domain.
- 2CHM: Early episode, 18-19 therapy visits, high score on clinical domain, high score on functional domain.
Targeted Focus of All Identified Counties of The J11 High Risk States For Tighter Control of Aberrant Providers – OIG Report Dated December 2012

• 2BHL: Early episode, 16-17 therapy visits, moderate score on clinical domain, high score on functional domain.

• 2BHM: Early episode, 18-19 therapy visits, moderate score on clinical domain, high score on functional domain.

• 4CGM: 3rd or later episode, 18-19 therapy visits, high score on clinical domain, moderate score on functional domain.
Targeted Focus of All Identified J11 High Risk States For Tighter Control of Aberrant Providers - OIG Report Dated August 2012

• 5CHK: 20 or more therapy visits, high score on clinical domain, high score on functional domain.
• 5CGK: 20 or more therapy visits, high score on clinical domain, moderate score on functional domain.
• 5BHK: 20 or more therapy visits, moderate score on clinical domain, high score on functional domain.
• 5AHK: 20 or more therapy visits, low score on clinical domain, high score on functional domain.
This MedPAC report indicated that the highest utilization of home health services is concentrated in a few areas of the country.

These top five states (Florida, Louisiana, Mississippi, Oklahoma, and Texas) account for about 35% of all home health care episodes.

The utilization in these five states is 34.7 episodes per 100 Fee-for-Service (FFS) beneficiaries, compared to 13.7 episodes per 100 FFS beneficiaries for all other states.
MedPAC Report to The Congress Medicare Payment Policy Dated March 2013

- 5BGK: 20 or more therapy visits, moderate score on clinical domain, moderate score on functional domain.
- 5AGK: 20 or more therapy visits, low score on clinical domain, moderate score on functional domain.
- 5BFK: 20 or more therapy visits, moderate score on clinical domain, low score on functional domain.
- 5AFK: 20 or more therapy visits, low score on clinical domain, low score on functional domain.
Provider-Specific Probe Edit Set For Providers With Aggregate Length Of Stay And Average Disbursement Per Beneficiary Greater Than The Average For The State

<table>
<thead>
<tr>
<th>State</th>
<th>Previous Claims Reviewed</th>
<th>Previous Claims Denied</th>
<th>Previous Dollars Denied</th>
<th>Previous CDR</th>
</tr>
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<tbody>
<tr>
<td>Mississippi</td>
<td>20</td>
<td>6</td>
<td>$7,356.00</td>
<td>20%</td>
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<tr>
<td>Oklahoma</td>
<td>72</td>
<td>6</td>
<td>-$53,178.40</td>
<td>-33%</td>
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<tr>
<td>Louisiana</td>
<td>214</td>
<td>29</td>
<td>$39,490.66</td>
<td>8%</td>
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<tr>
<td>Texas</td>
<td>72</td>
<td>15</td>
<td>$2,119.65</td>
<td>1%</td>
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<tr>
<td>Other 12 states</td>
<td>63</td>
<td>4</td>
<td>$8,922.00</td>
<td>6%</td>
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</table>
Provider-Specific Probe Edit Set For Providers With Aggregate Length Of Stay And Average Disbursement Per Beneficiary Greater Than The Average For The State

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<tr>
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<th>Claims Reviewed</th>
<th>Claims Denied</th>
<th>Dollars Denied</th>
<th>CDR</th>
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<td>38</td>
<td>9</td>
<td>$13,633.89</td>
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<tr>
<td>Oklahoma</td>
<td>8</td>
<td>1</td>
<td>$2,846.34</td>
<td>18%</td>
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<tr>
<td>Louisiana</td>
<td>52</td>
<td>9</td>
<td>$18,833.58</td>
<td>20%</td>
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<tr>
<td>Texas</td>
<td>170</td>
<td>43</td>
<td>$58,696.91</td>
<td>18%</td>
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<tr>
<td>Other 12 states</td>
<td>1294</td>
<td>433</td>
<td>$874,857.70</td>
<td>32%</td>
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</table>

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Beneficiary Edits

• When home health documentation is being reviewed for other edits, if it is determined that the beneficiary is not qualified or does not meet the homebound requirement, then that specific beneficiary is added to this edit.

• What that means is that every time a Home Health claims is billed for that beneficiary, regardless of the provider, it will hit this edit and be selected for medical review.

• This edit prevents inappropriate payments from being made.

• Over ten months, Medical Review has denied a total of $931,090.59 with this edit alone.

• The charge denial rate for this edit is 31.9 percent.

• Reason Code 54100.
# Medical Review Workload

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<td>Post Pay Complex reviews</td>
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<td><strong>HHH Total</strong></td>
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### Home Health Disbursement 32 X

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<tr>
<th>State</th>
<th>Provider Disbursement 2013H1</th>
<th>Provider Disbursement 2012H2</th>
<th>Provider Disbursement 2012H1</th>
<th>Provider Count 2013H1</th>
<th>Provider Disbursement per Provider 2013H1</th>
<th>Beneficiary Count 2013H1</th>
<th>Provider Disbursement per Beneficiary 2013H1</th>
<th>Provider Disbursement per Beneficiary 2012H1</th>
<th>Provider Disbursement. Billed Charge 2013H1</th>
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<td>AR</td>
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<td>35,334,439</td>
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<td>94,934,691</td>
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<td>29,612</td>
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<td>95,821,737</td>
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January 2014
## Home Health Disbursement 33 X

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January 2014
# Home Health Aggregate Length of Stay

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January 2014

68
Symptoms, Signs, and Ill-Defined Conditions
Symptoms, Signs, and Ill-Defined Conditions

- ICD 9:
  - Chapter 16: Symptoms, Signs, and Ill-Defined Conditions
  - 780-799

- ICD 10:
  - Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified
  - R00-R99
Symptoms, Signs, and Ill-Defined Conditions

This section includes symptoms, signs, abnormal results of laboratory or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.
Codes for Symptoms, Signs, and Ill-Defined Conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.


ICD-9-CM Official Guidelines for Coding and Reporting
### 32X

#### 780.2 Syncope and Collapse

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January 2014
# Dizziness and Giddiness

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*January 2014*
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January 2014
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Going Beyond Diagnosis®
Something Was Missing

Studies show that diagnosis alone does not predict:

- Service needs
- Length of hospitalization
- Level of care
- Functional outcomes
Something Was Missing

• If we use a medical classification of diagnoses alone, we will not have the information we need for health planning and management purposes.

• What we lack is data about levels of functioning and disability.
Let’s start at the beginning.....
Reciprocal Determinism

Reciprocal determinism is the theory set forth by psychologist, Albert Bandura, that a person's behavior both influences and is influenced by personal factors and social environment.

Biopsychosocial Approach

George Engel formulated the biopsychosocial model, a general theory of illness and healing.

Biopsychosocial Model

• The biopsychosocial model is a general model or approach positing that biological, psychological and social factors all play a significant role in human functioning in the context of disease or illness.

• Health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms.

The biopsychosocial model suggests every disease process can be explained in terms of an underlying deviation from normal function.

Healthy vs. Diseased

• Health is traditionally equated to the absence of disease.
• A lack of a fundamental pathology was thought to define one's health as good.
• Biologically driven pathogens and conditions would render an individual with poor health and the label "diseased".

http://cnx.org/Dr. Shaheen E Lakhan

January 2014
Biopsychosocial Approach

• Going Beyond Diagnosis® is based on the biopsychosocial approach
• Medical nor social model is adequate on it’s own
Engel stated:
"To provide a basis for understanding the determinants of disease and arriving at a rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model."
Image of the Psychological, Biological and Social factors.
This chart displays Part 1, Functioning and Disability, and Part 2, Contextual Factors in the Going Beyond Diagnosis® concept.
Health and Health Related Domains

Health Domains
- Vision
- Hearing
- Speech
- Digestion
- Bodily excretion
- Fertility
- Sexual activity
- Skin & disfigurement
- Breathing
- Pain
- Affect
- Sleep
- Energy / vitality
- Cognition
- Communication
- Mobility and Dexterity

Health Related Domains
- Self-care: Including eating
- Usual activities: household activities; work or school activities
- Social functioning: interpersonal relations
- Participation: societal participation including discrimination/stigma
Structural Impairments

A structural impairment is a significant deviation in the anatomical parts of the body such as an organ, limb and their components.
Functional Impairments

A functional impairment is a significant deviation in the physiological (to include psychological) functions of body systems.
Activity Limitations

• An activity is the execution of a task or action by an individual.

• An activity limitation is a difficulty an individual may have in executing activities.
Participation

• Participation is involvement in life situations.
• Participation restrictions are problems an individual may experience in involvement in life situations.
Capacity vs. Performance

- **Capacity**: the highest probable level of functioning that a person may reach
- **Performance**: what an individual does in the current environment
Environmental Factors

The physical, social, and attitudinal environment in which people live and conduct their lives.
# Contextual Factors

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<th><strong>Person</strong></th>
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<td>• Other health conditions</td>
<td>• Social Norms</td>
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<td>• Coping style</td>
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<td>• Social background</td>
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<td>• Education</td>
<td>• Political factors</td>
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<td>• Past experience</td>
<td>• Nature</td>
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</table>
Comorbid Conditions

Comorbid conditions may coexist and are distinct from the primary disease.

http://medicalimages.allrefer.com/large/obesity-and-health.jpg
Comorbid Conditions

A medical condition existing simultaneously but independently with another condition in a patient.
Secondary Conditions

Secondary conditions are directly related to the primary conditions.
Secondary Conditions

Images of various parts of the body

http://www.webmd.com/stroke/ss/slideshow-stroke-overview

http://top100doctors.com/


Documentation to Support Homebound Status
Supporting Documentation

A diagnosis explaining or supporting the patient’s functional limitation connects homebound status to the illness or injury, showing that the patient is confined to home because of a medical issue.

