The leaves are changing color and falling—a sure sign of the change of seasons. The last few months have been busy in home health and hospice! We’ve seen important new regulatory releases and legal opinions that will have far-reaching implications for our agencies and industry.

In this compliance alert, we’ll cover the following:

• **Physician Certifications of Home Health Eligibility**

• **Claim Denials**
  MLN Matters MM9585 contains new information on future claim denials when the home health patient assessment has not been received.

• **Home Health Change of Care Notice (HHCCN)**
  The HHCCN is a new form that was published in August and will replace the HHABN Options 2 and 3. The transition period is underway.

• **New Condition Code for Hospice Claims**
  MLN Matters MM9590 creates a new hospice-specific Condition Code in the event of a late recertification of terminal illness.

• **New Recovery Audit Contractor and New RAC Audit Rules**
  We have a newly appointed Recovery Audit Contractor for home health and hospice along with some new rules that will govern the recovery audit process.

• **New Emergency Preparedness Rules**
  Over the summer, CMS finalized its Emergency Preparedness rules for Medicare and Medicaid programs. The rule applies to all providers who participate in the Medicare and/or Medicaid programs with new rules that must be met by November 15, 2017.

---

### Physician Certifications of Home Health Eligibility

**What Providers Should Know**

Some months after CMS eliminated the physician narrative requirement for Face-to-Face Encounter Certifications, it also revised MLN Matters SE1219 which was titled “A Physician’s Guide to Medicare’s Home Health Certification, Including the Face-to-Face Encounter.”

Originally issued in 2012 and revised on August 19, 2015, SE1219 included provision that allowed a certifying physician, such as the individual signing the Plan of Care (485), to use encounter documentation from an informing physician who treated the patient in an inpatient setting as evidence of the Face-to-Face Encounter. The certifying physician simply had to sign and date the inpatient encounter documentation and subsequently provide the certification of eligibility. This little piece of guidance, buried in SE1219, allowed home health agencies to bridge the gap between clinical encounters—performed in an inpatient setting without benefit of a home health certification of eligibility—and orders...
for home health care from the patient’s attending or primary physician where the timely Face-to-Face Encounter was missing or unrelated to the reason for home health services. SE1219 has now been rescinded, so this option is no longer available.

What we are left with is MLN SE1436 “Certifying Patients for the Medicare Home Health Benefit” and the Medicare Policy Manual, Chapter 7, 30.5.1 which states, “If the patient is starting home health directly after discharge from an acute/post-acute care setting where the physician, with privileges, that cared for the patient in that setting is certifying the patient’s eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying physician must identify the community physician who will be following the patient after discharge.” [emphasis added] Thus, the handoff can no longer be considered bi-directional. Now, the inpatient physician must specifically identify the individual who will be following the patient’s home health services. Period. This was clearly the intent of the 2015 Final Rule; however, SE1219 preserved a bit of the flexibility that was available to agencies prior to January 2015. Now, that flexibility has been removed.

Don’t forget that the Face-to-Face Encounter clinical note must also accomplish two other important tasks:

1) It must establish the reason(s) why the patient has a skilled home health need, and

2) It must confirm the patient’s homebound status. If those two elements are missing from the encounter clinical note, the agency must fill the documentation gap with its own information.

**What Agencies Should Do**

Agencies should be very clear on what is required for to Face-to-Face Encounter documentation. For years, Face-to-Face documentation has been the nemesis of agencies trying to survive medical reviews. Adding Probe and Educate, Pre-Claim Review and a new emphasis on stepped-up post-payment reviews, it is imperative that agencies understand and implement thorough processes for acquiring, evaluating and augmenting encounter documentation for every new admission. Agencies cannot afford to wait until an ADR is received to evaluate whether the physician’s clinical encounter note is sufficient because, once the bill has been released, the opportunity to close gaps in the record are no longer available. Agencies should focus on the following:

1) Face-to-Face clinical encounter notes should be obtained from the physician who treated the patient during an inpatient stay or from the patient’s own physician, if that physician will also be signing the Plan of Care. This must be done upon referral of the patient to ensure that the patient is eligible for home health services.

