Tuesday, October 15, 2019 3:45 PM

805 Getting it Right: Improved Intake Under PDGM

Setting Sail with Start of Care: Getting it Right From Intake to Admission

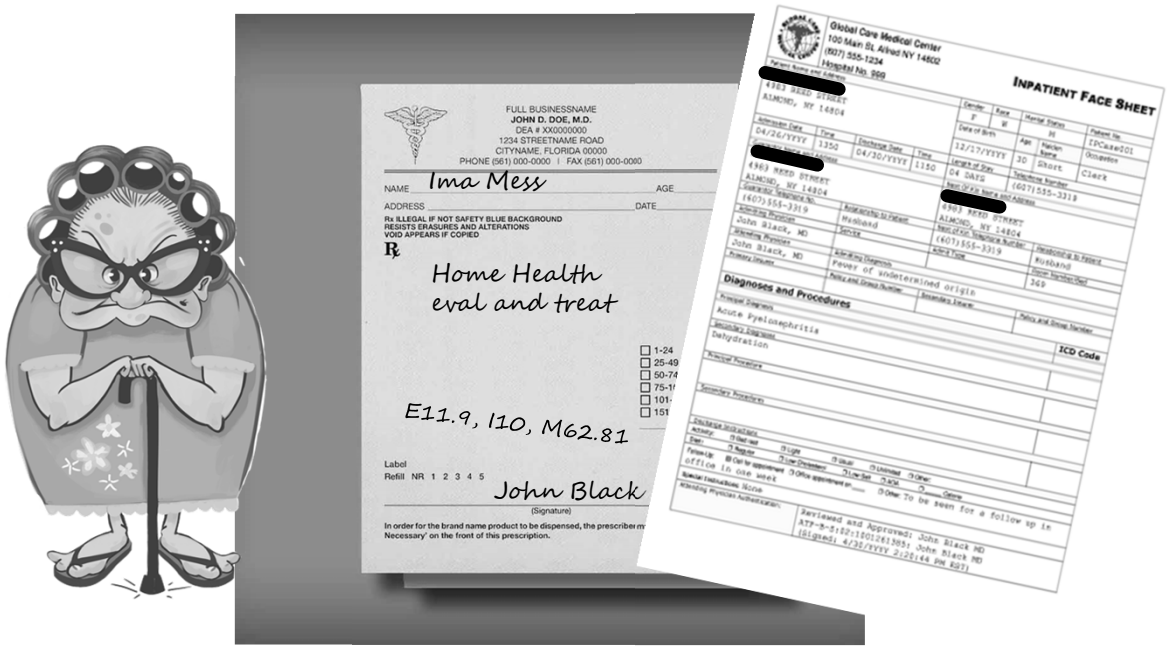
Home Health Solutions, LLC
Partners in Care

Setting Sail with Start of Care: Getting it Right from Intake through Admission

There are so many factors to consider when taking on a new patient. From the intake process, MD certification, face to face documentation, staffing…all of the parts and pieces have to mesh in order to have a proper referral and admission. If one, or more, of the parts are missing or are incorrect, agencies set themselves up for complaints, denials, ADRs and a host of other things we'd all rather avoid. By understanding the factors and documentation necessary for a proper referral and admission, agencies can better manage their patients and revenue flow from intake through discharge.

At the conclusion of the presentation, the participant will be able to:

- Identify the components of the home health eligibility criteria and required physician documentation.
- Cite Medicare compliant Face to Face documentation.
- Recognize what constitutes effective intake and referral information.



In the beginning: Improved Intake Processes

- Imperative that accurate information be obtained at time of intake.
  - Appropriate referral? Is patient eligible for home care?
  - Demographics and referral documents
  - CoPs
  - Payment
  - Diagnosis

Eligibility

Eligibility for Home health

- Be confined to the home with clearly documented home bound status
- Be under the care of an MD who will establish and periodically review the POC
  - NPI must match the MD signing the POC
- Be in need of skilled nursing &/or therapy which is both reasonable and medically necessary
  - Documentation must show care is necessary to:
    - Improve patient's current condition or,
    - Maintain current condition or,
    - Slow further decline in condition
- Accurate F2F documentation

Rank	Denial Code	Denial Description	# of Claims Denied	% of Claims Denied
1	5HC01	The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.	375	28%