Plan of Care Supports Documentation of Homebound Status *Homecare Insider*, February 15, 2010
Factors to Consider when Determining Homebound Status

• Distance
• Temporal
• Ambient
• Postural transition
• Terrain
• Attention
• Physical load
• Density

Pamela Teenier, RN, MBA, CHCE, COS-C, and Susan Sender, BSN, RN, CHCE A new way of Viewing Homebound patients Home Healthcare nurse Vol 24, no. 6 June 2006
Distance

• This is the most common factor taken into consideration related to determining homebound status.

• Evaluate the distance a patient is able to safely ambulate.

• The distance, as it relates to the specific patient’s needs, must be taken into account.
Temporal

- Need to walk at a certain speed.
- Can the patient cross a parking lot to get from a car to the physician’s office in a reasonable amount of time?
- Can the patient get across a busy intersection before the light changes?
- Documenting this difficulty can help demonstrate how a patient cannot effectively get all his/her medical care outside the home.

Pamela Teenier, RN, MBA, CHCE, COS-C, and Susan Sender, BSN, RN, CHCE A new way of Viewing Homebound patients Home Healthcare nurse Vol 24, no. 6 June 2006
Varying light levels and weather conditions.

Depending on where the beneficiary lives:

- Consider the effect that snow, ice, or extreme heat has on the person’s ability to move about in the community.
- As vision deteriorates, poor lighting conditions can further compromise the elderly person’s ability to ambulate.
Postural Transition

• Requirements to reach up or down for items.
• Does the patient lose his/her balance when reaching above the shoulder?
• Does he/she have the ability to bend to retrieve an object?
Terrain

• Various surface levels, including stairs, curbs, and escalators.
• Ambulating in an institutional setting typically is much easier than in the home or community setting.
• A person usually must maneuver over a variety of uneven surfaces in seeking services outside the home. evaluated.
• Does the patient have to walk down a gravel driveway or grassy area?
• Step onto a sidewalk?
• Across uneven pavement?

Pamela Teenier, RN, MBA, CHCE, COS-C, and Susan Sender, BSN, RN, CHCE A new way of Viewing Homebound patients Home Healthcare nurse Vol 24, no. 6 June 2006
Attention

• Demands on focus and ability when surroundings are loud, unfamiliar, or when the patient is alone.

• For a person to effectively function in the community, he/she has to be able to handle the input of sensory factors.
Physical Load

• Requirement to carry objects.
• As a person performs activities effectively in the community, he/she needs to be able to carry objects such as food and personal and household items.
• When patients need to seek medical care outside their home, frequently they need to take their medications, a purse or bag, or journal of medical information.
• Documenting a patient’s inability to carry small items and ambulate independently in a safe manner helps to better evaluate their homebound status.

Pamela Teenier, RN, MBA, CHCE, COS-C, and Susan Sender, BSN, RN, CHCE A new way of Viewing Homebound patients Home Healthcare nurse Vol 24, no. 6 June 2006
Density

- Crowded places.
- When in a crowded room or street, you have to frequently alter your gait pattern to maneuver around obstacles or people.
- This requires a level of balance and reaction time that may not typically be required in the home environment.
Lack of Transportation

- The mere fact that the patient and/or spouse no longer drives does not make him homebound.
- Look for the reasons he no longer drives as a clue to his homebound status:
  - short term memory problems
  - a seizure disorder or frequent TIAs
  - a history of CVAs with visible residual

http://homehealth101.com/homebound_status.html
Clinical Findings

• The documentation of the physical assessment and skilled need serves to illustrate the validity of this status.

• For example, “upon initial examination, the patient was severely SOB from the 3 minutes it took to ambulate to the front door from the bedroom... a distance of 35 feet.” Whereas the homebound status may just say “homebound due to SOB with minimal exertion”.

January 2014
Clinical Findings

• “Unstable blood sugars” is a valid homebound status for diabetes out of control, but it is further strengthened by documentation.

• “FBS 250 without symptoms. Insulin dose of 18 units of 70/30 taken. BS at lunchtime was 50 and patient c/o confusion, dizziness, headache, sweating, and trembling all over and unsteady gait. States this is pattern for last week. Verbalizes concern and fear of fainting or falling.”

• A high blood sugar for one day doesn't make him homebound. It is the lack of control that puts him in jeopardy of venturing out.
Homebound Status

- Relating the homebound status to a diagnoses is one approach to utilizing documentation to support the need for home care.
- When the homebound status and skilled need are both tied to a diagnosis, your documentation should provide adequate justification of meeting the criteria for homecare and for reimbursement.

Quan, Kathy, RN BSN. HomeHealth101.com Diagnosis Related Homebound Statements ©2009-13
Cardiovascular

- Cardiac restrictions due to angina
- Experiences angina even at rest
- Experiences angina with minimal activity
- Poor endurance, experiences SOB with minimal activity
- Experiences SOB at rest
- Able to ambulate only short distances (20 ft. or less) before experiencing SOB, angina
- Oxygen dependency (specify PRN or continuous)
- Edema in lower extremities limits ambulation
Cardiovascular

- Medical restriction to elevate LE due to edema
- Medical restrictions due to HTN-- BRPs only
- Orthostatic hypotension – symptomatic – at risk for falls
- Medical restriction to elevate LE due to PVD
- Activity or weight bearing status restrictions due to PVD
- Cardiac restrictions post CABG (X # vessels)
- Post op pain and weakness (S/P CABG X __)
- Right or Left Hemi paresis/paralysis due to CVA
- Requires assist with most ADLs/IADLs
Pulmonary

- SOB at rest
- Respiratory distress with minimal activity or speaking
- Oxygen dependency (L/min PRN or cont.)
- Minimal activity induces asthmatic attack
- Profound weakness due to hospital stay due to pneumonia
- At risk for further respiratory infection (esp. if in "flu season")
- Present weather conditions (high heat/humidity) exacerbate condition; requires air conditioned environment for optimum respiratory status
- Medical restrictions due to risk of post op infection
- Copious secretions – at risk for airway obstruction frequent suctioning of new tracheostomy
Cancer

- Pain (include site(s) and intensity) impedes mobility. (Pain medication impairs safety)
- Immunosuppression due to: chemotherapy, radiation, bone marrow transplant
- Profound weakness due to side effects of chemo/radiation (frequent N/V, diarrhea)
- With bone metastasis... at risk for pathological fractures
- Terminal status/ impending death
- With brain metastasis... impaired decision making capabilities
HIV/AIDS

- Medical restriction due to Immunosuppression
- On IV antibiotic therapy for complications (i.e. Cytomegalovirus retinitis)
- Requires continuous oxygen therapy
- Impaired mental status affects decision making skills
- Terminal status
- Severely weakened condition due to impaired nutrition/hydration status
- Requires 24 hour care and supervision
- Pain impairs mobility; pain medication impairs decision making ability
Musculoskeletal

- Medical restrictions on activity due to (partial/non) weight bearing status
- Unsteady gait, poor balance S/P surgery
- Unable to navigate uneven terrain, stairs (specify #) into/out of home-- no elevators or ramps available
- Activity limited due to brace, cast, traction etc.
- Pain with minimal activity
- Activity restricted due to pain
- S/P Right/Left/Bilat AKA/BKA awaiting prosthesis
- Unable to use prosthesis due to: stump wound, size change, malfunction etc.
- New pathological fracture (osteoporosis) with severe pain and limited mobility
Gastrointestinal

• Requires continuous feedings with non ambulatory pump
• At risk for infection due to immunosuppression
• S/P major surgery with medical restrictions
• Pain and weakness due to recent major surgery
• Pain and decreased mobility due to severe constipation/ fecal impaction
• New ostomy (specify)- patient fearful of lack of control of odors, leakage, noises
Neurological

• Unable to leave home unattended due to confusion
• Deteriorating mental status makes it unsafe for patient to leave home unsupervised
• Decision making capabilities are impaired
• Unsteady gait, dizziness, syncope
• At risk for falls due to shuffling gait
• Impaired neurological status
• Frequent seizure activity; requires supervision/assist of another
Integumentary

- Medical restrictions, site to be elevated
- Open wound with large amount of drainage
- Large open wound (size); at risk for infection
- Medical restriction -- non weight bearing status
- At risk for falls, further injury
- Movement restricted due to pain
Endocrine (Diabetes)

• Unstable blood sugar levels, experiences severe fluctuations
• Blindness
• BKA/AKA
• Requires assist or assistive device due to neuropathy/paresthesia in LES
• Activity restrictions due to diminished sensation/circulation in LES. Patient vulnerable to blisters or other breakdown on feet (esp. with history of) when ambulating >100 feet
Homebound Status

• Homebound status is not always permanent.
• A patient recovering from surgery, an accident, or episode of acute illness can be homebound for a short term.
• However, once that status changes, the patient must be discharged for outpatient care or follow up.

http://homehealth101.com/homebound_status.html
Characteristics that Raise Questions about Homebound

- No coordination or balance problems
- No need for assistive devices
- Have the ability to walk independently on even surfaces
- Independent with transportation
- Frequently go out of the home for non-medical reasons


January 2014
Examples of Homebound
Are these Good or Bad?
Scenario 1

A patient who has lost the use of his/her upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave his/her residence.
Scenario 2

Advising a patient to limit their normal activity so that the homebound criteria can be met.
Scenario 3

A patient who has just returned from a hospital stay involving surgery suffering from resultant weakness and pain and, therefore, his/her actions may be restricted by his/her physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.
Scenario 4

A patient with arteriosclerotic heart disease of such severity that he/she must avoid all stress and physical activity.
Scenario 5

Certifying a patient's plan of care as a “courtesy” to a patient, or Home Health Agency when you have not first made a determination of medical necessity.
Scenario 6

A patient with a psychiatric problem if the illness is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe to leave home unattended, even if he/she has no physical limitations.
Scenario 7

Unsteady gait, poor ambulation (with history of 2 falls in last month).
Scenario 8

Patient is unable to ambulate further than 10 feet without frequent rest periods (due to poor endurance, pain, SOB etc.).
Change Request 8444

This instruction clarifies the definition of the patient as being "confined to the home"

- **Effective Date:** November 19, 2013
- **Implementation Date:** November 19, 2013
Change Request 8444

- For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home.