2) In addition to the encounter note, the agency must also remember that the physician must certify that he or she had the encounter
3) If the Face-to-Face was performed as a part of an inpatient stay and the physician involved in that stay is not signing the Plan of Care, the primary care physician who is signing the Plan of Care and following the patient for home health services must be specifically identified somewhere on the certification document. If the primary care physician’s identity is missing from the inpatient record, the agency must elect to either ask the inpatient physician to offer a late entry for the record via an attestation or, alternatively, acquire Face-to-Face encounter documentation from the primary care physician within the allowed 30-day timeframe following the Start of Care.

4) Clinical encounter documentation should be carefully reviewed to ensure that the physician’s clinical note meets the required documentation standards including confirmation of the need for skilled intermittent services and homebound status. Remember, the reason for the encounter must be related to the reason that home health services are being ordered for the patient. The longer the length of time between the encounter and the Start of Care, the greater the likelihood that the reason for the encounter isn’t linked to the need for home health services. MACs are paying very close attention to this. If the encounter and the need for home health skilled services are not connected, the Face-to-Face Encounter will fail during medical review.

5) Finally, if the encounter clinical note fails to establish one or more of the required elements of the encounter, the agency has the opportunity to offer the physician information from its own assessment for incorporation into the physician’s medical record. More often than not, this is how homebound status actually gets documented for the physician’s record. Here is the hitch… the documentation must be signed and dated by the physician to indicate acceptance of the additional information into the record. This must be done prior to billing for services.

Agencies that adopt clear standards and a consistent process for acquiring and qualifying Face-to-Face Encounter documentation will be the winners in medical review.
Denial of Home Health Claims When Required Assessments Are Not Submitted

We often talk about the Conditions of Payment and the five things that establish eligibility for payment of Medicare services. We all know them by heart…

1) The patient must be under the care of a physician.
2) The patient must be homebound.
3) The patient must be receiving services that are governed by a Plan of Care that has been established and periodically reviewed by a physician.
4) The patient must be in need of a skilled intermittent service such as nursing, physical therapy or speech-language therapy, or
5) The patient must be in need of continuing occupational therapy.

Over time, a few other requirements have been added to the list, including the physician’s certification of how much longer care will be required for every recertification. CMS has long been cajoling agencies to submit OASIS information within required time limits. Now, with the release of MLN Matters MM9585 on October 27, 2016, CMS has announced its intention to require automatic claim denials for untimely OASIS submissions. The changes embodied in MM9585 take effect on April 1, 2017. Agencies that are not currently compliant with the submission rules for OASIS have about five months to correct their processes.

What Agencies Should Know
The Code of Federal Regulations at 42 CFR 484.210(e) states that HHAs “must submit to CMS the OASIS data… in order for CMS to administer the payment rate methodologies” described elsewhere in the regulations. In other words, CMS wants to confirm the HHRG calculations on the claim with the applicable OASIS.

In conjunction with recent MAC claim reviews, if the OASIS isn’t found during review, the claim will simply be denied. But, as we all know, these reviews are manual, rather than systematized. Back in April 2015, MLN Matters SE1504 gave us the hint of what was coming as CMS notified us that it “plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release [and] at that time Medicare will deny claims when a corresponding assessment is past due in the QIES” or not found in that system. The other shoe has dropped with the issuance of MM9585.

Starting April 1, 2017, CMS will enforce OASIS submissions as a condition of payment. OASIS reporting requirements say that the OASIS must be transmitted within 30 days of completing the assessment of the patient. If the OASIS is not found in the QIES upon receipt of the final claim for a given episode and the receipt of the claim is more than 30 days after the assessment completion date, Medicare will deny the claim. MM9585 also notes that while the regulation requires that the assessment submission be within 30 days, the initial implementation will allow for 40 days. No word on when that initial implementation period will expire.
The remittance message will show a Group Code of CO and a CARC of 272 for this type of denial.

**What Agencies Should Do**

Agencies that have documentation delays around clinician completion of OASIS must work now to shore up their processes for timely OASIS completion and submission. Otherwise, they will face the possibility of denials after services have been rendered. A best practice is to keep your submission timeframe within a maximum of 21 days following the event that triggers the need for the assessment. This will help you allow for system glitches, inopportune times when the network is down, and other delays that work against timely submission. OASIS documentation should be submitted at least weekly for most agencies unless the volume of documentation requires a more frequent submission schedule.

