Navigating the Medicare Maze for Home Health Providers
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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.
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
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

• 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
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?
• 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
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
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.
Health Information Supply Chain (HISC)

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.

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

DMAIC Step 1 – Define

The “D” in the DMAIC process focuses on clearly articulating the business problem, goal, potential resources, project scope and high-level project timeline

• Seek to clarify facts.
• Set objectives.
• Define which metrics are most important
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 historical performance.
• Measure key aspects of the current process and collect relevant data
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.
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”.

April 2014
Impact Severity Priority

- High (Red)
- Medium (Yellow)
- Low (Green)

Determined by mapping the a risk category and the observed probability of denial in the sampled claims

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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.

• Identify, test and implement a solution to the problem
Improve

• Test solutions.
• 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 = \frac{\text{Results of work efforts}}{\text{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
Figure 1 displays the elements of the Plan, Do, Study, Act (PDSA) Cycle

**PDSA Cycle, 1994**

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

**Model for Improvement, 1996, 2009**
Improve

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.
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
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 Disbursement 32 X

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## Home Health Disbursement 33 X

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<td>3,767</td>
<td>3,768</td>
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## Home Health Aggregate Length of Stay Jul-Dec 2013

<table>
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<tr>
<th>State</th>
<th>Median LOS</th>
<th>Mean LOS</th>
<th>Number of Bene</th>
<th>Number of Claims</th>
<th>% SSI</th>
<th>% Diabetes</th>
<th>% Vagueness</th>
<th>% Wound Care</th>
<th>% Alzheimers</th>
<th>% Hypertension</th>
<th>% Benes w/ Multiple Providers</th>
<th>% Benes w/ Discharge</th>
<th>Disbursement per Bene</th>
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<td>1.9</td>
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<td>7.5</td>
<td>11.9</td>
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<td>49.2</td>
<td>21.8</td>
<td>4,277</td>
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</tbody>
</table>
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.

- ☆ Strike Force city.
- ★ Strike Force city with individuals charged for billing potentially fraudulent HHA services in 2011.
- ○ City located in State with high percentage of HHA questionable billing identified by OIG.
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.
• 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>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>20</td>
<td>6</td>
<td>$7,356.00</td>
<td>20%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>72</td>
<td>6</td>
<td>-$53,178.40</td>
<td>-33%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>214</td>
<td>29</td>
<td>$39,490.66</td>
<td>8%</td>
</tr>
<tr>
<td>Texas</td>
<td>72</td>
<td>15</td>
<td>$2,119.65</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>
</tr>
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</table>

April 2014
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>Claims Reviewed</th>
<th>Claims Denied</th>
<th>Dollars Denied</th>
<th>CDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>38</td>
<td>9</td>
<td>$13,633.89</td>
<td>18%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>8</td>
<td>1</td>
<td>$2,846.34</td>
<td>18%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>52</td>
<td>9</td>
<td>$18,833.58</td>
<td>20%</td>
</tr>
<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>
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

<table>
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<th>Description</th>
<th>Count</th>
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<tr>
<td>Prepay Complex Reviews</td>
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<tr>
<td>Post Pay Complex reviews</td>
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</tr>
<tr>
<td>HHH Total</td>
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</table>
## Medical Review Outcomes for Home Health

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Region(s)</th>
<th>Claims Reviewed</th>
<th>Claims Denied</th>
<th>Dollars Denied</th>
<th>CDR%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2CGK</td>
<td>Midwest</td>
<td>10</td>
<td>8</td>
<td>$14,958.92</td>
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<tr>
<td>2CGK</td>
<td>Southeast</td>
<td>3</td>
<td>2</td>
<td>$2,044.58</td>
<td>91%</td>
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<tr>
<td>2CGK</td>
<td>Southwest</td>
<td>20</td>
<td>16</td>
<td>$27,559.57</td>
<td>80%</td>
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<tr>
<td>2CGK</td>
<td>Gulf Coast</td>
<td>8</td>
<td>3</td>
<td>$7,962.14</td>
<td>44%</td>
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<tr>
<td>1BGP</td>
<td>Midwest</td>
<td>758</td>
<td>494</td>
<td>$1,508,759.91</td>
<td>60%</td>
</tr>
<tr>
<td>1BGP</td>
<td>Southeast</td>
<td>733</td>
<td>428</td>
<td>$1,278,384.71</td>
<td>55%</td>
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<tr>
<td>1BGP</td>
<td>Southwest</td>
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<td>558</td>
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<td>1BGP</td>
<td>Gulf Coast</td>
<td>1,355</td>
<td>809</td>
<td>$2,572,126.84</td>
<td>57%</td>
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<tr>
<td>Total</td>
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<td>3,833</td>
<td>2,318</td>
<td>$7,161,092.51</td>
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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
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