- For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

CMS Manual System Internet Only Manuals Pub 100-02, Medicare Benefit Policy Manual, Chapter 7, Section 30.1.1. changes are in red italics
1. Criteria-One:
   • *The patient must either:*
     • *Because of* illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

   OR
   • *Have a condition such that* leaving *his or her* home is medically contraindicated.

   *If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.*

2. Criteria-Two:
   • There *must* exist a normal inability to leave home;

   AND
   • Leaving home *must* require a considerable and taxing effort.
Medical Necessity
Importance of the Home Care Record

• The only written source for communication among the home care team members
• The written source that supports insurance payment
• The written evidence of clinical decision-making
• The legal record of client care
• The basis for evaluation of care provided by peers; auditors; licensing, accreditation, and government surveyor review
• The evidence that demonstrates meeting the professional standard of care


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How to Chart

1. Date and time each entry.

2. Indicate both the time the entry is made into the record and the time the observation or activity took place.

3. All entries in the individual’s record should be written or printed legibly in permanent black ink.

4. Do not leave blank lines between entries. Draw a line through unused spaces before and after your signature.

5. Use only abbreviations and symbols approved in agency policies.

6. All entries in the individual's record should be written objectively and without bias, personal opinion, or value judgment.

7. The use of slang, clichés, or labels should be avoided unless used in the context of a direct quote.
How to Chart

8. Interpretations of data should be supported by descriptions of specific observations.

9. Documentation should be clear, concise, and specific.
   a. Don't use vague terms.
   b. Generalizations such as “good”, “fair”, “moderate”, and “normal” should be avoided.
   c. Findings should be as descriptive as possible including specific information about the appearance or findings related to size, shape, and amount.

10. Correcting errors:
    a. Draw one straight line through the incorrect entry,
    b. Write "error" above it,
    c. Initial and date the correction.
    d. Never use white-out, erase, or obliterate an entry in the individual’s record.
11. Late entries: If you forget to chart something, it may be entered into the record at a later time but you must clearly state the date and time the entry is being made and the date and time the care or observations actually occurred. The entry should begin with the words "Late entry".

12. All entries in the nursing notes should be signed. The signature should include the first initial, last name and title (e.g., S. Jones, RN).

13. Use of a stamped signature is not allowed.

14. A record of initials and signatures should be maintained according to facility policy so that the person using the initials and signatures used in documentation can be identified.
The Nursing Process

http://nursingprocesssteps.com/
Nursing Process

• Assessment
• Nursing Diagnosis
• Planning
• Implementation
• Evaluation
Assessment

• Assessment is the first step
• Involves systematic and deliberate collection of information to determine the person’s current and past functional and health status.
• Evaluates the person’s present and past coping patterns.
Assessment

Information for the nursing assessment is obtained through:

• Interview with the person or appropriate family or staff member
• Physical examination
• Observation
• Review of records
• Collaboration with other health professionals

Assessment Example

• John visits his general physician on Monday because he was feeling sick over the weekend.
• When he is called back from the waiting room, the nurse on staff takes his temperature, heart rate, and blood pressure.
• She then asks John a series of questions about how he's been feeling lately.
• The nurse notes his responses when he says he's been having difficulty breathing and has been feeling very tired.
• She also sees on John's medical history that he has had previous problems with his cholesterol levels and blood pressure.
• John also has a blood sample taken during his doctor's visit.

http://www.nursingprocess.org/Nursing-Process-Example.html
Diagnosis

• Diagnostic reasoning is the second step
• Involves the analysis of information obtained during the assessment step and the evaluation of the person's health status based on that information.

Nursing Diagnosis versus Medical Diagnosis

- A medical diagnosis deals more with the medical condition.
- Any diagnosis or finding made by the doctor is based on the physiologic state of the patient.

Nursing Diagnosis versus Medical Diagnosis

• A nursing diagnosis is a diagnosis that is based upon the response of the patient to the medical condition.
• Nurses treat the patient with everything that is related to human response to a specific disease.
• This includes anything that is a physical, mental, and spiritual type of response.

Nursing Diagnosis versus Medical Diagnosis

• Medical diagnosis: chronic obstructive pulmonary disease (COPD)
• Possible nursing diagnosis:
  • Activity intolerance
  • Ineffective breathing pattern related to reduced forced expiratory airflow
  • Impaired gas exchange related to alveolar hypoventilation secondary to atelectasis/ventilation perfusion mismatch
  • Decreased cardiac output related to diminished in venous return
  • Fluid and electrolyte imbalance
  • Acid base imbalance
  • Alteration in nutrition
  • Ineffective coping mechanism
  • Risk for infection
  • Knowledge deficit/ fear and anxiety
Diagnosis Example

• The nurse looks over John's symptoms and notes that his heart-rate is higher than average and his blood pressure is elevated.
• She also considers that he's experienced fatigue and shortness of breath before when his cholesterol levels were very high.
• The nurse determines that John is experiencing Hyperlipidemia, also known as having high levels of fat within the blood.
• John's blood tests confirm this hypothesis.
• The nurse is also concerned that John is at risk for heart disease.

http://www.nursingprocess.org/Nursing-Process-Example.html
Planning

Planning is the third step in the nursing process and involves setting priorities, developing desired outcomes to problems/needs, and designing nursing interventions.

Planning Example

- John returns on Tuesday for a follow-up visit.
- The nurse sits down with him in a closed room and explains his cholesterol levels and high blood pressure.
- She suggests that John be put on medication to help lower these numbers and recommends he exercise at least twice a week.
- The nurse also tells John he should stay away from salty foods and eat less red meat.
- John agrees with the nurse, and they setup a follow-up appointment two weeks later.
- The nurse reminds John to call if there are any changes in his condition, or if he starts to feel worse.
Implementation

Implementation is the fourth step in the nursing process and involves preparation, intervention, and documentation.

Implementation Example

• John is prescribed the medication and takes it as recommended.
• One week later, he has a day where he feels especially sick and calls the doctor's office.
• The nurse explains that the medication could cause nausea as a side-effect and advises John to drink Ginger-Ale and avoid any foods that generally upset his stomach.
• John continues taking the medication and goes to the gym four times during the two week period.
• Once the two weeks has passed, he returns to the doctor's office for his follow-up appointment.

http://www.nursingprocess.org/Nursing-Process-Example.html
Evaluation

• Evaluation is the fifth step in the nursing process.
• The nurse determines:
  • The person’s progress toward meeting health goals.
  • The value of the nursing plan of care in achieving those goals.
  • The overall quality of care received by the person.
Evaluation Example

• When John returns, the nurse asks him a series of questions about how he's been feeling.
• John replies that he has been having an easier time breathing and feels significantly less tired since exercising and taking the medication.
• The nurse marks “Patient's Condition Improved” on his official medical records and congratulates John on his well being.
• She then advises him to remain on the medication for one more month and to continue his exercise.

http://www.nursingprocess.org/Nursing-Process-Example.html
How Do you Document your Assessment and Intervention?

• **The Who**: of course is the patient, but if the problem related to your documentation is, for example, about family discord, the who could be the family or a specific family member.

• **The What**: the increased nausea and fear of imminent emesis.

• **The When**: began with the fact that the last dose of Tigan did not completely relieve the nausea.

• **The Where**: Mr. James lying in his bed on his right side (to alternate the pressure on his skin)
How do you Document your Assessment and Intervention?

• **The Why**: the nausea is presumed to be due to an exacerbation of his cirrhosis but it's unclear why the Tigan was ineffective this time.

• The patient states he thinks "lying on my right side is so uncomfortable that I can't relax and let the medication work." [Use patient quotes for subjective details.]
How do you Document your Assessment and Intervention?

**The How**: the intervention:

[include the VS and assessment findings] No apparent significant change in condition noted. At this time, patient requests to try other measures and to wait for MD assessment before requesting additional medications. Assisted patient to turn slowly to his left side without incident. Placed cold cloths on his forehead and back of his neck as requested. Patient reports feeling immediately “much better.” Reduced outside stimuli including turning off the TV, turning off the lights, closing the door and drawing the curtain around the bed. Patient performed deep breathing and relaxation techniques as instructed. Patient able to fall asleep within 5 minutes without further c/o nausea and no vomiting. Expect MD to make rounds within the hour.
New Symptoms or Conditions

Each of the following should be documented in the nursing notes (or other designated documents) at the time of occurrence along with nursing action taken and the person’s response:

a. Abrasions, cuts, pressure marks
b. Falls and bumps, with or without apparent injury
c. Elevated temperature
d. Pressure ulcers including description and treatment until resolved
e. Rectal checks for constipation including findings and treatment
f. Seizures with complete description and treatment, if any
New Symptoms or Conditions

Each of the following should be documented in the nursing notes (or other designated documents) at the time of occurrence along with nursing action taken and the person’s response:

g. Possible adverse reactions to food or medicine
h. Refusal of meals or medications
i. Vomiting including type, amount, and treatment
j. STAT medications including time order is received and time medication is given
k. Unusual behavior or condition of the individual
l. Diarrhea or any change in bowel pattern
m. Any significant increase or decrease in weight
n. Changes or unusual difficulty in obtaining vital signs
Documentation Examples

• “Was in hospital for bronchitis, had decline in function.”
  • *Which functions?*
  • *How can one tell?*

• Pain: = 0
  • *Why are we in this home?*
Documentation Examples

• Living situation “capable”
• Prior Level of function: “Independent”
  • How does “independent” differ from “capable?”
• Posture: “Kyphotic”
  • To what extent? And how is it adversely affecting the patient? This is never again mentioned in any note. Where did the posture issue go?
• Full weight bearing, with standby assistance
• Quality/Deviations/Postures: “Decreased endurance with ambulation”

Rowan, Tim Real-world examples of clinical documentation that will result in payment denials
Charting Tips

When to Chart

• Record nursing actions and individual responses as soon after they occur as possible.