**Home Health Change of Care Notice (HHCCN)**

On August 22, 2016 CMS issued new instructions for providing notice to Medicare beneficiaries about changes to or reductions of care. The new HHCCN Form replaces the two notice formats of the Home Health Advance Beneficiary Notice of Noncoverage (ABN). We are now in a transition period when agencies can either use the new form or continuing using the old version. CMS has not yet published the date after which the old ABN forms will no longer be permitted. Watch for an announcement of the date at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html).

**What Agencies Should Know**

The new HHCCN form replaces two ABN formats for Medicare FFS patients. Following a decision by the Second Circuit Court of Appeals in *Lutwin v. Thompson*, home health agencies must provide the change of care notice whenever there is a reduction or termination of service due to a physician order change or an agency imposed change such as a staffing issue. For example:

- **Your doctor’s orders for your home care have changed.**
  - The home health agency must follow physician orders to give you care.
  - The home health agency cannot give you home care without a physician order.
  - If you don’t agree with this change, discuss it with your home health agency or the doctor who orders your home care.

- **Your home health agency has decided to stop giving you the home care listed above.**
  - You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
  - If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.
  - If you get care from a different home health agency, you can ask it to bill Medicare.

The triggering events are essentially any reduction or termination of care. In the examples provided by CMS, a triggering event may be something as simple as a decrease in visit frequencies for wound care or a discontinuation of certain previously ordered interventions. The example cited in the instructions that accompany the new form is a change from daily wound care to every other day wound care, followed by a
discontinuation of wound care altogether. In this example, two HHCCNs would be required to establish effective notification of the patient as to changes in care delivery.

Agency-related reasons are generally the inability to staff the case due to loss of staff or a staffing shortage. Another example is a staff safety issue (such as a threatening encounter with a family member) that arises and precipitates an agency decision to discontinue care.

Note that if a termination involves the end of all Medicare-covered services such that no additional care is being provided, the only required notice is the NOMNC (Notice of Medicare Non-Coverage, CMS 10123).

What Agencies Should Do
Agencies should visit the CMS website to download the new forms and begin implementing them. Forms can be accessed at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHCCN.html.

A minimum of two copies of the form should be prepared in cases where they are needed—one for the agency’s records and one for the patient’s records. The notices cannot exceed one page and must be in an easily read font (at least 12 point). Forms consist of a Header, the Body of the Form and a Signature block (with space for a date). Explanations of why changes are occurring should be in language that is informative and easily understood by the patient. Avoid abbreviations unless they are so common that the patient or his/her family will clearly be familiar with the terminology. Remember that the time limit to deliver the change of care notice is governed by the CoPs and/or State law, whichever deadline is stricter. The CoPs require notification within two days, but some states require more advanced notification, which will prevail if that is the case.

New Condition Code for Hospice Claims
MLN Matters MM9590 was issued on August 5, 2016 and will become effective on January 1, 2017. A new condition code will be used to identify when Occurrence Code 77 is caused by a late recertification of the terminal illness. This change is intended to correct certain processing problems. There is no change in payment policy.

What Hospices Should Know
Currently, hospices use Occurrence Code 77 with an associated date range to report non-covered days when a recertification was not received within the required time. The Fiscal Intermediary Standard System (FISS) prohibits Occurrence Code 27 (the certification date) from being reported within the Occurrence Code 77 date range.

Since October 2014, Medicare regulations also require that hospice Notices of Election (NOEs) must be filed within five calendar days after the hospice admission date. If the NOE is not timely filed, Medicare does not cover the days of hospice care from the hospice admission date to the date the NOE is submitted to (and accepted by) the MAC.
The FISS compares incoming hospice claims to the NOE receipt date and enforces the presence of Occurrence Code 77 for the appropriate dates. An Occurrence Code 27 date within the Occurrence Code 77 date range in the case of an untimely NOE is appropriate. However, claims are rejected when Occurrence Code 27 falls within the Occurrence Code 77 date range and also when Occurrence Code 77 is used to report an untimely NOE.

