WEBINAR

READY, SET... 2015

New Challenges, New Opportunities for Home Health & Hospice

with Sharon Harder of C3 Advisors, LLC & Jill Dyer, BSN, RN, HCS-D, HCS-O of JID Consulting and Coding, LLC
The software that powers post-acute care

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ABOUT THE PRESENTERS

SHARON HARDER
President
C3 Advisors, LLC
OPERATIONAL AND CLINICAL CHANGES

• OASIS – C1

• ICD-10

• CODING GUIDELINES FOR BOTH HOME HEALTH AND HOSPICE

• COVERAGE OF HH INSULIN INJECTIONS – NEW J11 LCD

• HOME HEALTH QUALITY REPORTING
OPERATIONAL AND CLINICAL CHANGES

• FACE TO FACE ENCOUNTERS

• THERAPY REASSESSMENTS

• HOSPICE SATISFACTION SURVEYS

• HOSPICE NOTICE OF ELECTION FILING REQUIREMENTS
FINANCIAL CONSIDERATIONS

- HOME HEALTH CASE MIX RECALIBRATIONS
- BILLING COMPLIANCE REVIEWS
- HOSPICE COST REPORTING
- HOSPICE CAP CALCULATIONS
- MEDICARE SECONDARY PAYER ISSUES
OTHER IMPORTANT TOPICS

• HUMAN RESOURCES ISSUES
  ▪ WAGE AND HOUR RULES
  ▪ WORKER CLASSIFICATION

• HIPAA CHECK-UPS
  ▪ SECURITY ASSESSMENTS
  ▪ BUSINESS ASSOCIATES AGREEMENTS

• COMPLIANCE PLAN UPDATES
ABOUT THE PRESENTERS

JILL DYER,
BSN, RN, HCS-D, ICD-10, HCS-O
Home Health Executive, Consultant
J.I.D. Consulting
HOME HEALTH - OASIS C-1

• New submission requirements as of Jan 1, 2015

• Intended to be compatible with ICD-10

• Being implemented with adjustments for ICD-9 followed by the scheduled transition to C-1/ICD-10 on Oct 1, 2015

• Schedule for grouper updates for ICD-10 should be released in Spring/Summer 2015
HOME HEALTH - OASIS C-1

• Some items deleted
• Data dropped at various time points
• Existing items revised/refined
HOME HEALTH - OASIS C-1

- Items replaced with new assessment questions
- No ICD-10 coding on OASIS C-1/ICD9
- Items where “e.g.” changed to “for example,” “i.e.” to “specifically”
GETTING READY FOR ICD-10

• Will it really happen on October 1, 2015?
• Review internal processes
• Staff training and refreshers
• Dual Coding
• Preparing for the financial impact
HOSPICE CODING

• Need to follow official coding guidelines

• Claims will be returned to the provider if the principal diagnosis is a non-specific or a manifestation code

• Principal diagnosis code must match the terminal illness on the certification

• The assigned codes must address both the patient’s principal terminal illness as well as comorbidities
DIABETES AND INSULIN INJECTIONS

- We know that episodes with high visit volume for insulin injections are under the microscope at CMS

- Average number of visits for these episodes is 160

- Specific diagnosis codes that support a patient’s inability to self inject must be used to support the limitation
INSULIN INJECTION SERVICES

- New J11 LCD (L35413) guidance effective as of 12/30/2014

- Documentation requirements
  - Patient is physically or mentally unable to self-inject
  - No other willing or able person
  - Results of the most recent HbA1c (within last 120 days)
HOME HEALTH QUALITY REPORTING

• Data submission thresholds were established in the Final Rule for 2015

• Measurement period will be from July 1, 2015 through June 30, 2016

• For episodes starting on or after July 1, the QAO score must be at least 70% to avoid the 2% payment penalty
HOME HEALTH QUALITY REPORTING