• Never document medications or treatments before they are given or completed.
Charting Tips

What to Chart

• *Symptoms*: Use the person’s own words, communication gestures, or non-verbal cues as much as possible.

• *Your observations*: Failure to document leaves gaps in the record that can be interpreted as neglect.

• *All injuries, illnesses and unusual health situations* until they are resolved. There should be entries in the nursing notes on a regular basis until the problem is no longer present. When the problem is resolved, it should be documented.

• *Response to a medication or treatment*: This includes therapeutic effects as well as side effects.
Good Documentation Reflects the Nursing Process

Scenario: A patient complains of chest pain. The nurse takes the patient seriously, as the subjective complaint may indicate a myocardial infarction. He or she acts quickly, performing a focused assessment and documenting the essential information. Here are the critical elements of good documentation of a patient with chest pain.

Miller, Patricia DuClois. Home Health Documentation: Proven Strategies for Clinicians
Subjective Data

7/15/13 1600

Patient stated, “Nurse, I am having chest pain.” See pain flow sheet for description, location, intensity noted. Patient in chair, increasingly anxious. Used calm, reassuring behavior with patient. Redirected her to focus on remaining calm for interventions to work. Patient responded, and pulse and respirations decreased. See VS section of flow sheet.
Good Documentation

The patient’s exact description of the symptom was noted, and the nurse used quotations around the patient’s words, rather than recording his or her interpretation of them.
Good Documentation

• On the pain flow sheet, the nurse indicates pain was located in the substernal region, radiating to the left shoulder. Pain level 10 out of 10. The nurse appropriately uses the pain scale to measure the level of intensity.

• The nurse also notes on the pain flow sheet: No preceding activity or past history of this type of pain. Steady pain: 2–3 minutes. No SOB.
Documentation of What Was Assessed: Objective Data

• AR. *Irregular regular rhythm*. No JVD. O2 sats on RA: *92%*. Color ashen, skin cool and clammy.

• The nurse documents the vital signs, noting tachycardia, an increased respiratory rate, and above-baseline blood pressure for this patient. In addition, the nurse records auscultation of heart sounds (e.g., regular/irregular heart rate, murmur, gallops, rubs).
Objective Data

The nurse assesses lung sounds and the respiratory rate and pattern, and measures abnormal O2 saturation via pulse oximetry. The patient’s actions are already noted as increasingly anxious. There is no clutching of the chest by the patient. Skin assessment also is conducted and documented.
Good Documentation

• In the cognitive section of the patient care flow sheet, the notations indicated:
  • *No changes in mental status; no decreased level of consciousness, disorientation, or confusion.*

• In the narrative notes, the nurse notes:
  • *Skin cool, clammy, no peripheral edema, ashen in color. No cyanosis noted.*

• Documentation of what was done: Intervention
  • The nurse continues to document his or her interventions and the patient’s responses.
Good Documentation

- **Frequent monitoring**: The VSS were noted every few minutes until the chest pain subsided. 911 was called. All treatment activities are documented, including medications administered, such as aspirin and/or nitroglycerin.

- **Oxygen therapy**: The nurse documents the patient’s initial pulse-oximetry reading, respiratory-assessment findings. The pulse-oximetry assessments are documented until within normal range or transferred to emergency personnel.
Good Documentation

Cardiac monitoring: 7/15/13 1615

• Patient placed on cardiac monitor by EMS. Patient informed as to the reason for continuous monitoring.

• The nurse does document notification of the physician of the patient’s change of condition and transfer to the hospital. He or she records the physician’s response and his or her actions.
Good Documentation

- **Communication**: The nurse is good at documenting his or her communication with other healthcare team members. It is found in his or her narrative notes, names, time of notification, etc.

- **Emotional support**: 7/15/13 16:20 Patient increasing in anxiety; reassurance given and questions answered.
Therapy Medical Necessity
Therapy Medical Necessity

• Focus on function
• Focus on underlying causes
• Focus on progress
• Focus on safety
• State expectations for progress
• Explain slow progress or lack of progress
• Summarize skilled services delivered

http://ajot.aotapress.net/content/51/6/436.full.pdf
Prior Level of Function

One of the most critical components of any initial home care therapy evaluation is documentarian of the prior level of function.
Prior Level of Function

• A statement that incorporates environmental clues can note a level of function beyond simple independence. For example:

• "Before hospitalization, the client was living independently in a three-story home, was independent in all self-care and homemaking, and used bathroom facilities on the second floor and laundry facilities in the basement."
Identify and Focus on Meaningful Activities

Probing interview skills are essential for identifying meaningful activities that the client was previously able to perform, that he or she is able or unable to currently perform, and that he or she can be expected to resume.
Organize by Performance Areas

The format or organization of the progress note should emphasize the functional goals.
Example

Bathing: Client’s left hemiparesis, visual skill deficits, and dynamic balance deficits make this task difficult. During an actual performance evaluation, he required moderate assistance of one person to safely enter and exit the tub using a rub-transfer bench. He is expected to progress to needing standby assistance.
Relate Performance Component Deficits to Functional Outcomes

• It may be beneficial to keep the information together in progress notes.

• For instance, to extend the previous example, the practitioner's next visit could include the following:
Example Continued

Bathing: Client's need for moderate assistance in bathing is associated with an impairment in dynamic balance. He was involved in activities to challenge the development of postural control in dynamic sitting and standing and was instructed in proper biomechanics necessary for safe transfer into the rub.
Functional Outcomes

Relate performance component goals to functional outcomes.
Functionality

• “Increase active RUE [right upper extremity] shoulder flexion from 110° to 140°”

• Ask yourself:
  • Why? or What will the consumer be able to do (functionally) with the increased shoulder flexion?
Focus on Progress

A progress statement is more than that of current status; it should include a comparative analysis that informs the reader of change.
Skilled Evaluation

• Practitioners do not "monitor performance" or simply "observe client perform" a task; the skilled evaluation’s purpose of the session must be clearly stated. For example:
  • Dressing: OT evaluated the effectiveness of compensatory methods demonstrated last session. Methods were modified to increase safety. Client demonstrated inconsistency in her ability to remember the proper movement sequence needed in donning her blouse.
Image of a poor example of documentation.

January 2014
Good Example:

Underlining a functional area emphasizes the focus on function.

Concise statement of skilled services is provided. Unnecessary treatment details are avoided.

**Tub Bathing:** ADL retraining was provided; OT instructed client in compensatory methods to use during transfers and during bathing. LLE weakness, nonfunctional grasp in his left hand, and trunk control deficits make the transfer in and out of the tub unsafe and difficult. Client inconsistently recalls the cues needed for safe transfer. Client is expected to progress from requiring moderate assistance (current status) to needing only minimal assistance by the end of this certification period.

**Plan:** Bathing training to increase consistency in using compensatory methods. Activities to increase trunk control and left hand grasp.

Plans offer specificity related to functional areas to be addressed and general reference to activities for developing related performance components.

Image of a good example of documentation.
http://ajot.aotapress.net/content/51/6/436.full.pdf
Face-to-Face

CMS Internet Only Manual (IOM),
Publication 100-2, Medicare Benefit Policy Manual,
Chapter 7, Section 30.5.1.1
Face-to-Face Encounter

The certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient.
Face-to-Face Encounter

• The documentation must include:
  • The date when the physician or allowed NPP saw the patient
  • A brief narrative composed by the certifying physician who describes how the patient’s clinical condition as seen during that encounter supports the patient’s homebound status and need for skilled services.
  • The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.
  • It may be written or typed.
Face-to-Face Encounter

• It is acceptable for the certifying physician to dictate the documentation content to one of the physician’s support personnel to type.

• It is also acceptable for the documentation to be generated from a physician’s electronic health record.
Face-to-Face Encounter

It is unacceptable for the physician to verbally communicate the encounter to the home health agency, where the home health agency would then document the encounter as part of the certification for the physician to sign.
Face-to-Face Encounter

The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
Face-to-Face Encounter

• The certifying physician cannot merely co-sign the encounter documentation if performed by an NPP.

• He or she must complete/sign the form or a staff member from his or her office may complete the form from the physician’s encounter notes, which the certifying physician would then sign.

• The Face-to-Face documentation must be clearly labeled, dated, and signed by the certifying physician before the home health agency submits a claim to Medicare.
Face-to-Face Encounter

Face-to-Face documentation must include:

• The date of the Face-to-Face encounter

• Clinical findings to support that the encounter is related to the primary reason for home care, the patient is homebound and in need of Medicare covered home health services
Face-to-Face Encounter

- The Face-to-Face documentation and cannot be altered/changed in any way by the home health agency.
  - The agency can label and date the document.
- The Face-to-Face documentation is part of the certification, and the certification is required at the time the home health agency bills Medicare.
Face-to-Face Encounter

Because the Face-to-Face is a requirement for payment, when the Face-to-Face requirements as previously outlined are not met, the entire claim is denied.
Most Common Error

The most common error is insufficient documentation of clinical findings by the physician/NPP to show:

• The encounter was related to the primary reason for home care
• How the patient’s condition supports the patient’s homebound status
• How the patient’s condition supports the need for skilled services
Insufficient Documentation

Homebound Status

• Functional decline
• Dementia or confusion
• Difficult to travel to doctor’s office
• Unable to leave home
• Weak
• Diabetes
• Unable to drive
Insufficient Documentation

Need for Skilled Services:
• Family is asking for help
• Continues to have problems
• List of tasks for nurse to do
• Patient unable to do wound care
• Diabetes
Appropriate Documentation

“The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD medical regimen.”