<table>
<thead>
<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>Provider Count 2013H1</th>
<th>Provider Disbursement per Beneficiary 2013H1</th>
<th>Provider Disbursement per Beneficiary 2012H2</th>
<th>Provider Disbursement per Beneficiary 2012H1</th>
<th>Billed Charge 2013H1</th>
<th>Covered Charge 2013H1</th>
<th>Claim Count 2013H1</th>
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<tr>
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<td>106,875</td>
<td>41</td>
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<td>2,554</td>
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<td>2,972</td>
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<td>2,840</td>
<td>2,902</td>
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April 2014
## 780.4 Dizziness and Giddiness

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April 2014
### Headache

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| GA    | .                            | .                            | 4,923                 | .                                        | .                        | 4,923                                       | .                           | .                                           | .                   | .                   | .                   |
| IL    | .                            | 8,399                       | 6,927                 | .                                        | .                        | .                                           | 2,800                       | 2,309                                       | .                   | .                   | .                   |
| IN    | 2,178                        | 523                         |                      | 1                                        | 2,178                    | 1                                           | 2,178                       | 523                                         | 4,209               | 4,209               | 4,209               | 1
| KY    | .                            | .                            | 3,865                 | .                                        | .                        | .                                           | .                           | .                                           | 1,933               | .                   | .                   |
| LA    | 2,826                        | 2,990                       | .                     | 1                                        | 2,826                    | 1                                           | 2,826                       | 1,495                                       | 2,761               | 2,761               | 2,761               | 1
| NC    | 3,534                        | 0                           | 2,009                 | 2                                        | 1,767                    | 2                                           | 1,767                       | 0                                           | 2,009               | 5,777               | 5,777               | 2
| OH    | 7,682                        | 3,818                       | 398                   | 4                                        | 1,921                    | 4                                           | 1,921                       | 3,818                                       | 398                 | 7,143               | 7,143               | 4
| OK    | 3,008                        | .                            | 2                     | 1,504                                    | 2                        | 1,504                                       | .                           | .                                           | 2,343               | 2,343               | 2,343               | 2
| SC    | 1,263                        | 2,807                       | .                     | 1                                        | 1,263                    | 1                                           | 1,263                       | 2,807                                       | .                   | 1,800               | 1,800               | 1
| TX    | 17,016                       | 20,711                      | 13,942                | 8                                        | 2,127                    | 8                                           | 2,127                       | 2,071                                       | 2,788               | 13,605              | 13,605              | 8
| Other | 2,281                        | 8,731                       | 2,637                 | 1                                        | 2,281                    | 1                                           | 2,281                       | 2,910                                       | 2,637               | 2,410               | 2,410               | 1
| TOTAL | 47,357                       | 73,184                      | 46,086                | 24                                       | 1,973                    | 24                                          | 1,973                       | 2,287                                       | 2,095               | 46,666              | 46,666              | 24

April 2014
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| April 2014 | 75 |
# 787.3 Flatulence/Gas Pain

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Going Beyond Diagnosis®
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.

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


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.

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
Image of the Psychological, Biological and Social factors.

http://www.ashburnpsychologist.com/images/woman.jpg
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.
Comorbid Conditions

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

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

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

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

http://top100doctors.com/


April 2014
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.
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.

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
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
Ambient

• 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.

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
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.

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
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.

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
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”.

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

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

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

April 2014
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

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.
How to Chart

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

http://www.naijanursesforum.com/viewtopic.php?f=22&t=180&sid=a8aeaa09fa6be6d568a1495e83c9b8ac
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.

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

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.
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.
• 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 documentation 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 tub-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:
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 tub.
Functional Outcomes

Relate performance component goals to functional outcomes.

• 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.
**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.

Underlying factors are clearly related to functional problems.

Expectations for progress in this area are clearly stated.