- Matching sets of assessments will be required

- SOC/ROC + EOC OASIS

- Most agencies should have no trouble meeting the 70% requirement, but the goal is for an 80% to 90% submission rate

- Compliance levels in 2015 will provide guidance for next year’s Final Rule
HOSPICE SATISFACTION SURVEYS

• Data collection starts as of Jan 1, 2015

• There must be a contract in place with a qualified survey vendor

• An 85% eligibility rate is expected with a 50% response from primary caregivers of hospice patients

• Non-compliant hospices will receive a 2% payment penalty as of 2017
HOSPICE SATISFACTION SURVEYS

• Remember, data is based on patients served during the prior calendar year and is for deceased patients only

• Qualified decedents are:
  ▪ Over the age of 18 at the time of death
  ▪ Patients who did not expire within 48 hours of admission
  ▪ Those for whom the identified caregiver is not listed, not a legal guardian and not a person with a foreign address
  ▪ With a caregiver who is willing to be contacted
HOSPICE NOTICE OF ELECTION FILING

• NOE filing deadlines went into effect in October

• NOEs and Revocations must be filed within 5 days of the election, discharge or revocation

• Some questions as to how fast the MACs are going to be able to process the notices
HOME HEALTH
FACE TO FACE ENCOUNTERS

- For episodes starting on or after Jan 1, 2015 the narrative requirement is gone for home health providers

- Now required at every SOC

- Agency and physician or discharging facility records must both contain adequate information concerning medical necessity and homebound status and must provide this information upon request to review entities, and/or CMS
HOME HEALTH
FACE TO FACE ENCOUNTERS

• Face to Face must include:
  ▪ Need for intermittent SN care, PT, and /or SLP services
  ▪ Patient is confined to the home (homebound)
  ▪ Occurred within the required time frame
  ▪ Show that the encounter was conducted by a qualified physician or NPP (non-physician practitioner)
Recommended HH process changes:

- New guidance states that information from the HHA status can be incorporated into the physician’s record.
- In order for the information to be valid, the physician must review and sign any document that is provided by the home health agency and incorporate the information into their records.
- And, remember that the information must be consistent between the diagnosis contained in the physician’s records and the comprehensive assessment.
HOME HEALTH
FACE TO FACE ENCOUNTERS

• Recommended resources for the new Face to Face guidance:

• MLN article: SE1436 (Revised 12/31/2014)

Home Health Physician Face-to-Face Video by Palmetto:
https://www.youtube.com/watch?v=LOeacNPxB0
HOME HEALTH VERBAL ORDERS

• Medicare Benefit Policy Manual, Chapter 7, Home Health Services, 30.2.5, Use of Oral (Verbal) Orders

“When services are furnished based on a physician’s oral order, the orders may be accepted and put in writing by personnel authorized to do so . . .

Oral orders must be countersigned and dated by the physician . . .

Services which are provided from the beginning of the 60-day episode . . . before the physician signs the plan of care are considered to be provided under a plan of care established and approved by a physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a plan of care.”
HOME HEALTH
VERBAL ORDERS

• Having valid orders to cover all visits that are being provided is a condition of payment
• When signature on the 485 is pending, a VO is used to “cover” the visits that are done in the interim
• Not enough for merely a date to be entered in Locator 23 of the 485
• There must also be a documented VO in the record to substantiate delivery of care and prior approval by the patient’s physician
HOME HEALTH THERAPY REASSESSMENTS

• Assessments every 30 days by therapy discipline replaces the prior 13th and 19th visit rules

• This is for episodes starting on or after Jan 1, 2015

• Count starts the day after service is provided

• Billing reviews – rule about visits that are in the “gap” still applies
HOME HEALTH
CASE MIX ISSUES

• Case mix recalibration is the single most important financial change in the Final Rule

• Important because just under a fifth of the case mix weights changes by more than 5%

• Every agency should do the analysis between payment rates in 2014 versus expected reimbursement in 2015 by HIPPS or HHRG Code

