Home health agencies are bombarded on all sides by rules and regulations. From Federal regulations all the way down to agency policies and procedures, the list of “do this, don’t do that” seems to grow daily. What does it all mean? Which one trumps the other? What do we do when nothing address our issue? By knowing and referencing the major home health governing regulations, agencies can ensure compliance and “take the reins” of agency success.

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

- Recognize the major “players” in home health regulation.
- Compare what areas of agency operations are covered by the various regulatory documents.
- Demonstrate knowledge of both state and agency specific requirements that can affect agency processes.
So What’s the Big Deal?

Why do regulations matter?

- Define the parameters of our “contract” with Medicare, Medicaid and other payors.
- Ensure staff members are both qualified and competent.
- Promote ongoing improvement to quality and outcomes.
- Protect the rights of the patient, staff and agency.
- Regulate how and when our payments are calculated and received.
Regulation round up!

<table>
<thead>
<tr>
<th>Regulations to review</th>
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<tbody>
<tr>
<td>• Medicare Benefit Policy manual</td>
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<tr>
<td>• State Operations Manual</td>
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<td>• Medicare Claims Processing Manual</td>
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<td>• State Regulations</td>
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<td>• Agency Policy</td>
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<td>• Medicare Administrative Contractors</td>
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<td>• Accrediting Organizations</td>
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Medicare Policy Manual

Medicare Policy Manual, Chapter 7

Medicare Policy Manual

• What is it?
  • The definitive guide to covered services under the MCR benefit.
  • Covers inpatient, outpatient, hospice, ambulatory care, etc.
  • Chap. 7 deals specifically with the HH benefit.

• Why do I need it?
  • Defines homebound status, reasonable and necessary care, requirements for eligibility and skilled services under HH

• How do I apply it?
  • Should be the “go to” guide for daily clinical operations
30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

- 30.1.1 Be confined to the home;
- 30.3 Under the care of a physician;
- 30.2 Receiving services under a plan of care established and periodically reviewed by a physician;
- 30.4 Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- 30.4 Have a continuing need for occupational therapy.

30.2.10 - Sequence of Qualifying Services and Other Medicare Covered Home Health Services

- Once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care.
- The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care.
Question

• Q7.1. M0030. If PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can the home health aide make a "reimbursable" visit prior to the day the therapist makes the first "skilled" visit for a Medicare patient? And wouldn’t the aide’s visit establish the SOC? [Q&A EDITED 10/18; EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

• A7.1. The "start of care" is defined as the first billable visit. It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide’s visit is both reimbursable and establishes the start of care for the episode. Instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services 30.2.10) does state "once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care."

30.5 - Physician Certification and Recertification of Patient Eligibility for Medicare Home Health Services

Physician must certify that Medicare HH eligibility has been met to include the following:

1. Be confined to the home;
2. Under the care of a physician;
3. Services are provided under a plan of care established and periodically reviewed by a physician;
4. Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy.
5. Have a documented F2F encounter with physician or allowed non-physician practitioner (NPP)
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
Documentation Requirements

• F2F information must be based on certifying MD medical records and/or acute/post-acute care facility’s medical records
• Certifying MD or facility medical record must include the actual clinical note for the F2F encounter visit that supports the required components.
• Information from the HH records can be incorporated into the certifying physician’s medical record and be used to support homebound status and need for skilled care. 
  • Cannot be used as the sole basis to support HH and must corroborate other MD or facility records

Examples of Appropriate Documents

• Discharge summary
• MD office visit note
• Progress note from acute/post-acute facility
• Note on MD letterhead summarizing the required information
• Clinical summary from the date of the actual visit
• Admission summary
• History & Physical
Examples of Inadequate Documentation

- Diagnosis list alone
- Recent procedures alone
- Recent injuries alone
- F2F form only (must have actual visit note)
- Generic statement without specific clinical finding to indicate what makes the patient homebound:
  - “taxing effort to leave home”
  - “gait abnormality”
  - “weakness/muscle weakness”
• No mandated face to face form or template