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

Because the Face-to-Face is a requirement for payment, when the Face-to-Face requirements 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

April 2014
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
“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.”
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.
Checkboxes

The face-to-face documentation can include, or exist as, checkboxes so long as it comes from the certifying physician.
Face to Face Checklist

General:
• Is the face to face document labeled and dated?
• Is it performed within the time frame (90 days before - 30 days after)?
• Is it legible?
• Is it signed and dated prior to the submission of the claim for billing?
• Does it contain the date of the encounter
Face to Face Checklist

• Clinical Findings:
• Does it describe the patient's condition and symptoms, not just a list of diagnoses?
• Is this a new problem or an exacerbation of a previous problem?
Face to Face Checklist

• Clinical Findings:
• If this is a post operative patient:
  • How long ago was the surgery?
  • Were there any complications?
  • If pain is documented, how severe is the pain?
Skill Need:

- Is there evidence that skilled Physical Therapy (PT) is needed? (Note this is not an all-inclusive list.)
- Assessment of functional deficits and home safety evaluation
- Therapeutic Exercises
- Restore joint function for post joint replacement patient
- Gait Training
- ADL Training
Face to Face Checklist

Homebound Status:

• Description is not limited to weakness, considerable and taxing effort, poor endurance
• Does it contain a description of the patient's condition and symptoms, not just a diagnosis and not just the need for an assistive device?
• If shortness of breath is applicable, describe the severity (severe at rest, with minimal exertion, etc)
Face to Face Checklist

- Weakness as evidence by ________________
- Does the patient exhibit symptoms when attempting to walk (increase pain, shortness of breath, etc.)
- The patient has medically restricted the patient to the home due to: ________________
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
Who Moved My Cheese?

The Cheese Experience

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

By Spencer Johnson, M.D.
Four Characters
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

April 2014
When You Can Change What You Believe, You Can Change What You Do!
Imaging Yourself Enjoying *New Cheese*, Even Before You Find It, Leads You To It
Picture Plus *Passion*

Powers You

Through The Maze
Vision and Reality.

Imagine
The Results You Want

Hold that Vision
Until It Is Reality

ENJOY THE FEELING!

April 2014
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?

WOW... HOW DID HE DO THAT SO FAST?
Navigating the Maze to the End!
Agenda

• Medicare Regulatory Updates
• Who Can Review Your Medicare Claims?
  • Recovery Audit Contractor (RAC)
  • Zone Program 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
• Web Resources
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.
  - Enhanced guidance on appropriate documentation
  - The Jimmo v. Sebelius settlement agreement 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 as it pertains to skilled services
Change Request 8458

• Re-reviews of claims can be requested on maintenance care denials that became final and non-appealable from 1/18/11-1/23/14. These will be handled as re-openings. Requests may be submitted through 1/23/15.

• Learn more by listening to Palmetto GBA’s recorded webcast at www.PalmettoGBA.com/hhh. Select Learning and Education>Self-Paced Learning.
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

• CMS revised MLN Matters SE1249 on February 10, 2014
  • Implementation of CR 8248 is delayed
  • CMS will provide at least 90 days advanced notice of the new termination date
• Palmetto GBA providers will use Online Provider Services (OPS) for eligibility inquiries
  • 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)
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

April 2014
RAC

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

• Under Important Links, click on ‘Approved Issues’
• Search Box above the Issue Name: Type in Home Health
### 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 - C004882013</td>
<td>Complex</td>
<td>Home Health</td>
<td>Region C - (FL, TX, LA, NC)</td>
<td>12/3/2013</td>
<td>Details</td>
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<tr>
<td>Hospice related services billed with Condition code 07- Home Health: C006802012</td>
<td>Automated</td>
<td>Home Health</td>
<td>Region C</td>
<td>11/26/2012</td>
<td>Details</td>
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<tr>
<td>Home Health Agency - Medical Necessity and Conditions to Qualify for Services Issue Number: C002222011</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, Virginia 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: C006662011</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, Virginia 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, Virginia Islands, Virginia, West Virginia</td>
<td>1/27/2012</td>
<td>Details</td>
</tr>
</tbody>
</table>
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

Scroll to ‘Search Criteria’ and enter ‘Home Health’ in the Claim Type Box
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>MI, IL, OH</td>
<td>12/3/2013</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, KY</td>
<td>4/2/2013</td>
<td>Details</td>
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<tr>
<td>Home Health Skilled Nurse Length Of Stay</td>
<td>Complex</td>
<td>Home Health (HHA)</td>
<td>MI, IL, OH</td>
<td>8/1/2013</td>
<td>Details</td>
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<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