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/face-to-face-requirement-powerpoint.pdf
Appropriate Documentation

Lung sounds coarse throughout. Patient finished antibiotic therapy today for pneumonia, and to see pulmonologist tomorrow for follow up due to COPD and emphysema. Short of breath with talking and ambulation of 1-2 feet. Nurse to assess respiratory status for s/s of recurring infection/ changes in respiratory status.
The face-to-face documentation can include, or exist as, checkboxes so long as it comes from the certifying physician.
Face to Face Audit Tool

• A face-to-face checklist has been developed and posted to Palmetto GBA’s website to assist providers with determining if the face-to-face documentation meets all requirements
  • www.PalmettoGBA.com>Face-to-Face>Home Health
Change Management
The Cheese Experience

An A-mazing Way To Deal with Change In Your Work and In Your Life

By Spencer Johnson, M.D.
Sniff
Scurry
Haw
Who Moved My Cheese?

• Every day they mice spend time in the maze looking for their own special cheese.
• Sniff and Scurry were not quite as smart as Hem and Haw, but they had very good instincts.
• They worked hard each day searching for the cheese that they liked best.
WHO ARE YOU IN THE STORY?
Each character illustrates potential parts of ourselves. Which character most represents the way you typically deal with change?

Sniff?  Who can smell change in the air.

Scurry?  Who goes into action immediately.

Hem?  Who does not want to change. “It’s Not Fair!”

Haw?  Who is startled by change, but then laughs at himself, changes and moves on to enjoy New Cheese.
Having Cheese Makes You Happy!
The More Important Cheese Is To You, The More You Want To Hold Onto It!
If You Do Not Change,
You Can Become
EXTINCT!
It Is Safer To Search In The Maze Than Remain In A Cheeseless Situation
When You Move Beyond Your Fear, You Feel Free!
Smell The Cheese Often So You Know When It Is Getting Old.
The Quicker You Let Go Of Old Cheese

The Sooner You Find New Cheese
When You Can Change What You Believe, You Can Change What You Do!

January 2014
Why Is It That Some Things That People Envision *Never* Happen?

The Missing Ingredient Is **PASSION!**
Imaging Yourself Enjoying *New Cheese*, Even Before You Find It, Leads You To It
Picture Plus *Passion*

Powers You

Through The Maze
What Excites You About The Picture You Have Painted Of What You Would Like To Brie?

Capture That Passion - That Feeling - And Apply It To Finding Your New Cheese!
Vision and Reality.

Imagine
The Results You Want

Hold that Vision
Until It Is Reality

ENJOY THE FEELING!
The Handwriting On the Wall
CHANGE HAPPENS
*They Keep Moving the Cheese*
Anticipate Change
*Get Ready For the Cheese To Move*
Monitor Change
*Smell the Cheese Often So You Know When It Is Getting Old*
Adapt To Change Quickly
*The Quicker You Let Go Of Old Cheese, The Sooner You Can Enjoy New Cheese Change*
Move With the Cheese
Enjoy Change!
*Savor the Adventure And Enjoy the Taste Of New Cheese*
Be Ready To Quickly Change & Enjoy It, Again, And Again!
*They Keep Moving the Cheese*
Questions?

![Cartoon Image with Text: Wow... how did he do that so fast?](offthemark.com)
What Now?
Agenda

• Who Can Review Your Medicare Claims?
  • Recovery Audit Contractor (RAC)
  • Zone Process Integrity Contractor (ZPIC)
  • Comprehensive Error Rate Testing (CERT)
  • Strategic Health Solutions
  • Office of Inspector General (OIG)
  • The Medicare Administrative Contractor (MAC) Additional Documentation Requests (ADRs) Process and Procedures
  • Comparative Billing Reports (CBRs)
Agenda

• Redeterminations – Step-by-Step
• Medicare Overpayment Process
• Medicare Regulatory Updates
• Web Resources
Who Can Review Your Medicare Claims?
Think of Your Internal Process

• Who submits your claims?
• Who reviews your claims for denials?
• Who responds to medical records requests?
• Who views your remittance advice?
• Who handles your overpayments?
• Who submits your appeals?
Recovery Audit Contractor (RAC)
RAC

• Medicare recovery audit services for CMS as mandated by the Tax Relief and Health Care Act of 2006
  • RACs detect and correct *past improper payments*
    • Identification of past improper payments will prevent future improper payment
RAC

• Issues reviewed by the Recovery Auditor will be approved by the CMS prior to posting to the Connelly website

• **Approved issues** will be posted to the RAC’s website
  • Reviews claims on a post-payment basis
    • RACs look back three years from the date the claim was paid

• Three types of reviews:
  • **Automated** (no medical record needed)
  • **Semi-Automated** (claims review using data and potential human review of a medical record or other documentation)
  • **Complex** (medical record required)
Connolly Approved Audit Issues

www.connolly.com/healthcare/Pages/CMSRacProgram.aspx
### CMS Approved Audit Issues

This list includes all CMS-approved audit issues:

<table>
<thead>
<tr>
<th>Issue Name</th>
<th>Issue Type</th>
<th>Claim Types</th>
<th>States</th>
<th>Date Approved</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepayment Review: Home Health - Medical Necessity &amp; Conditions to Qualify for Services - C004482013</td>
<td>Complex</td>
<td>Home Health</td>
<td>Region C - (FL, TX, LA, NC)</td>
<td>12/3/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Hospice related services billed with Condition code 67- Home Health: C006802012</td>
<td>Automated</td>
<td>Home Health</td>
<td>Region C</td>
<td>11/26/2012</td>
<td>Details</td>
</tr>
<tr>
<td>Home Health Agency - Medical Necessity and Conditions to Qualify for Services Issue Number: C005222011</td>
<td>Complex</td>
<td>IHA</td>
<td>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia</td>
<td>6/29/2012</td>
<td>Details</td>
</tr>
<tr>
<td>RAP claim without corresponding home health claim CMS Issue Number: C000682011</td>
<td>Automated</td>
<td>IHA</td>
<td>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia</td>
<td>5/22/2012</td>
<td>Details</td>
</tr>
<tr>
<td>Incorrect billing of Home Health Partial Episode Payment claims CMS Issue Number: C002022011</td>
<td>Automated</td>
<td>IHA</td>
<td>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia</td>
<td>1/27/2012</td>
<td>Details</td>
</tr>
</tbody>
</table>

January 2014
Connolly RAC Home Health Approved Issues

• Prepayment Review: Home Health – Medical Necessity & Conditions to Qualify for Services (Complex)

• Hospice related services billed with Condition code 07 (Automated)

• Medical Necessity and Conditions to Qualify for Services Issue (Complex)

• RAP claim without corresponding home health claim (Automated)
Connolly RAC Home Health Approved Issues

• Incorrect billing of Home Health Partial Episode Payment *(Automated)*

• Non-Routine Medical Supplies and Home Health Consolidated billing *(Automated)*

• Home Health Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold *(Complex)*
CGI Federal RAC Issues

https://racb.cgi.com/Issues.aspx
CMS Approved issues on CGI Federal’s Website

<table>
<thead>
<tr>
<th>Issue Name</th>
<th>Issue Type</th>
<th>Claim Types</th>
<th>States</th>
<th>Date Approved</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Medical Necessity and Conditions To Qualify For Services - CMS</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MI, IL, OH</td>
<td>12/3/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Home Health Medical Necessity and Conditions To Qualify For Services - CMS</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MI, IL, OH</td>
<td>12/3/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Home Health Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MN, WI, MI, IL, IN, OH, KY</td>
<td>4/29/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Home Health Pre-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
<td>Complex</td>
<td>Home Health</td>
<td>MI, IL, OH</td>
<td>8/1/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Home Health Skilled Nurse Length Of Stay</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MI, IL, OH</td>
<td>12/3/2013</td>
<td>Details</td>
</tr>
<tr>
<td>No Skilled Service</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MI, IL, OH</td>
<td>12/3/2013</td>
<td>Details</td>
</tr>
<tr>
<td>Skilled Nurse Length Of Stay</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MN, WI, MI, IL, IN, OH, KY</td>
<td>10/25/2012</td>
<td>Details</td>
</tr>
</tbody>
</table>

Search Criteria: Claim Type: home health
CGI Federal RAC Home Health Issues

• Home Health Medical Necessity and Conditions to Qualify for Services (*Complex*)
• Home Health Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold (*Complex*)
• Home Health Pre-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold (*Complex*)
• Home Health Skilled Nurse Length of Stay
• No Skilled Service (*Complex*)
• Skilled Nurse Length of Stay (*Complex*)
RAC Review Decision Correspondence

- RACs are required to send a ‘Review Results Letter’ for all Complex review

- Providers will Only receive a ‘Demand Letter’ from the MAC for Automated and Semi-Automated reviews when an improper payment has been identified
RAC Statement of Work (SOW)

- CMS Recovery Audit Program *Statement of Work* (SOW)
RAC Discussion Period

- Opportunity to discuss the improper payment determination with the RAC
- Opportunity for the RAC to explain the rationale for the overpayment decision
- RAC could decide to reverse their decision
- RAC must respond within 30 days of receipt of discussion period request form
  - Will not respond if an Appeal is filed to the MAC
- Discussion period can occur by teleconference and/or by written correspondence
Rebuttal

• Providers, physicians and suppliers have **15 days** from the date of this *demand* letter to submit a rebuttal statement.

• The MAC will advise you of its *decision* in writing within **15 days** of your request.