• Whether the face-to-face documentation is on the certification form itself or is an addendum to it, it must be separate and distinct and must include the necessary components

• Should be clearly titled and as such be easily recognizable as documentation of the face-to-face encounter

State Operations Manual
State Operations Manual

• What is it?
  • Standards of compliance with interpretive guidelines for health care entities and other services
  • Appendix B: Conditions of Participation
  • Appendix Z: Emergency Preparedness
  • Chap. 10: Survey & enforcement process for HHA

• Why do I need it?
  • Establishes what conditions an agency must meet to participate in MCR program
  • Provides guidance in ensuring the health and safety of patients

• How do I apply it?
  • Use to determine that agency administrative standards are in place (i.e. governing body, administrator, etc.)
  • Provides the instructions for patient assessment, documentation and other clinical factors.
  • Preparation of your agency’s emergency preparedness plan

Conditions of Participation

• §484.55(a)(1): Initial assessment within 48 hrs.
  • An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient’s return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or to accommodate the convenience of the agency.

  • In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record.
Conditions of Participation

• §484.60 Standard: Plan of care

• §484.60(a)(1) Each patient must receive the home health services that are written in an *individualized plan of care that identifies patient-specific measurable outcomes and goals*, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

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.
Home Health Care Planning Improvement Act

**THIS LEGISLATION WOULD:**

- Allow Non-Physician Providers to certify a patient’s eligibility for the Medicare Home Health Benefit.
- Enable NPPs eligibility to certify the face-to-face encounter requirement.

**Conditions of Participation**

- §484.105 (a) Standard: Governing body.

- A governing body (or designated person/s so functioning) must assume full legal authority and responsibility for the agency’s overall management and operation, the provision of all home health services, fiscal operations, review of the agency’s budget and its operational plans, and its quality assessment and performance improvement program.
§484.105 (a) Standard: Governing body

- Difficult area to achieve compliance for many agencies

- Standards are scattered throughout the SOM
  - §484.65 QAPI
  - §484.105(b) Appointment of administrator

- Check your accrediting organization’s standards for more specific guidance.
  - ACHC (Standard HH1-5A.01):
    - The governing body, or it’s designee, writes and conducts annual evaluation of the administrator.
    - Not a MCR requirement

Oasis D Manual

OASIS D Manual
OASIS D Manual

• What is it?
  • Provides guidance for HH agencies on how to collect accurate OASIS data
  • Includes general conventions and items specific guidance
  • 335 pages

• Why do I need it?
  • Outlines Item specific guidance on each M items, GG and J sections

• How do I apply it?
  • Use as a teaching tool for new and seasoned OASIS qualified HH clinicians
  • Apply given examples to real world situations
  • Assist QA staff in accurate review of OASIS

What else is in the manual?

• Outlines which patients require an OASIS.

• Specifies timepoints for OASIS data collection.

• Defines who may complete an OASIS.

• Many examples included for the new GG and J sections!
Other Follow-up (RFA 5) during the home health episode of care

- Will gain importance under PDGM.

- Can change your billing HIPPS code in the second 30 day period in the case of acute patient changes or exacerbations.

- Consider a policy NOW on when staff will complete a follow up.

**Medicare Claims Processing Manual**

*Medicare Billing Manual, Chap. 10*
Medicare Claims Processing Manual

• What is it?
  • Defines billing processes for all health care providers including inpatient, outpatient, SNF, Physicians, etc.
  • Chap. 10 deals specifically with home health

• Why do I need it?
  • Outlines how to file RAPs and claims and other special billing situations

• How do I apply it?
  • Ensure correct processes are followed when billing
  • Understand conditions that must be met for billing
  • Understanding the HHRG/HIPPS codes

Home Health PPS

• Outlines the creation and terms of the HHPPS episode

  10.1.6 - Split Percentage Payment of Episode
  • Defines terms of RAP payments and end of episode claims
    • Initial episode = 60/40
    • Subsequent episode = 50/50