To correct this, a new Condition Code 85 has been created and will be used for claims submitted on or after January 1, 2017. This new Condition Code is designed to signify a “delayed recertification of hospice terminal illness.” When hospices report this code, Medicare systems will ensure the Occurrence Code 27 date does not fall within the Occurrence Code 77 date range.

MM9590 also discusses FISS errors with respect to high Routine Home Care payments during the first 60 days of care and errors in SIA payment calculations, which are being corrected.

**What Hospices Should Do**

We have seen several recent instances in which patients have revoked their hospice benefits shortly after the first of a month to seek aggressive care only to re-elect soon after. Agencies should keep the limitations of the FISS in mind to ensure an uninterrupted payment flow. For purposes of the FISS, NOEs and/or NOTRs are considered “claims” and must be submitted sequentially. Without an NOE on file for a given benefit period, a claim for that period will not process. Likewise, a NOTR for a date that is beyond the last ending date on a submitted claim is an error and will be returned to the provider. It is extremely important for the hospice revenue cycle team and the admission team to collaborate and ensure a seamless approach to sequential “claim” submissions that includes not only actual claims but also submission of election notices.

Generally, the presence of Occurrence Code 77 with an associated date range followed by a KX modifier on the first level of care line in a claim should signify to the MAC that there was an unavoidable problem in getting the NOE filed timely for a re-election and getting the final claim(s) for a prior election submitted before filing the new NOE. The KX modifier is essentially a request for a review and approval of the claim when it is out of sequence due to unavoidable circumstances that are beyond the hospice’s control. This usually works, but we have seen recent examples of revocations and re-elections in which the payment process is either significantly delayed or derailed altogether, even when claims are coded appropriately. It is imperative to ensure that the hospice billing group is immediately made aware of all NOTRs and the potential for a readmission to ensure that claims and election notices are submitted in order.

Billing groups should also be made aware of new Condition Coding for claims submitted after January 1, 2017.
New Recovery Audit Contractor and New RAC Audit Rules

On October 31, 2016, CMS announced new RAC appointments, including Performant Recovery, Inc., for home health and hospice post-payment reviews and identification of improper payments. There are also some new rules that all agencies should consider.

What Home Health and Hospice Agencies Should Know

Under the old RAC rules, contractors qualified for payments based on provider overpayments that were identified in less than 45 days. Under the new rules, the RACs will be paid only after providers have a chance to appeal through a request for redetermination followed by a second level request for reconsideration. Previously, RACs could invoke a three-year look-back, but under the new rules, claims that come under a RAC review can be no more than six months old. That’s the good news. Nonetheless, many industry experts expect that there will be more of the same as the RACs focus on eligibility questions that are open to interpretation and debate issues such as terminal prognosis for hospices and homebound status for home health providers. Medical necessity is also certain to be an area of concentration.

What Home Health and Hospice Agencies Should Do

Agencies simply have to focus on documentation improvement. It really doesn’t matter if it is a RAC, the MAC, a CERT Contractor, or a ZPIC – the key to being paid in a pre-payment review or keeping the money during post-payment review is being able to fully and undeniably demonstrate that the documentation in the record meets the required criteria. As the first of the year approaches, and this new contractor gears up, this is a good time to revisit documentation standards and QA review processes to ensure that your organization is ready for renewed RAC scrutiny.

New Emergency Preparedness Rules

Back in 2013, CMS released a proposed emergency preparedness rule entitled “Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.” This rule had been pending for three years, but just before time ran out, CMS made it final on September 8, 2016. All providers, including home health agencies and hospices, must comply with the rule by November 2017.

What Providers Should Know

The new Emergency Preparedness Rule applies to 17 different provider types that participate in the Medicare and Medicaid programs. The rule requires providers to establish plans for dealing with disasters. The plans must coordinate with federal, state and local emergency preparedness systems and must be in place by November 15, 2017.

The Survey and Certification Group at CMS is working on the addition of interpretive guidelines to the State Operations Manual. These guidelines
Creating a emergency preparedness plan will be a time-consuming process and agencies should not wait until next fall to start thinking about the requirements.