• However, the rebuttal statement is not an appeal of the overpayment determination, and it will not delay/cease recoupment activities.
# RAC Overpayment Options – Discussion period, Rebuttal or Redetermination

<table>
<thead>
<tr>
<th>Option</th>
<th>Discussion Period</th>
<th>Rebuttal</th>
<th>Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who to Contact</strong></td>
<td>RAC</td>
<td>MAC</td>
<td>MAC</td>
</tr>
<tr>
<td><strong>Timeframe</strong></td>
<td>Day 1-40</td>
<td>Day 1-15</td>
<td>Day 1-120</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>Must be submitted within 120 days of receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 days.</em></td>
</tr>
<tr>
<td><strong>Timeframe Begins</strong></td>
<td>Automated Review: Upon receipt of Demand Letter</td>
<td>Date of Demand Letter</td>
<td>Upon Receipt of the Demand Letter</td>
</tr>
<tr>
<td></td>
<td>Complex Review: Upon receipt of Review Results Letter</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Timeframe Ends</strong></td>
<td>Day 40 (offset begins on day 41)</td>
<td>Day 15</td>
<td>Day 120</td>
</tr>
</tbody>
</table>
Example of How RAC Automated Accounts Will Appear on the RA

RAC adjustments are identified by remark code **N432**
RAC Documentation Submission

- CD/DVD
- Fax
- esMD
- Direct electronic connection with Healthport
  - Note: *Connolly Only*
- Paper
RAC Contractor Responsibilities

- Identify improper payments and Produce Review Results letters for complex reviews

- Submit claim adjustment to the MAC

- Respond to any audit specific questions you may have, such as their rationale for identifying the potential improper payment
**MAC Contractor Responsibilities**

**Issue demand letters**
- Demand letters will be sent to the provider’s *physical address*.
- The letter number on the RAC demand letters begins with an “R”.

**Perform claim adjustments based on the RAC’s review.**
- RAC adjusted claims are identified by type of bill (TOB) *xxH*.

**Handle administrative concerns such as timeframes for payment recovery and the redeterminations.**

**Issue Remittance Advice with Remark Code *N432*: Adjustment Based on RAC.**
Overpayment Demand Letter Envelope

• Demand letter envelopes have a red strip on the top.
  • With the exception of cost report, rate review, and hospice CAP related overpayments that are issued by Audit and Reimbursement.

• Any envelopes received from Palmetto GBA with a red strip will contain overpayment demand letters.
Overpayment Demand Letter
Envelope

January 2014
Sample RAC Demand Letter

Date: 07/02/2013

RE: Claims Accounts Receivable - MMA 605
Provider Name:
Provider Number:
Outstanding Balance: $7,630.50

Dear Sir/Madam,

This is to inform you that you have received a Medicare payment in error which has resulted in an overpayment subject to the 936 Limitation on Recoupment in the amount of $7,630.50. The purpose of our letter is to request that this amount be repaid to our office. The attached listing explains how this happened.

This finding was a result of a Recovery Audit Program review. If you have any questions relating to this letter or the recoupment process, you should contact us at 866-830-3465. If you have any questions relating to the review rationale, or you feel that this finding is in error and would like to submit additional documentation or discuss the issue further, please contact the Recovery Auditor. If you are unable to locate the name and contact information for the Recovery Auditor from prior correspondence, please contact the Medicare Administrative Contractor at the above number for further information.

Why you are responsible:

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment in this situation, you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below. Applicable authorizes: Section 18709(c) of the Social Security Act, Subsections 406.350 - 406.359 of Title 42 CFR, Subsections 404.506 - 404.509, 404.515a and 404.512 of Title 20 of the United States Code of Federal Regulations and 20 CFR.
RAC Resources

www.cms.hhs.gov/RAC

www.connollyhealthcare.com/RAC
RAC Toll Free #: 866.360.2507
Email: racinfo@connolly.com

www.racb.cgi.com
Email: racb@cgi.com
Phone: 1-877-316-RACB

January 2014
Zone Program Integrity Program Contractor (ZPIC)
ZPIC

• Zone Program Integrity Contractors (ZPICs) [formerly known as Program Safeguard Contractors (PSCs)]

• ZPICs detect and deter potential *fraud, waste, and abuse* in the Medicare program
  • Seven program integrity zones were created based on the MAC jurisdictions
ZPIC Jurisdictions Map

January 2014
ZPIC Contractor Responsibilities

- ZPIC Responsibilities:
  - Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement
  - Conducting investigations in accordance with the priorities established by the Center for Program Integrity’s (CPI’s) Fraud Prevention System
  - Performing medical review, as appropriate
ZPIC Contractor Responsibilities

• ZPIC Responsibilities continued...
  • Performing *data analysis* in coordination with CPI’s Fraud Prevention System
  • Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits
  • Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution
ZPIC Contractor Responsibilities

• In performing these functions, ZPICs may, as appropriate:
  • Request medical records and documentation
  • Conduct an interview
  • Conduct an onsite visit
  • Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
  • Withhold payments
  • Refer cases to law enforcement
MAC Contractor Responsibilities

**Issue demand letters**
- Demand letters will be sent to the provider’s *physical address*

**Perform claim adjustments based on the ZPIC’s review.**
- ZPIC adjusted claims are identified by a reason code with “Z” in second position (i.e. 5Z74H)

**Handle administrative concerns such as timeframes for payment recovery and the redeterminations**
ZPIC Review Decision Correspondence

• For pre-payment edits
  • Denial on the claim (xZxxx)
  • Remittance advice (RA) that shows the adjusted claim
• For claims where medical documentation is requested
  • You will receive a letter from the ZPIC outlining their decision
  • You will receive an overpayment Demand letter from the MAC
ZPIC Reason Code Examples:

- **5Z7PS**: “Edit to deny claims submitted with attending/ordering/rendering provider. Physician is on the compromised physician list and was also identified through the national fraud prevention program”
- **5Z7IV**: “Edit to deny claims submitted due to no valid plan of care and/or orders based on referring/ordering physician who signed a statement-task order 1”
ZPIC Resources

www.cms.hhs.gov/ZPIC

www.safeguard-servicesllc.com

www.healthintegrity.org

Advance Med an NCI company www.nciinc.com
COMPREHENSIVE ERROR RATE TESTING (CERT)
CERT

• **Federally mandated** program created by the Centers for Medicare & Medicaid Services (CMS) to measure the **paid claims error rate** for Medicare claims submitted to MACs.
  
  • Ensures that the Medicare program is paying claims correctly.
  
  • The CERT program measures **national, contractor-specific**, and **service-specific** paid claim error rates.
The CERT program uses a \textit{random} and a \textit{service-specific} sampling of claims.

There are \textit{two contractors} responsible for administering the CERT program on behalf of CMS.

- The CERT review contractor selects \textit{samples of claims} from Palmetto GBA.
- For each claim selected, the CERT documentation contractor (CDC) \textit{requests medical records}, from the providers, physicians or suppliers that billed for the services, and prepares the documentation for review.
CERT Review Decision Correspondence

• If no overpayment is found, you will **NOT** hear anything else about the claim from CERT
• If an overpayment is found, you will receive the following from the MAC:
  • Overpayment *Demand letter*
  • Remittance advice *(RA)* that shows the adjusted claim
CERT Documentation Submission

- CD
- Fax
- esMD
- Paper
- The preferred method of delivery by the CERT contractor is by **CD** or **fax**
CERT Contractor Responsibilities

1. Identify improper payments
2. Submit claim adjustment to the MAC
3. Respond to any audit specific questions you may have, such as their rationale for identifying the potential improper payment
MAC Contractor Responsibilities

Issue demand letters
- Demand letters will be sent to the provider’s physical address

Perform claim adjustments based on the CERT’s review.
- CERT adjusted claims are identified by type of bill (TOB) xxH.

Handle administrative concerns such as timeframes for payment recovery and the redeterminations.
CERT Resources

CERT resources on J11 HHH website:
• www.PalmettoGBA.com/HHH

CMS CERT website:
• www.cms.gov/CERT

CERT Provider website:
• https://www.certprovider.com/Home.aspx

CMS Program Integrity Manual
• Publication 100-08
Introduction to CERT Webcast
Strategic Health Solutions
Strategic Health Solutions

• As the Supplemental Medical Review Contractor (SMRC), Strategic has been contracted to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs.

• One of the primary tasks will be conducting nationwide medical review as directed by CMS.

• The medical review will be performed on Part A, Part B, and DME providers and suppliers to determine whether Medicare claims were billed in compliance with coverage, coding, payment and billing practices.
The SMRC will request documentation from providers and/or suppliers through mailing Additional Documentation Request (ADR) letters.

- The SMRC will mail the ADR letters to the address the provider or supplier has on registry with CMS.

- The SMRC is assigned each project through Technical Direction Letters (TDL) issued by CMS.
SMRC Responsibilities

- Notify CMS of any identified improper payments and noncompliance with documentation requests.

- CMS in turn directs the MAC to initiate claim adjustments and/or overpayment recoupment actions.

- Respond to any audit specific questions you may have, such as their rationale for identifying the potential improper payment.
MAC Contractor Responsibilities

- Issue demand letters
  - Demand letters will be sent to the provider’s physical address

- Perform claim adjustments based on the CMS referral from SMRC’s review.

- Handle administrative concerns such as timeframes for payment recovery and the redeterminations
SMRC Documentation Submission

- Fax
- esMD
- Paper
SMRC Review Decision

Providers will receive a *Review Results Letter* once the review is complete advising on the claim payment decision.
Office of Inspector General (OIG)
The OIG is at the forefront of the Nation’s efforts to fight waste, fraud and abuse in Medicare, Medicaid and more than 300 other U.S. Department of Health & Human Services (HHS) programs.

Their mission is to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries.
OIG

• A nationwide network of audits, investigations, and evaluations results in timely information as well as cost-saving or policy recommendations for decision-makers and the public.
  • That network also assists in the development of cases for criminal, civil and administrative enforcement.
The MAC ADR Process
ADR

- Request by the MAC for copies of *medical records* on a specific beneficiary for specific dates of service.
- Providers will receive an *ADR letter*.
- ADRs are mailed in *white* Palmetto GBA *envelopes*.
ADR

• Watch for the Palmetto GBA envelope containing the ADR.