• PDGM changes:
  • Will move to 30 day billing periods
  • 60 day episode timing will remain unchanged
  • Newly certified HHAs (MCR certified on or after 1/1/19) would not be allowed to receive RAP payments.
    • Would have to submit a "no-pay" RAP at the beginning of care to establish the episode as well as every 30 days thereafter.
Home Health PPS

• 10.1.10.3 - Submission of Request for Anticipated Payment (RAP)
  • 4 conditions that must be met to submit a RAP:
    • OASIS assessment is complete, locked or export ready
    • Physician’s verbal orders for home care have been received and documented
    • Plan of care has been established and sent to the physician
    • First service visit under that plan has been delivered
  • PDGM effects:
    • Would need increased timeliness of clinician documentation submission and signed & completed orders
    • Two RAPS and two EOE claims for a 60 day episode.

LUPAs

• 10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)
  • Agency provides 4 visits or less
  • Paid a standardized per visit rate for the episode
  • LUPA add-on adjustment made if LUPA episode is the first in a sequence of episodes or the only episode of care received by the patient.

MAJOR CHANGE UNDER PDGM
LUPA Thresholds by Clinical Group

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
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<td>Behavioral Health</td>
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<td>Complex</td>
<td>16</td>
<td>13</td>
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<tr>
<td>MMTA - Cardiac</td>
<td>6</td>
<td>9</td>
<td>17</td>
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<tr>
<td>MMTA - Endocrine</td>
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<tr>
<td>MMTA - GI/GU</td>
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<tr>
<td>MMTA - Infectious</td>
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<td>5</td>
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<td></td>
</tr>
<tr>
<td>MMTA - Other</td>
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<td>10</td>
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<tr>
<td>MMTA - Respiratory</td>
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<td>8</td>
<td>16</td>
<td>3</td>
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<tr>
<td>MMTA - Surgical</td>
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<td>12</td>
<td>5</td>
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<tr>
<td>MS Rehab</td>
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<td>9</td>
<td>12</td>
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<td>Wound</td>
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<td>Grand Total</td>
<td>94</td>
<td>128</td>
<td>137</td>
<td>63</td>
<td>10</td>
</tr>
</tbody>
</table>

LUPA Percentage by Clinical Grouping/Timing

(Courtesy Blacktree Healthcare Consulting)
80 - Special Billing Situations Involving OASIS Assessment

A. Changes in a Beneficiary’s Payment Source
   • Payment Source Changes From MA Organization to Medicare Fee-For-Service (FFS)
     • Must do a new start of care OASIS to generate HHRG
   • Payment Source Changes From FFS to MA Organization
     • Would update OASIS at next assessment time point
     • No need to discharge and readmit
   • Payment Source Changes Involving Medicaid (dual coverage)
     • New SOC OASIS required if change from MCD to MCR
     • Update OASIS at next time point (MCR to MCD)

State Regulations
State Regulations

• What is it?
  • Regulation set forth by individual states to regulate how home health agencies operate

• Why do I need it?
  • Must know and operate within ALL regulations that apply to your agency
  • May have more stringent standards than federal sources

• How do I apply it?
  • To ensure state, as well as federal, compliance with standards and billing practices

Agency Administrator

<table>
<thead>
<tr>
<th>MCR CoPs</th>
<th>Colorado Dept of Public Health</th>
</tr>
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<tbody>
<tr>
<td>• (ii) Has experience in health service administration, with at least 1 year of supervisory or administrative experience in home health care or a related health care program.</td>
<td></td>
</tr>
<tr>
<td>• §484.115(a)(2)</td>
<td>• Have at least two years healthcare or health service administration experience with at least one year of supervisory experience in home care or a closely related health program.</td>
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<tr>
<td></td>
<td><a href="https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7003&amp;fileName=6%20CCR%201011-1%20Chapter%2026">https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7003&amp;fileName=6%20CCR%201011-1%20Chapter%2026</a></td>
</tr>
</tbody>
</table>
Other Examples

• Texas:
  • Must contact patient within one business day of the referral.
  • Louisiana also has one business day.