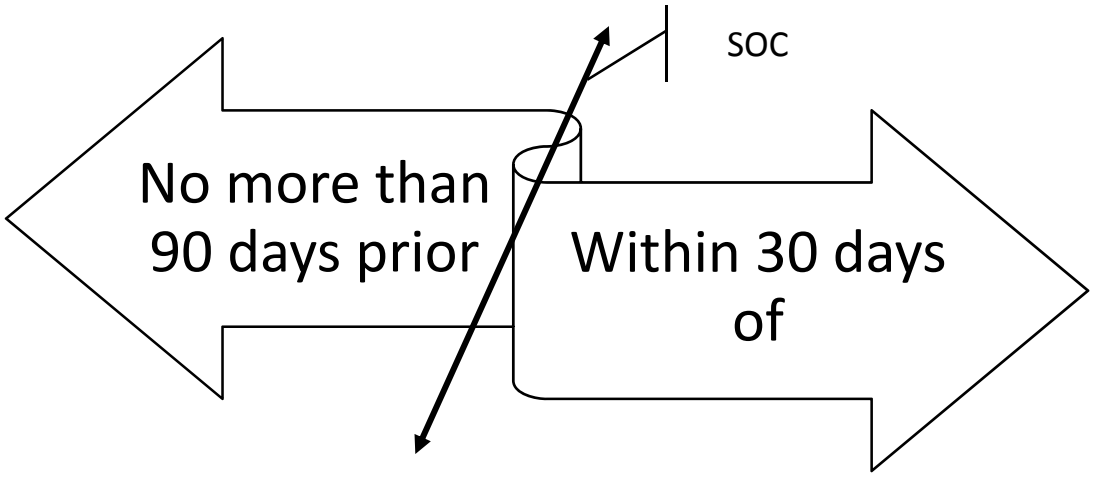
CGS
Jan-Mar 2019

Rank	Denial Code	Denial Description	# Claims	% Claims Denied
1	56900	Auto Denial — Requested Records not Submitted	1,479	40.0
2	5FF2F	Face-to-Face Encounter Requirements Not Met	1,165	31.5
3	5F023	No Plan of Care or Certification	471	12.7
4	5FNOA	Unable to Determine Medical Necessity of HIPPS Code Billed as Appropriate Oasis Not Submitted	213	5.8

Palmetto
Oct-Dec 2018

Face to Face $$$

Face to Face	
	MD/NPP: _____ Date of visit: _____
	Visit note appropriate & attached?: _____ Visit within timeframe?: _____
	F2F visit pending with: _____
	Scheduled F2F date: _____ Within 30 days of SOC?_____



Who May Complete the F2F?

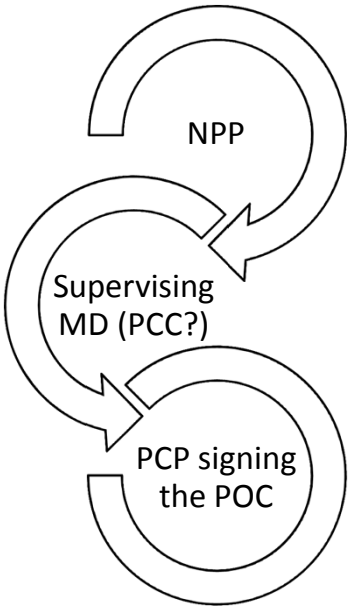
- Certifying physician
- Physician/NPP who cared for patient in acute/post-acute facility
- Nurse practitioner
- Clinical Nurse Specialist
- Certified nurse-midwife
- Physician Assistant

***But remember only an MD (doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license) can order home health, write ongoing orders for home health, and sign the Plan of Care ***

FAQ on SOM manual released Jan. 23, 2019

- Q. Can mid-level providers, such as nurse practitioners and physician assistants, write orders for home health services?
- A. No, only a physician can write orders for home health services. Section 1861(m) of the Social Security Act requires that the home health plan of care be established and maintained by a physician and does not include other licensed practitioners, such as nurse practitioners and physician assistants. Only physicians may establish and maintain the home health plan of care, including reviewing, signing, and ordering home health services.

What will complete your F2F circle?