• Utilization review by HIPPS/HHRG is an absolute must
HOME HEALTH
CASE MIX ISSUES

- The five biggest losers under the recalibration will have a base rate loss of between $186 and $268

  3CGL ($186), 3CHL ($206), 3BHK ($215), 3CGK ($237), 3CHK ($268)

- The five biggest winners will gain between $436 and $621 at the base rate level

  5CGK ($436), 4CFM ($468), 5BFK ($496), 5AFK ($$562), 5CFK ($621)
<table>
<thead>
<tr>
<th>HIPPS</th>
<th>HHRG</th>
<th>2014</th>
<th>2015</th>
<th>Gain (Loss)</th>
</tr>
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<tbody>
<tr>
<td>3CGL</td>
<td>C3F2S2</td>
<td>$2,895</td>
<td>$2,703</td>
<td>$ (192)</td>
</tr>
<tr>
<td>3CHL</td>
<td>C3F2S2</td>
<td>$3,130</td>
<td>$2,917</td>
<td>$ (213)</td>
</tr>
<tr>
<td>3BHK</td>
<td>C2F3S1</td>
<td>$2,206</td>
<td>$1,984</td>
<td>$ (222)</td>
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<tr>
<td>3CGK</td>
<td>C2F3S1</td>
<td>$2,433</td>
<td>$2,188</td>
<td>$ (245)</td>
</tr>
<tr>
<td>3CHK</td>
<td>C3F3S1</td>
<td>$2,638</td>
<td>$2,361</td>
<td>$ (277)</td>
</tr>
<tr>
<td>5CGK</td>
<td>C3F2S1</td>
<td>$6,320</td>
<td>$6,769</td>
<td>$ 450</td>
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<tr>
<td>4CFM</td>
<td>C3F1S3</td>
<td>$5,505</td>
<td>$5,987</td>
<td>$ 483</td>
</tr>
<tr>
<td>5BFK</td>
<td>C2F1S1</td>
<td>$5,362</td>
<td>$5,874</td>
<td>$ 512</td>
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<tr>
<td>5AFK</td>
<td>C1F1S1</td>
<td>$4,962</td>
<td>$5,542</td>
<td>$ 580</td>
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<tr>
<td>5CFK</td>
<td>C3F1S1</td>
<td>$5,973</td>
<td>$6,614</td>
<td>$ 640</td>
</tr>
</tbody>
</table>
HOSPICE COST REPORTS

• If yours is a freestanding hospice, these requirements apply

• If the hospice is within another certified provider organization such as a home health agency, the new reporting rules are not yet effective

• Most cost reporting years began on Jan 1

• Remember that the cost allocations will now be done by each level of care

• Don’t forget the payroll implications of the new rules
HOSPICE AGGREGATE CAP CALCULATIONS

• The self reporting requirement goes into effect for the hospice cap year that ended on October 31, 2014

• Calculation must be performed no earlier than January 31 and by March 31

• Payment deadline is March 31

• Cap positions should be monitored at least every quarter if your hospice is vulnerable
HOSPICE AGGREGATE CAP CALCULATIONS

• Which hospices should be most vigilant?
  ▪ Any historical aggregate cap liability
  ▪ For profit organizations with high profit margins
  ▪ Hospices with very long lengths of stay

• Payment must be made by Mar 31 or a Request for an Extended Repayment Schedule can be requested
IMPORTANT HR ISSUES

• Wage and hour issues for “exempt” field staff members
  - New challenges to hybrid compensation arrangements for exempt staff members such as nurses and therapists

• Exempt versus non-exempt status and the overtime rules
  - If any portion of the compensation is based on time, the person cannot qualify as exempt under the “learned professional” rules and may be eligible for overtime
  - Agencies with hybrid or combination calculation methodologies for professional staff should consider reworking their compensation programs
IMPORTANT HR ISSUES

• Worker misclassification issues
  ▪ When are independent contractors really employees and why should I care?