• Providers are also encouraged to monitor the claims system for ADRs.
  • Direct Data Entry (DDE)
  • Online Provider Services (OPS)

• The provider has **30 days** from the **date on the ADR** to respond to Palmetto GBA with copies of the requested medical records.
Why is the Due Date in DDE Greater Than 30 Days from the Date of the Hardcopy Letter?

• The “Due Date” in DDE reflects the actual date that the claim will be denied if the provider does not respond to the ADR.

• The “Original Date Requested” field reflects the date of the hardcopy letter.

• Providers are required to respond to an ADR request within **30 days** from the date of the hardcopy letter.

• When a response is not received within **45 days** of the date of the letter, the claim is then denied.
Sample MAC ADR Letter

<table>
<thead>
<tr>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2014</td>
<td></td>
</tr>
</tbody>
</table>
ADR Response Calculator

The ADR Response Calculator option on Palmetto GBA’s website.
Responding to a Home Health ADR Checklist

View the Home Health ADR Checklist on Palmetto GBA’s website.
MAC ADR Documentation Submission

- CD/DVD
- Fax
- esMD
- Paper
  - **Note:** Please do not staple your documentation
MAC ADR Review Decision

• If full payment is allowed
  • The claim will finalize and be seen on their remittance advice (RA).

• If partial payment is allowed
  • The provider can access the Remarks section of the claim to determine the reason for any denials/down codes of claims.
MAC ADR Review Decision

• If payment is *denied*
  • The claim denial will be reflected on the RA with a *denial reason code* that begins with the number five (5).
  • The provider can view *Remarks* on claim to obtain a more detailed explanation of the denial reason.
What is the Next Step for a Provider if the Claim is Denied?

• Once a claim is reviewed and *denied*, the claim cannot be reopened.

• If the provider disagrees with the denial, the provider can appeal the decision by submitting a request for a *Redetermination* to the MAC Appeals Department.

• NOTE: If a claim is denied with reason code 56900 (records not received), the provider can submit the *documentation to Medical Review* and request a reopening of the claim.
MAC ADR Resources

ADR resources on J11 HHH website:
• www.PalmettoGBA.com/hhh

Palmetto GBA Medical Review Fax:
• 803-699-2436

Consolidated Call Center
• 855-696-0705

January 2014
Comparative Billing Reports
Comparative Billing Reports (CBRs)

- **Not** intended to be *punitive* or sent as an indication of fraud.
- Intended to be a *proactive* statement that will help the provider identify potential errors in their billing practice.
- Contains *peer comparisons* which can be used to provide helpful insights into their coding and billing practices.
- The information provided is designed to help the *provider prevent improper billing* and payment.
CBR Resources

CMS IOM Publication Program Integrity Manual, Chapter 3, Section 3.7.2
Appeals Statistics
# Top Redeterminations by Denial Source

<table>
<thead>
<tr>
<th>Denial Source</th>
<th>Total Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connolly (RAC)</td>
<td>64,001</td>
</tr>
<tr>
<td>Cahaba (ZPIC)</td>
<td>9,664</td>
</tr>
<tr>
<td>AdvanceMed (ZPIC)</td>
<td>8,227</td>
</tr>
<tr>
<td>Health Integrity (ZPIC)</td>
<td>5,970</td>
</tr>
<tr>
<td>Trust Solutions (ZPIC)</td>
<td>623</td>
</tr>
<tr>
<td>CERT</td>
<td>503</td>
</tr>
<tr>
<td>SGS (ZPIC)</td>
<td>456</td>
</tr>
</tbody>
</table>

January 2014
# Top Claim Line Denial Reasons for Redetermination of Home Health Claims

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Definition</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>31947</td>
<td>A DDE/EMC claim has a line(s) with provider submitted non-covered charges equal to the total charge amount, then the non-covered amount will be moved to claim page 32.</td>
<td>51</td>
</tr>
<tr>
<td>5Z41H</td>
<td>Health Integrity denial for beneficiary's that are not homebound-Task order 1</td>
<td>22</td>
</tr>
<tr>
<td>5Z43H</td>
<td>Health Integrity denial for beneficiary's that are not homebound</td>
<td>10</td>
</tr>
<tr>
<td>5Z7MN</td>
<td>Info provided does not support the m/n for this service</td>
<td>10</td>
</tr>
</tbody>
</table>

January 2014
Redeterminations – Step-by-Step
Provider Options

• What Are The Providers’ Options?

• If you *agree* with the determination:
  • Pay the Overpayment
    • Pay by check
    • Use the e-Check feature in OPS
    • Allow recoupment from future payments
    • Request or apply for extended repayment plan
  • If you *disagree* with the determination:
    • Appeal
Appellate Procedure - Redetermination

- Redetermination
  - Provider has **120 days** from the date on the Medicare remittance advice to file appeal.
    - File by **Day 30** to prevent recoupment on day 41
  - Attach copy of denial letter and the appropriate *Request for Redetermination Form*. 
This figure shows the process for the determination/appeals process.

January 2014
First Level Appeal Submission via OPS

• Function gives users the ability to submit secure forms – *redetermination requests* and more to come
  • Can submit attachments
    • Up to five attachments
    • Each attachment can be up to 5 megabytes
    • Must be PDF documents

• Forms are pre-populated with information from user’s registration record
OPS Messaging Forms Screen.
Example of one of the forms in OPS where the User’s information would be pre-populated.
OPS Message Inbox Screen
First Level Appeals - Redetermination

- Appeals Forms: www.PalmettoGBA.com/HHH
  - The following forms are available:
    - 1st Level Appeal
    - 1st Level Appeal – Late Submission
    - Recovery Audit Contractor (RAC)
    - Recovery Audit Contractor (RAC) – Late Submission
    - Comprehensive Error Rate Testing (CERT)
    - Comprehensive Error Rate Testing (CERT) – Late Submission
    - Zone Program Integrity Contractor (ZPIC)
    - Zone Program Integrity Contractor (ZPIC) – Late Submission
Copy of a Redetermination CERT Form
Sample
Redetermination
CERT Form –
Late Submission
Sample Reconsideration Request Form
What Is The Status of My First Level Appeal?

• Palmetto GBA now issues *letters* for ALL appeal decisions.
  • Once a decision has been rendered on an appeal, information is loaded to the *remarks field* on the original claim.
  • If you submitted the Appeal via Online Provider Services (OPS), you can check status in *OPS*.
  • **COMING SOON**: Providers will be able to check Appeals status via the *IVR*!
Sample Medicare Redetermination Receipt Letter Concerning Recoupment

July 10, 2013

Dear Sir/Madam:

This letter serves to notify you that we have received your request for redetermination for the above listed invoice number.

Your request for redetermination was received in our office and all collection processes have ceased. However, interest will continue to accrue on any outstanding unpaid balance of the overpayment as explained in your demand letter.

You will receive a redetermination notice once the appeals department has completed their review.

If you have any questions or concerns in this matter, please write to our office or contact Palmetto GBA at 1-877-567-9249 (Part A Providers), 1-866-864-5301 (Home Health and Hospice Providers) or 1-888-614-8992 (Part B Providers). You may also visit us through our Web site at www.PalmettoGBA.com.

Sincerely,

[Signature]

Finance & Accounting
Palmetto GBA
July 02, 2013

MEDICARE REDETERMINATION DISMISSAL NOTICE

Medicare Beneficiary: [Redacted]

Case Number: A201318225444
Dates of Service: Not Provided
iFlow DCN: 13182002001080

Dear Medicare Patient Accounts:

This letter is in response to your redetermination request that was received in our office on July 01, 2013. Your redetermination request has been dismissed because it did not contain all of the information that we need to process your request. In order to process a redetermination request, we need the following pieces of information:

- The beneficiary’s name;
- The Medicare health insurance claim number of the beneficiary;
- The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service; and
- The name and the signature of the person filing the redetermination request.

Your request has been dismissed because the documentation did not contain a valid request for redetermination.

You may file your request again if it has been 120 days or less since the date of the receipt of the initial determination. When you file your request, please make sure you include all the listed items. Please send your request to:

Palmetto GBA
Part A Appeals, Mail Code AG-630
P.O. Box 100217
Columbia, SC 29202

Palmetto GBA
Part A Appeals, AG-630
Post Office Box 100217•Columbia, SC 29202
Sample Medicare Redetermination Dismissal Due to RAC Retraction Letter

August 21, 2013

Dear [Medicare Beneficiary],

Palmetto GBA received your request to reconsider the claim for the services provided to you on 01/27/2011 to 02/17/2011. Subsequently we received notification from CMS that a retraction has been made. Therefore, we are dismissing the appeal without review.

If you have any questions regarding this matter, you may write or call Palmetto GBA using the information listed in the Contact Information section above.

Sincerely,

[Appeals Coordinator]
[Part A Appeals]

Palmetto GBA
Part A Appeals, AG-630
Post Office Box 109217, Columbia, SC 29217

[Contact Information]

Please note: This is a sample letter. The actual contact information and dates will vary.
MEDICARE REDETERMINATION DECISION

Medicare Beneficiary: [Redacted]

Contact Information:
If you have questions, write or call:
Palmetto GBA
P.O. Box 100217
Columbia, SC 29202

Provider: 1-866-830-3455
Beneficiary: 1-800-633-4227

IPFlow DCN: 1313402002423

Dear [Redacted],

This letter is to inform you of the decision on your Medicare Appeal, Case Number A201313534041, for services rendered by Palmetto GBA on 07/23/2012 - 09/22/2012. After review, it has been determined that payment will be made for full episode for HIPPS 3BGK1 as there was not a face to face requirement for a recertification.

This appeal decision is fully favorable. Our decision is that your claim is covered by Medicare. More information on this decision, including the amount Medicare will pay, will follow in a future Remittance Advice or Medicare Summary Notice.

Sincerely,

Palmetto GBA
A Medicare Contractor

Palmetto GBA
Part A Appeals, AG-530
Post Office Box 100217+ Columbia, SC 29202
Sample Medicare Redetermination Decision Letter Concerning Recoupment

September 3, 2013

Dear Administrator:

This letter is in reference to the Medicare redetermination decision, for the overpayment in the amount of $3,116.41, dated to you on June 13, 2013. This decision has been noted as unfavorable.