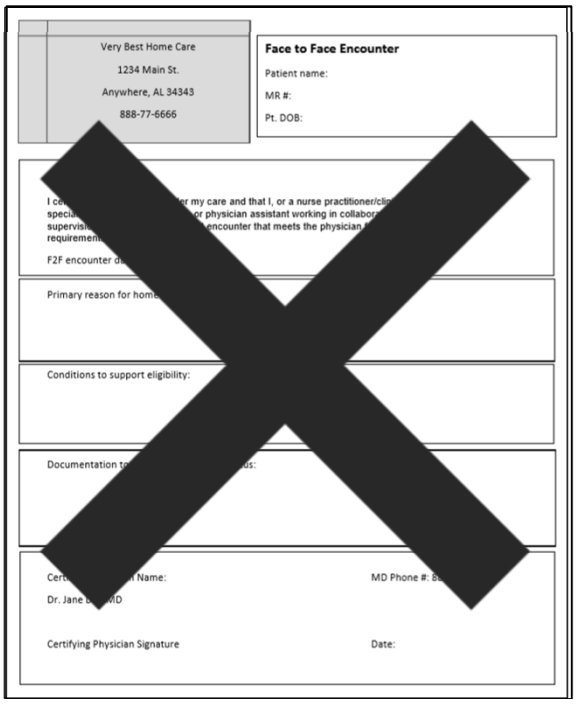


Required Components of the F2F

- ***Documentation of the name of the MD or NPP who saw the patient and the date of the encounter.
- Clinical condition that supports homebound status
- Need for skilled services
  - Supports primary reason the patient required home health
- ***Reason for home health referral
- ***MD name, signature and date

*** items must come directly from MD

Additional items may be located throughout the medical record but must be clearly identifiable



F2F Documentation

APPROPRIATE	INAPPROPRIATE
• Discharge summary • MD office visit note • Progress note from acute/post-acute facility • Note on MD letterhead summarizing the required information. Must include the date of the actual encounter. • Clinical summary • Admission summary • History & Physical	Diagnosis list alone Recent procedures alone Recent injuries alone Generic statement without specific clinical finding to indicate what makes the patient homebound: "taxing effort to leave home" "gait abnormality" "weakness/muscle weakness"

Word Up on F2F

- Address the F2F proactively
- Have a process for monitoring pending F2F visits
  - Who will monitor & maintain the F2F log? Add to the job description and HAVE A BACKUP!!!
- Know what barriers the patient may have when making the MD F2F visit and address ASAP.
- Must have the actual visit or encounter note
- F2F is a condition of payment

The Basics

Demographics

Demographics	
	Referral date: _____ Patient Name: _____ DOB: _____ Address: _____ Phone #: _____ Email: _____ Gender: ☐ Male ☐ Female

- Referral date:
  - When was the referral received?
  - This will be your M0104 date of referral unless updated or MD ordered SOC received.
  - UPDATE with additional information if patient SOC to be delayed.
    - 48 hr. window for initial assessment starts with this date

So what?

Home Health Compare

Process of care measures

Process of care measures show how often home health agencies gave recommended care or treatments that research shows get the best results for most patients. The list of process measures includes:

Process measures	As listed on Home Health Compare	Data source
Timely initiation of care	How often the home health team began their patients' care in a timely manner.	OASIS
Influenza immunization received	How often the home health team made sure that	OASIS