Search | Reset
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 (*Complex*)
• 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 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 the *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.
<table>
<thead>
<tr>
<th>Option</th>
<th>Discussion Period</th>
<th>Rebuttal</th>
<th>Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who to Contact</td>
<td>RAC</td>
<td>MAC</td>
<td>MAC</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Day 1-40</td>
<td>Day 1-15</td>
<td>Day 1-120</td>
</tr>
<tr>
<td></td>
<td>[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.]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeframe Begins</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>Timeframe Ends</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**

![RA Document Example](image-url)
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

April 2014
Upcoming RAC Program Improvements

• CMS plans to contract with four A/B Recovery Auditors and one national DME and Home Health/Hospice Recovery Auditor

• These changes will be effective with the next Recovery Audit Program contract awards
  • Recovery Auditors must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment.
  • Recovery Auditors must confirm receipt of a discussion request within three days.
  • Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.
Upcoming RAC Program Improvements

- These changes will be effective with the next Recovery Audit Program contract awards (cont.)
  - The CMS is establishing revised ADR limits that will be diversified across different claim types.
  - CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider’s denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.
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.
Sample RAC Demand Letter

April 2014
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
Zone Program Integrity 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
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”

• **5Z71V**: “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.
CERT

• The CERT program uses a *random* and a *service-specific* sampling of claims.

• There are *two contractors* responsible for administering the CERT program on behalf of CMS.
  
  • The CERT review contractor selects *samples of claims* from Palmetto GBA.

  • For each claim selected, the CERT documentation contractor (CDC) *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

- Identify improper payments
- 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
Medicare A/B Contractor CERT Task Force

- National educational task force
- Includes representatives from each MAC contractor across the country
- Intended to enhance not replace ongoing educational activities and material created by CMS and individual contractors
Medicare A/B Contractor CERT Task Force

• Develop and disseminate education on CERT issues of mutual concern
• Educational topics to focus on common Part A, Part B, or Home Health and Hospice CERT errors
• Shared goal of reducing CERT error rate through national awareness and education
• http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Jurisdiction%20Home%20Health%20and%20Hospice~CERT~CERT%20Task%20Force?open&expand=1&navmenu=CERT
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

April 2014
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.
Strategic Health Solutions

• 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.
Strategic Health Solutions Resources

www.strategichs.com

4211 South 102ND Street
Omaha, NE 68127

Customer Service at 888.963.5527
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.
OIG Resources

WWW.OIG.HHS.GOV
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*. 

April 2014
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
The ADR Response Calculator option on Palmetto GBA’s website.

If you have received an Additional Documentation Request (ADR) for one or more claims, you will have 30 days from the date of the letter to submit supporting records. If we do not receive your documentation within 45 days, your claim will be denied for lack of a response.

Our ADR Calculator can help you submit your documentation timely. Just enter the date found on your ADR letter and click 'Calculate'. The tool will tell you the last date you can submit your records to our office.

If you have questions about how to read your ADR letter, please call the Home Health and Hospice Provider Contact Center at 855-696-0705. Representatives are available from 8 a.m. to 5 p.m. ET.

Enter the date of the ADR letter: 01/14/2014

Return requested information by:

©2014, Palmetto GBA, LLC
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 the 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
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>
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<td>Health Integrity (ZPIC)</td>
<td>5,970</td>
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<tr>
<td>Trust Solutions (ZPIC)</td>
<td>623</td>
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<tr>
<td>CERT</td>
<td>503</td>
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<tr>
<td>SGS (ZPIC)</td>
<td>456</td>
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April 2014
<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Definition</th>
<th>Number</th>
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<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>
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
First Level Appeal - 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.
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

[Redacted]

[Redacted]

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 1-877-562-0249 (Part A Providers), 1-866-801-5391 (Home Health and Hospice Providers) or 1-888-414-4392 (Part B Providers). You may also visit us through our Web site at www.PalmettoGBA.com.