• Independent contractor characteristics

• Addressing prior misclassification issues under the IRS’ Voluntary Classification Self Reporting Program
IS OUR HR MANUAL OUT OF DATE?

• New state and federal laws that could affect HR policies and practices
  - Minimum wage changes in 21 states
  - FLSA minimum weekly wage threshold increases
  - Medical marijuana changes in 23 states

• Rule of thumb is that if your manual is more than 3 years old, it is obsolete

• Policy errors or omissions can be costly
HIPAA

✓ Security Risk Assessment
  - Administrative, physical and technical safeguards in place to protect security
  - Opportunity to uncover and address weaknesses
  - Both privacy and security rules must be addressed

✓ Business Associate Agreements
  - Review the agreements on file
  - Any that are dated prior to 2009 should be updated
  - Make sure that the agency or organization has active agreements with all business associates
COMPLIANCE CHECKUP

• Elements of a compliance plan
  ▪ Designation of a compliance officer or person responsible for the program
  ▪ Written compliance policies and procedures
  ▪ Standards to be followed by employees with evidence of individual employee training and acceptance of compliance policies
  ▪ Communication and training methodology to ensure employees’ understanding of the plan
COMPLIANCE CHECKUP

• Elements of a compliance plan
  ▪ Monitoring and auditing systems for detecting compliance issues
  ▪ Disciplinary mechanisms
  ▪ Procedures for responding to detected or alleged compliance violations
  ▪ A periodic reassessment schedule
MEDICARE AS A SECONDARY PAYER – MSP

• When should MSP evaluations be performed?

• What is a conditional payment?

• What happens if Medicare discovers years later that a settlement was reached that affects my patient’s eligibility for Medicare services?

• How can the intake department quickly estimate whether there is a potential MSP issue?
<table>
<thead>
<tr>
<th>If the patient . . .</th>
<th>And this condition exists . . .</th>
<th>Primary Payer</th>
<th>Secondary Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is 65 or older and is covered by a Group Health Plan (GHP) through current employment or a spouse's employment</td>
<td>The employer has fewer than 20 employees</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>Is 65 or older and is covered by a Group Health Plan (GHP) through current employment or a spouse's employment</td>
<td>The employer has 20 or more employees, or if it is a multi-employer group, there are 20 or more employees among the members of the group</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>Is 65 or older and has an employer retirement plan</td>
<td>The patient is entitled to Medicare</td>
<td>Medicare</td>
<td>Retiree coverage</td>
</tr>
<tr>
<td>Is disabled and covered by GHP through his own current employment or through a family member's employment</td>
<td>The employer has fewer than 100 employees</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>Is disabled and covered by GHP through his own current employment or through a family member's employment</td>
<td>The employer has 100 or more employees, or if it is a multi-employer group, there are 100 or more employees among the members of the group</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has ESRD and GHP</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare coverage</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has ESRD and GHP</td>
<td>After 30 months</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>Has ESRD and coverage through COBRA</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare coverage</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has ESRD and coverage through COBRA</td>
<td>After 30 months</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Is covered under Workers Comp because of a job related illness or injury</td>
<td>The patient is entitled to Medicare</td>
<td>Workers Comp for claims related to the job illness/injury</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has been in an accident or other situation where no-fault or liability insurance coverage is present</td>
<td>The patient is entitled to Medicare</td>
<td>No fault or liability insurance for related services</td>
<td>Medicare</td>
</tr>
<tr>
<td>Is 65 or older or is disabled and covered by Medicare and COBRA</td>
<td>The patient is entitled to Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
</tbody>
</table>
SUMMARY

• We have covered several focus areas for 2015 both those that are brand new for many and some that are not new but important.

• 2015 will be a pivotal year for both home health and hospice. The future is very bright in terms of a continuing and growing market for our services.

• The organizations that truly thrive in 2015 and beyond will be those that are able to effectively deal with the business imperatives discussed in this presentation.