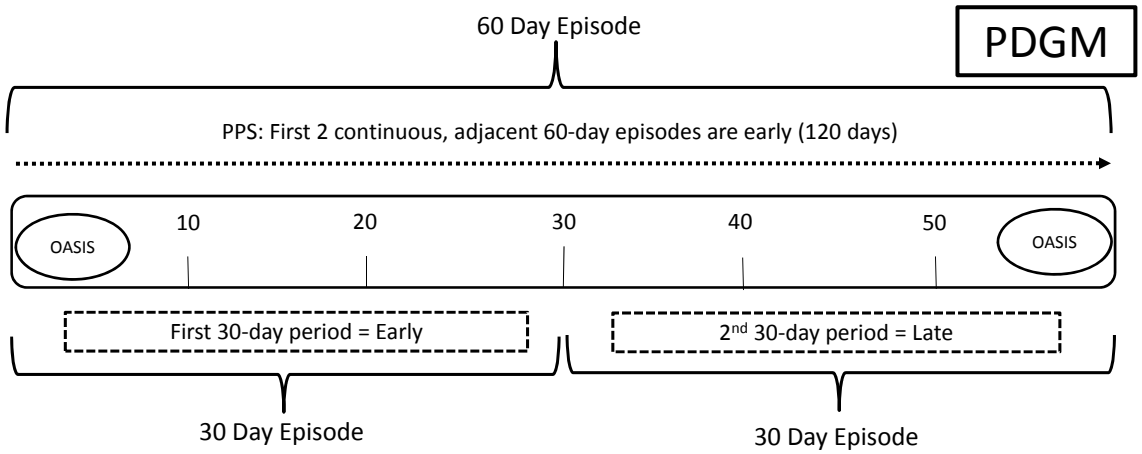
Insurance

Insurance	
	Medicare #: _____ Medicaid #: _____ 2nd payor: _____
	MCR Advantage: _____ MCR Adv #: _____ Auth required: _____
	SSN: ____-_____-____ Eligibility checked by/date: _____ Episode timing: ☐ Early ☐ Late

PDGM

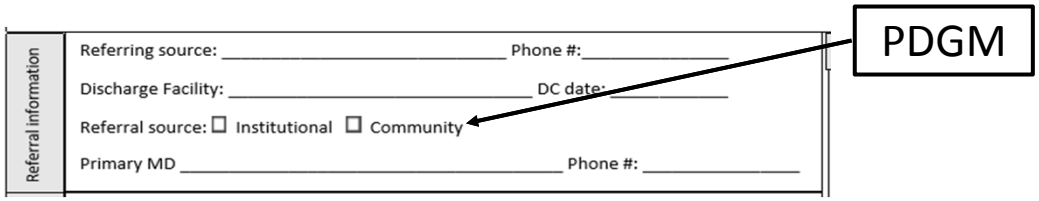
- Who will be paying the bill for home care?
- If an MCR Advantage plan, is your agency a provider for the plan?
- Does this payor require auth?
  - Is this insurer quick to give auth or does it take a week or longer?
  - Make sure your clinicians are aware of auth.
- Does the plan pay per visit or episodic?
  - Need to have a budget for your payor mix and make sure your intake department is aware

Episode Timing: PPS vs. PDGM



Must have greater than 60-day break to restart count

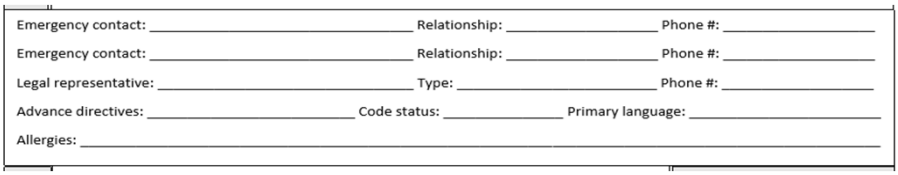
Referral source



- Where did the referral originate from?
- Primary MD
  - Who will be signing your POC? Intake should call to verify MD will sign orders.
- Was it an institutional source?
  - ACH, LTACH, SNF, IRF
- Community source?
  - MD office, outpatient source (i.e. same day surgery, etc.), emergency room, urgent care

~45% drop in CMW from institutional early to community late

Other information CoP



- Emergency contact
  - What is their relationship to the patient? Are they the primary CG?
  - §484.55(c)(6): (must identify) The patient's primary caregiver(s), if any, and other available supports
- Legal representative
  - §484.55(c)(7): The patient's representative (if any): (can be legal or patient determined)
- Advance directive:
  - §484.60(a)(2) The individualized plan of care must include the following: (xv) Information related to any advanced directives;
- Primary language:
  - Multiple instances in CoPs that discuss meeting the needs for patients with limited English proficiency and accessibility for those with disabilities

Referral Documentation

Requirements

- Must support homebound status
- Show medical necessity
- Support need for requested skilled services
  - Does the documentation support the ordered disciplines?
  - “Therapy diagnosis”
- Match the agency’s focus of care

Documentation Checklist

- ☐ H&P
- ☐ DC summary
- ☐ Progress Note
- ☐ Op report
- ☐ Consult
- ☐ MD visit note
- ☐ Therapy evals
- ☐ DC med list
- ☐ HH order
- ☐ Pertinent labs
- ☐ Xray/other reports
- ☐ Other