Sincerely,

S. | Finance & Accounting
Palmetto GBA

[Redacted]
Dear Medicare Beneficiary:

Case Number: A201318225444
Dates of Service: Not Provided
Ref. DCN: 13182002001080

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
Sample Medicare Redetermination Dismissal Due to RAC Retraction Letter

August 21, 2013

Dear [Name],

Palmetto GBA received your request to reconsider the claim for the services provided to [Benefits Effective Date] to [EndDate] in February 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,

[Appeal Coordinator Name]

Part A Appeals

Palmetto GBA
Part A Appeals, AG-630
Post Office Box 109217
Columbia, SC 29202-0921
This letter is to inform you of the decision on your Medicare Appeal, Case Number A201313534014, for services rendered by on 07/23/2012 - 09/22/2012. After review, it has been determined that payment will be made for full episode for HIPP 3BGX1 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
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 issued 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 $3,166.99, which includes interest.

Since the redetermination decision was unfavorable and if the debt has not been paid in full, recoupment will begin or resume. We 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 date of this letter to submit a statement of opportunity to rebate. The rebatement process provides the debtor the opportunity to submit a statement and/or evidence asserting why recoupment should not be initiated. The outcome of the rebatement process could change how or if we recoup. If you have reason to believe the withhold should not occur, you must notify the state within 15 days of the date of this letter. CMS will review your documentation. Our office will advise you of our decision in 15 days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment. The rebatement process does not cease recoupment activities in accordance with section 955 of the NPA.

All rebates can be found at the following numbers below:

Part A overpayment rebates: 800-264-0244
Part B overpayment rebates: 800-264-6309
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>Redetermination</td>
<td>File by Day 30 *To prevent offset on day 41 (You have 120 days to request a redetermination)</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>Reconsideration</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>Administrative Law Judge (ALJ), Appeals Council Review or Judicial Review in U.S. District Court</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

April 2014
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
Web Resources
Top Links

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

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.

Select a Contract: AI

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Time</th>
<th>Type</th>
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</thead>
<tbody>
<tr>
<td>Evaluation and Management (E/M) Services:</td>
<td>01/15/2014 -</td>
<td>02/26/2014</td>
<td>Series</td>
</tr>
<tr>
<td>Webcast Series for Part B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation and management (E/M) Webcast</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>services are a ‘key component’ to every</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>practice.</td>
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<td></td>
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<tr>
<td>Skilled Nursing Facility (SNF) Consol</td>
<td>01/16/2014</td>
<td>10:00 AM -</td>
<td>Webinar</td>
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<tr>
<td>ided Billing Webcast (Part A)</td>
<td></td>
<td>11:00 AM</td>
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<tr>
<td>Join Palmetto GBA for the Skilled Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Consolidated Billing webcast on</td>
<td></td>
<td></td>
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<td>January 16, 2014, from 10 to 11 a.m. ET.</td>
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<td>Registration Deadline: 01/16/2014</td>
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<td>Ask the Contractor Teleconference:</td>
<td>01/16/2014</td>
<td>02:00 PM -</td>
<td>Telecon</td>
</tr>
<tr>
<td>Documentation for Medical Necessity (Part</td>
<td></td>
<td>03:00 PM</td>
<td></td>
</tr>
<tr>
<td>A)</td>
<td></td>
<td></td>
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<tr>
<td>Palmetto GBA will host an ACT to discuss</td>
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<td></td>
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<tr>
<td>‘Documentation for Medical Necessity’.</td>
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<td></td>
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<td>Registration Deadline: 01/16/2014</td>
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<tr>
<td>Ask the Contractor Teleconference (HIPAA &amp; Part A)</td>
<td>01/21/2014</td>
<td>02:00 PM - 03:00 PM</td>
<td>Teleconference</td>
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<td>Palmetto GBA will host ‘Ask the Contractor Teleconferences’ (ACTs) on various topics throughout the year. Registration Deadline: 01/21/2014</td>
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<tr>
<td>Debridement of Ulcers and Wounds Webcast:</td>
<td>01/22/2014</td>
<td>10:00 AM -</td>
<td>Webinar</td>
</tr>
<tr>
<td>Part B</td>
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<td>11:30 AM</td>
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<tr>
<td>Palmetto GBA is offering a FREE webcast to review our Local Coverage Determination Debridement of Ulcers and Wounds guidelines. Registration Deadline: 01/22/2014</td>
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<td>Ask the Contractor Teleconference (HIPAA)</td>
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<td>02:00 PM -</td>
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<td>Palmetto GBA will host ‘Ask the Contractor Teleconferences’ (ACTs) on various topics throughout the year. Registration Deadline: 04/15/2014</td>
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Requesting Education

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.
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
Questions?