• Utah:
  • For patients receiving skilled services, the written plan of care shall be approved by a physician at intervals not to exceed 63 days.

• Alaska:
  • Still required to have a professional advisory committee (PAC) appointed by the governing body.

Agency Policy
Agency Policy

• What is it?
  • Internally defined policies governing the day to day operations of an agency.

• Why do I need it?
  • Further defines the specifics of what is required within the agency which are not governed through other regulatory language

• How do I apply it?
  • A review of the agency’s overall performance should help to define where a policy would be necessary.

Examples of agency policies:

• Timeliness of documentation submission
  • A policy defining when OASIS, visit notes, etc. would be due.
  • 48 hours submission of SOC & ROC OASIS
  • 24 hour submission of evals and daily notes
  • May be more stringent per state regs so check!

• Scheduling changes
  • All changes to a clinician’s schedule would be handled through the scheduler.
    • Clinician must notify the scheduler of request to move a visit and supply appropriate documentation for request (i.e. communication note that patient has appointment with podiatrist and needs to reschedule)
    • May be more important under PDGM to avoid missed visits (and LUPAs)
Medicare Administrative Contractors

- **What is it?**
  - A private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.
  - "The Middleman"
- **Why do I need it?**
  - To process claims for agency's fee-for-service Medicare patients
- **How do I apply it?**
  - Use website to ensure compliance with MCR guidelines.
  - Participate in calls and educational opportunities to increase knowledge of MCR processes such as F2F, TPE, PDGM, etc.
**Medicare Administrative Contractors**

“The Hub of the Medicare FFS Program”

- **Recovery Auditors (RA)**
- **Qualified Independent Contractors (QIC)**
- **Supplemental Medical Review Contractor (SMRC)**
- **Benefits Coordinators & Recovery Center (BCRC)**
- **Program Integrity Contractors (PSC)/FISD/UPC**
- **Virtual Data Centers (VDC)**
- **Healthcare Integrated General Ledger Accounting System (HIGLAS)**
- **Cell Center Operations (CCO)**
- **OMS Regional Office Survey & Certification**

**Who are the MACs?**

- **Palmetto GBA**
  - [Palmetto GBA website](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html)
- **CGS**
  - [CGS website](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html)
- **NGS**
  - [NGS website](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html)

**MACs**

*When you don’t follow directions*
Accrediting Organizations
Accrediting Organizations

• What is it?
  • Organizations that review and certify that an agency demonstrates the ability to meet regulatory requirements and standards established by MCR and a recognized accreditation organization.

• Why do I need it?
  • Demonstrates an agency’s commitment to quality, compliance with industry standards and commitment to ongoing improvement.

• How do I apply it?
  • An agency will use the organization standards to drive daily operations in both policy and procedures.
  • Standards are often above and beyond CMS standards

Who are the Accrediting Agencies?

• Accreditation Commission for Health Care, Inc.
  Phone: (855) 937-2242
  Web: www.achc.org

• Community Health Accreditation Program
  Phone: (212) 363-5555 or (800) 669-1656, ext. 242
  Web: www.chapinc.org

• Joint Commission on Accreditation of Healthcare Organizations
  Phone: (630) 792-5000
  Web: www.jointcommission.org
Standards are often more stringent so be aware!

Regulatory Take-aways

• The most stringent regulation will always trump any other, regardless of the source of the regulation.
  • If your agency policy is the more stringent, it will override both Federal and State regulations.
  • Agency could be cited under survey even though it is an internal or agency policy.
  • KNOW YOUR REGS!
• Be aware of what is a compliance regulatory measure and what is a payment measures.
  • Even if you demonstrate 100% compliance with the CoPs, inadequate F2F documentation can cause a denial.
• Ensure that appropriate departments are aware of any regulatory measures that may apply.
  • QA dept. should be very familiar with both MCR Policy Manual and SOM
• Start looking at what processes will need to be amended under PDGM
  • Will affect all departments and processes
  • DON’T WAIT UNTIL THE LAST MINUTE!
Links

  - Internet only manuals
  - They are CMS’ program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives.

Questions?

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