77yo, hospital referral, RN/PT/OT

- Primary Discharge Diagnosis
Active and Suspected Problems (Last Reviewed 05/03/19 @ 03:03 by

Acute exacerbation of systolic CHF (congestive heart failure) (Acute)

- Secondary Discharge Diagnosis
Chronic Problems (Last Reviewed 05/03/19 @ 03:03 by

History of loop recorder (Chronic)
Implant: 01/11/2016 at WCH
Serial number: RLA801774S
Model number: LNQ11
Manufacturer: Medtronic
Carotid bruit (Chronic)
Ischemic cardiomyopathy (Chronic)
Renal disease (Chronic)
Presence of aortocoronary bypass graft (Chronic)
9/21/95 CABGx4 LIMA to LAD,SVG to first diagonal,the second diagonal,and to posterolateral branch of RCA
Atherosclerotic heart disease of native coronary artery without angina pectoris (Chronic)
9/21/95 CABGx4 LIMA to LAD,SVG to first diagonal,the second diagonal,and to posterolateral branch of RCA
Syncope (Chronic)
Status post placement of implantable loop recorder (Chronic)
Diarrhea (Chronic)
Nausea & vomiting (Chronic)
Weight loss, unintentional (Chronic)
COPD (chronic obstructive pulmonary disease) (Chronic)
History of successful cardiopulmonary resuscitation (Chronic)
CAD (coronary artery disease) (Chronic)
History of stroke (Chronic)
Left bundle branch block (Chronic)
Carotid artery disease (Chronic)
HLD (hyperlipidemia) (Chronic)
HTN (hypertension) (Chronic)

The patient is a 77 year old M with a PMH of CAD and ischemic cardiomyopathy s/p ICD, HFrEF (EF of 30%), COPD and CKD 3,who was admitted with a complaint of 1 month history of progressively worsening shortness of breath with a severe flare on the day of presentation. He had associated PND and orthopnea as well as increased LE swelling. Family though he had gained ~ 8 pounds in the last 10 days. BNP was >5000 on admission, and patient had not been on any lasix at home. EKG shwoed no acute ST changes. H was admitted and managed for acute exacerbation of Heart failure with reduced EF. He was started on IV lasix 40mg bid, with monitoring of input and output. Fluid restriction 2500 mg daily. He had a repeat echo which showed EF of 15 to 20% with severe global hypokinesis which was similar to previous echo. Patient shortness of breath currently and lower extremity edema resolved. He was saturating well on room air. He remained stable and was discharged home on 5/5/2019 with a prescription for p.o. Lasix 40 mg twice daily as well as p.o. potassium 20 mg daily. He is to continue his metoprolol and Entresto. He is follow-up with his primary care doctor and cardiologist within 1 week.

Consult: Case Management Routine **Start:** 05/03/19 11:27

Case Management Referral For: Home Health
Other Reason: RN, PT/OT

69yo male, MD office referral, SN/PT/MSW

Diagnosis	**Muscle weakness** **ICD-10: M62.81: Muscle weakness (generalized)**
Order Name	**Orders included: 1** **Muscle weakness** **ICD-10: M62.81: Muscle weakness (generalized)** **• HOME HEALTH REFERRAL / FACE-TO-FACE ENCOUNTER** **Schedule Within: provider's discretion** **Additional Services: HH RN, PT, MSW for community resources, specifically transportation** **Medical necessity (describe condition) which requires the above skilled services: Muscle weakness, CHF, unsteady gait** **This patient is homebound due to:: Muscle weakness, CHF, unsteady gait**

Electronically Signed by: [redacted], PA, PASUP

76yo female, Hospital referral, SN/PT/OT

Communication Order
05/14/19 15:32:00 CDT, Consult for Home Health OT PT and Nursing to eval and treat. Home Aide to assist with bathing and adl's, Constant Indicator

ASSESSMENT AND PLAN

1. This is a 76-year-old with general weakness, decondition, most likely multifactorial. The patient is going to continue daily physical therapy, occupational therapy, and skilled nursing facility.
2. Recent sepsis due to methicillin-resistant Staphylococcus aureus wound infection, resolved.
3. Methicillin-resistant Staphylococcus aureus right foot wound infection with cellulitis, dorsal abscess status post debridement. Blood culture negative. Magnetic resonance imaging consistent with cellulitis, gas gangrene. The patient on intravenous antibiotic therapy per I [redacted] Follow up with [redacted] at the outpatient setting at Wound Clinic.
4. Breast cancer.
5. Poliomyelitis with post-polio syndrome.
6. Constipation.
7. Nausea. Continue Zofran.
8. Hypertension with occasionally low normal BP. The patient is going to continue her home regimen.