According to our records, the overpaid amount is $3,116.41. The balance owed on this account is $3,106.99, which includes interest.

Since the redetermination decision was unfavorable and the debt has not been paid in full, recoupment will begin or resume. You may begin to recoup no earlier than 60 days after the date of this letter. Please note that if recoupment is stopped, interest continues to accrue.

Rebatement Process:

Under our existing regulations 42 CFR 405.374, providers, physicians and suppliers will have 15 days from the date of this letter to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence setting forth why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. If you have reason to believe the withhold should not occur, you must notify this office within 15 days from the date of this letter. CMS will review your documentation. One office will advise you of our decision in 60 days from your request. However, this is not an appeal of the recoupment determination, and it will not delay recoupment. The rebuttal statement does not delay recoupment activities consistent with Section 935 of the NPA.

All rebates can be found to the following numbers below:

Part A overpayment rebates 803-264-6244
Part B overpayment rebates 803-264-6301

Electronic Business Center 803-264-6262

October 2014
Medicare Overpayment Process
## Key Timeframes for Stopping Overpayment

### Recoupment in Relation to Appeals

<table>
<thead>
<tr>
<th>Appeal</th>
<th>Deadline</th>
<th>Date</th>
<th>Important</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Redetermination</strong></td>
<td>File by Day 30</td>
<td>From the date on the demand letter</td>
<td>Interest begins to accrue at day 31 and continues to accrue throughout the appeals process</td>
</tr>
<tr>
<td></td>
<td>*To prevent offset on day 41 (You have 120 days to request a redetermination)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reconsideration</strong></td>
<td>File by Day 60 (You have 180 days to request a reconsideration)</td>
<td>From the date of the unfavorable or partially favorable redetermination decision letter</td>
<td>Even when recoupment is stopped, interest continues to accrue</td>
</tr>
<tr>
<td><strong>Administrative Law Judge (ALJ), Appeals Council Review or Judicial Review in U.S. District Court</strong></td>
<td>Recoupment will begin or resume on Day 76 (You have 60 days to request ALJ)</td>
<td>From the date on the original demand letter</td>
<td>Recoupment will begin or resume whether or not you appeal to any further level</td>
</tr>
</tbody>
</table>
Section 935 Overpayment Recoupment Process Job Aid on Palmetto GBA’s Website

Jurisdiction 11 Home Health and Hospice
SECTION 935 OVERPAYMENT RECOUPMENT PROCESS

This job aid provides guidance and direction on the 935 Overpayment and Recoupment Process. Section 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provides limitations on the recoupment of Medicare overpayments.

Overpayments subject to the Limitation on Recoupment
- Post payment review determinations made by any of the following claim review programs:
  - Palmetto GBA Medical Review (MR)
  - Zone Program Integrity Contractor (ZPIC)
  - Comprehensive Error Rate Testing (CERT) contractor
  - Recovery Auditor (RA)
  - Medicare Secondary Payer (MSP) recovery for a duplicate primary payment to a provider
  - MSP recovery because the provider failed to file a claim with a third-party payer

Overpayments Not Subject to the Limitation on Recoupment
- Other MSP recoveries not mentioned above
- Beneficiary overpayments
- Cost report determinations
- Hospice CAP overpayments
- Provider-initiated adjustments
Finance & Accounting Training Modules on Palmetto GBA’s Website

Jurisdiction 11 Home Health and Hospice
FINANCE & ACCOUNTING TRAINING MODULES

Palmetto GBA is excited to announce that our education team has developed a Finance and Accounting educational series that consists of two Web-based Training modules. These self-paced training modules provide an introduction to finance and accounting principles at Palmetto GBA. The following training modules are available:

- Finance & Accounting: Part I
- Finance & Accounting: Part II

The self-paced learning modules will assist providers in understanding the various elements included in the financial and accounting processes for Palmetto GBA including the overpayment process, the demand letter process, the intent to refer process, etc. These training modules are intended to assist providers in learning the entire finance process from the beginning to the completion of various accounting procedures. Please ensure that these self-paced modules are shared with your finance and billing staff. Our goal is to ensure that our self-paced learning products are available for individual staff development and training at each provider facility.

last updated on 10/10/2013
Affiliated Providers and the Recoupment Process

• CMS has the authority to adjust payments to related providers and suppliers on the basis of their **tax ID number**.

• An affiliated provider is a provider that shares the same Tax Identification Number (TIN) and is noted as part of a Hospital Group (i.e., sub-units).

• On the Electronic Remittance Advice (ERA), a code of 'OA' is used for Part A Affiliated Withholdings and a code of 'OB' is used for Part B Affiliated Withholdings.
e-Check Payment via OPS

- Allows payments to be sent electronically to Palmetto GBA
- Only *check payments* are accepted through this form
- Utilizes PHT A-Claim technology to make payment with your financial institution
- No transaction fee
- Just need your checking *routing* and *account* number
OPS e-Check Form Screen
e-Offset via OPS

• Allows offset information to be sent electronically to Palmetto GBA
• Users have option to request immediate offset
• Users can make request for permanent offsets
OPS e-Offset Form Screen
Final Thoughts

• What Can Providers Do?
  • Learn from previous improper payments
  • Self Audit
  • Identify corrective actions
  • Appeal when necessary
  • What’s In It For Me “WIFM”? Remember this is part of provider compliance in the Medicare program and it can lead to future review of your claims
Medicare Regulatory Updates
Change Request 8458

- Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius.

- Summary of Changes: In accordance with the Jimmo v. Sebelius Settlement Agreement, CMS has agreed to issue revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services.
  - “...does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care.” Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

- Effective Date: January 1, 2014
- Implementation Date: January 6, 2014
Change Request 8458

• Manual clarifications:
  
  • No “Improvement Standard” is to be applied in determining Medicare coverage for maintenance claims that require skilled care.
  
  • Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition).
  
  • Coverage depends not on the beneficiary’s restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves.

January 2014
Change Request 8458

- Manual clarifications...
  - Enhanced guidance on appropriate documentation
    - Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care.
  - While the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.
Change Request 8458

- Manual clarifications...
  - The Settlement Agreement. The Jimmo v. Sebelius settlement agreement itself includes language specifying that “Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage.”
  - The intent is to clarify Medicare’s longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.
Change Request 8441

• Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care.

• Summary of Changes:
  • For claims with episodes that begin on or after July 1, 2014, the home health agency (HHA) shall report on the claim the NPI and the name of the physician who certifies/re-certifies the patient's eligibility for home health services as well as the NPI and the name of the attending physician who signs the home health plan of care (POC).
Change Request 8248

• Termination of the Common Working File ELGA, ELGH, HIQA, HIQH, and HUQA Part A Provider Queries
  • Effective Date: April 7, 2014
  • Implementation Date: April 7, 2014

• Summary of Changes: CMS needs to eliminate the CWF ELGA/ELGH/HIQA/HIQH/HUQA Part A queries as they can no longer support the approach of allowing providers online access to CWF non-HIPAA compliant data
Change Request 8248

• Palmetto GBA providers will use Online Provider Services (OPS) for eligibility inquiries effective April 7, 2014
  • Ensure that your office staff are enrolled in OPS and know how to access eligibility information!

• The IVR may also be used

• HIPAA Eligibility Transaction System (HETS) Help (270/271)
OPS Eligibility Screen
Web Resources
Palmetto GBA’s Top Links option on the website contains the most common links.
NEW! Claims Processing Issues Log (CPIL) Enhancement

Article Update Notification screen that allows providers to request regular updates on a specific item listed on the CPIL.

last updated on 01/03/2014
Self-Service Tools

The Self-Service Tools Option on Palmetto GBA’s website contains a number of tools to assist providers with their questions.
Self-Service Tools

The Self-Service Tools Option on Palmetto GBA’s website contains a number of tools to assist providers with their questions.
The Left Navigation under Learning and Education displays the Event Registration Portal option on Palmetto GBA’s website.
Sample of Palmetto GBA’s Event Registration Portal

Welcome to Palmetto GBA Event Registration Portal

Palmetto GBA is excited to announce this portal as our one-stop shop for all Palmetto GBA hosted events. Replacing the Workshops database, this new portal was designed with a more intuitive event registration process and a user-friendly layout. To register for an event, first use your Event Registration Portal user name and password to login, then select the event you want to register for. New users must create a profile before registering. Read More for additional registration instructions.

| Contract: AI
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Event</strong></td>
</tr>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>Evaluation and Management (E/M) Services: Webcast Series for Part B</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) Consolidated Billing Webcast (Part A)</td>
</tr>
<tr>
<td>Ask the Contractor Teleconference: Documentation for Medical Necessity (Part A)</td>
</tr>
<tr>
<td>Ask The Contractor Teleconference (HRA &amp; Part A)</td>
</tr>
<tr>
<td>Debridement of Ulcers and Wounds Webcast: Part B</td>
</tr>
<tr>
<td>Ask The Contractor Teleconference (HRA)</td>
</tr>
</tbody>
</table>

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To request education, select the “forms Option on the left navigation on Palmetto GBA’s website.
Educational Resources Available

The Learning & Education options is located on the left navigation on Palmetto GBA’s website.
Other Resources Available

The Resources option is located on the left navigation of Palmetto GBA’s website.
Foresee Survey

ForeSee Website Satisfaction Survey Article on Palmetto GBA’s website. See why it is important for you to take the survey.
Other Important Resources

- www.cms.gov/Medicare/Medicare.html
  Medicare Fee-for-Service Payment

- www.cms.gov/manuals
  CMS Internet Only Manuals (IOMs)

- www.cms.gov/MLNMattersArticles
  Explanation of Change Requests, training guides, articles, educational tools, booklets, brochures, fact sheets, web-based training courses

January 2014
Questions?