CMS has not specifically prescribed how each provider should create emergency plans, but it has provided a comprehensive checklist for download here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SandC_EPChecklist_Provider.pdf.

There are four core elements to a comprehensive emergency plan that providers must consider:

1) The provider must conduct a risk assessment that employs an “all hazards” approach to planning. The findings of the risk assessment will be used to identify the essential planning components of the emergency plan. The “all hazards” approach to planning takes into consideration the specific location of each provider organization with types of disasters (such as applicable weather events) that are particular to each area of the country. But other, non-location specific contingencies such as cyber-attacks, power interruptions, water and flood emergencies must also be considered.

2) Each agency must develop emergency policies and procedures that are reflective of the overall planning process such that execution of the plan can be predicted and measured.

3) A communication plan must be part of the preparedness process. The communication plan must be consistent with applicable law and coordinated across the spectrum of interested parties, including state and federal health departments and emergency management agencies.

4) Training and testing is a required part of each provider’s plan. An effective training program will include initial training for new staff, as well as refresher training on an annual cycle. Staff will be expected, as a part of the training exercise, to demonstrate knowledge and understanding of agency procedures.

What Providers Should Do
Creating a emergency preparedness plan will be a time-consuming process and agencies should not wait until next fall to start thinking about the requirements of this new rule. Plans must be in place by November 15, 2017. Surveyors will be prepared to start measuring compliance late next year. Get started on your emergency preparedness plans now!

Visit the CMS Website:

Get Training Plan Info from FEMA:
Other Interesting Developments

In a couple of interesting legal developments over the summer, we learned more about how the Supreme Court views the theory of “implied certification” under the False Claims Act (FCA). Over the past several years, there have been several whistleblower cases with allegations of false claims based on the failure of a provider to comply with various Conditions of Participation, as opposed to applicable conditions of payment that can be the basis for FCA liability. The tendency has been to separate the two, so providers have not been held liable for noncompliance with Conditions of Participation that are not directly associated with a condition of payment that creates FCA exposure. For example, the Conditions of Participation contemplate that every patient will be treated in accordance with a Plan of Care. Likewise, the conditions of payment require that a Plan of Care be established and reviewed periodically by a physician. In this way, the two areas of compliance essentially intersect and the absence of a Plan of Care to defend a submitted claim would create payment exposure. However, lesser CoP requirements would not necessarily cause provider liability for payment if the condition were not met.

Now comes the Supreme Court in the matter of Universal Health Services, Inc. v. United States et al ex rel. Escobar et al. There was a little good news in that the Supreme Court said that not every condition of payment creates a basis for FCA liability. The bad news is that the Court also said that there can be liability under implied certification if two requirements are met. First, the claim must, in essence, imply that certain services were provided. Second, submission of a claim where there has been significant noncompliance with a material regulatory or contractual requirement (such as a Condition of Participation) makes the claims essentially fraudulent. The trigger is whether the noncompliant behavior on the part of the provider is material or not and whether the condition is also material.

This brings us to the recent decision on September 30, 2016 by the Sixth Circuit Court of Appeals. In this case, which was at one point dismissed by the Federal District Court, an individual was hired by the provider organization to perform utilization review services on backlogged claims. Essentially, charts for which claims had not been submitted were reviewed by a temporary utilization review group to “resolve documentation, coverage and compliance issues” for the purpose of getting the unbilled claims backlog reduced. The original case boiled down to four patient charts for which the physician Face-to-Face Encounter documentation was not received until after the care had already been provided and the episode was over. The whistleblower alleged that this documentation was untimely and disqualified the submission of the claims even though the documentation was in hand before the claims were sent in. The basis of the allegation was the verbiage in the Medicare Policy Manual, Chapter 7, which states that certification as to the patient’s need for home health services be obtained at the time the Plan of Care is established or “as soon thereafter as possible.” The opinion that resurrected the case hinged on the timeline that is suggested by the quoted phrase and whether a physician certification that is not received until after services have been provided is timely enough to permit submission of a claim for reimbursement.

We all know that obtaining critical documentation from physicians is often a challenge for agencies as they try to provide timely care following a referral for services. And, for that very reason, this case will be worth watching.