INFECTIOUS DISEASE PROGRESS NOTE

ASSESSMENT/PLAN

1. Right Foot wound Infection MRSA, CRP almost normal
2. H/o Polio

Plan: Cont abvx until next week then d/c

Post Hospital Wound Care Order Set

Location of wound (s): Right dorsal foot

Cleanse wound and peri-wound skin with Normal Saline

Apply _____ to peri-wound skin to protect.

Dress wound with Purachol plus Ag, cover with a dry gauze, wrap with Kling and secure.

Change dressing: BID

Daily

(Every other Day)

97yo male, MD office referral, PT

Reason for Visit

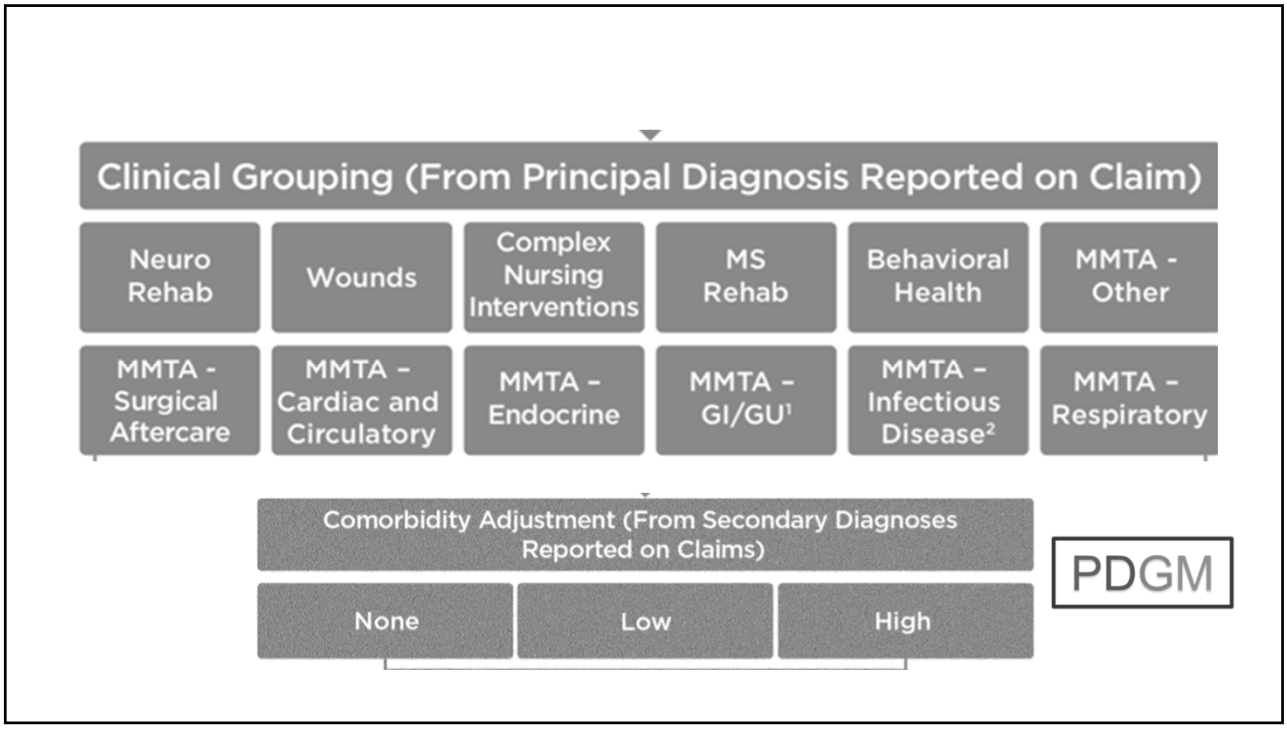
Old-age

Old-age
ICD-10: R54: Age-related physical debility
• PHYSICAL THERAPY REFERRAL

Reviewed Problems
- Malignant tumor of colon
- Anemia
- Mitral valve regurgitation - Onset: 09/28/2018
- Gastroesophageal reflux disease
- Hiatal hernia
- Diverticular disease
- Benign prostatic hyperplasia
- Cramp in lower limb - Onset: 07/26/2018
- Osteoporosis
- Kyphosis of thoracic spine
- Abnormal glucose level
- Old-age - Onset: 07/26/2018

[redacted] presents today for feeling of fullness in his right ear canal. He denies any pain associated with this. He states he recently did have a sinus issue however it is resolving at this point. He denies any sore throat nasal congestion or ear pain. Denies any cough fevers or chills. On evaluation the right tympanic membrane is completely occluded with cerumen on the left is also however not as severe. Blood pressure today is 114/60 pulse rate of 73 denies any headaches dizziness visual disturbances.

Intake Diagnosis



M62.81 Muscle weakness	R26.81 Unsteadiness on feet	R29.6 Repeated falls	Use the Grouper Tool
M19.91 Primary OA, unspecified	•M54.5 •Low back pain	M06.9 RA, unspecified	
M25.5- Joint pain	All R codes	•Superficial injury codes	

List not all inclusive

AVOID diagnosis that will result in claim being returned to provider (RTP)

Points to Ponder

- Invest in education and training for your intake/marketing departments and liaisons on the updated requirements for referrals
  - Have your CM (or other clinical staff) verify necessary information has been obtained.
- Provide up to date tools
  - PDGM grouper is free and easy to use.
- Consider a certified coder/coders on your intake/marketing team to cut down time spent running around to clarify and correct.

- Determine YOUR agency's questionable diagnosis
  - Review your EMR reports for the most frequently used primary diagnosis within your agency.
  - Identify trends with physicians
  - An all-inclusive list would be cumbersome
  - Educate, educate, educate!!!

- Avoid upcoding referral diagnosis without proper documentation
  - The physician must be the one to say right knee pain is really osteoarthritis of the right knee, not the clinician or coder!
- Develop a physician query process to ensure coding specificity
  - Provide information that would make it easier for the MD
  - CHF > weight gain, edema, BNP, etc.
- Begin to educate your physicians on PDGM.
  - Accelerated billing periods requiring timeliness of signing orders
  - Increased emphasis on coding specificity
  - F2F requirements

- Review your current process for intake flow in the agency
  - Is it fragmented?
  - Where can you streamline?
  - Define the roles in your job descriptions
- Have a process for authorization management beginning at intake.
- Disease management protocols
  - Possible frequencies
  - Suggested disciplines
  - Evidence based practice measures to promote consistency in care and improve outcomes
  - Market your programs
- Increase clinical competency
  - Consider specialty programs

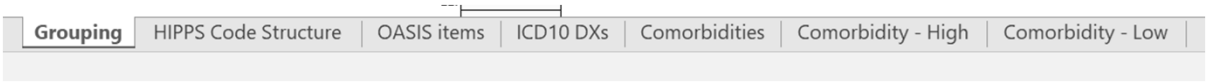
Links

- https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html <PDGM grouper tool version date July 2019>

From CMS site

- **CMS-1711-P**
  - CY 2020 HH PPS Wage Index
  - CY 2019 HH PPS Case Mix Weights for 60-day episodes into CY 2020
  - CY 2019-CY 2022-Rural-Add-On-Payment Designations
  - CY 2020 PDGM Case Mix Weights and LUPA Thresholds (Updated 07/12/2019)
  - CY 2020 PDGM Grouper Tool
  - CY 2020 PDGM Agency Level Impacts
  - CY 2019 Home Infusion Therapy - Geographical Adjustment Factors (GAFs)

Grouper Tool (Excel file)



Links

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf <MCR Benefit Policy Manual, Chap. 7>
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf <State Operations Manual, Appendix B>
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf <MCR Claims Processing Manual, Chap. 10>

Apryl Swafford RN, BSN, COS-C, HCS-D, HCS-H
888-418-6970

aprylswafford@homehealthsolutionsllc.com

www.homehealthsolutionsllc.com

Home Health Solutions, LLC
Partners in Care