From the Top!

Referral, Intake, FTF and Admission

Presented by: Annette Lee RN, MS, COS-C, HCS-D
Home Health Fundamentals
February 2023

THE TEAM: Where's the impact?

Administrator/Office

Annie

Intake

Ivon

Clinician

Catherine

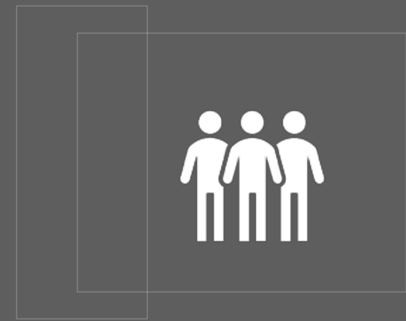
Marketer

Mark

Billing/CFO

Bella

PDGM COMPONENTS



SOURCE

Institution or Community

TIMING

Early (1st 30 days), Late (more than 30 days)

PRIMARY DX

Puts patient in a "Group"

Must be on the "list"

ADD'L DX

High (interactions) and low comorbids

Up to 24 addl dx

FUNCTION

Only driver direct from OASIS (ADLs, plus risk for hosp)

Success

Who's Your Market?

- Each agency is unique- some are hospital based, some are public health based, others are privately held and affiliated with ALFs
- Do you use marketers/liaisons?
- What's the expectation for information that must be gathered and provided by marketer or referral?

Allergies: ____________________

Referral information	Referring source: ________ Phone #: ________ Discharge Facility: ________ DC date: ________ Referral source: ☐ Institutional ☐ Community ☐Primary Agrees- Home Health Primary MD ________ Phone #: ________	Documentation Checklist: ☐ Hx & Physical ☐ DC summary ☐ Progress note ☐ Operative note ☐ Consultation ☐ MD Visit note ☐ PT eval ☐ OT eval ☐ ST eval ☐ Discharge med list ☐ Home health order ☐ Pertinent labs ☐ X-ray/other reports ☐ Other
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? ________	
Diagnosis	________ ________ ________ (Avoid symptoms, muscle weakness, unsteady gait, joint pain not attributed to a disease process, skin tears, abrasions)	

Home Health Referral Orders

SN	PT	OT	ST	MSW	HH AIDE
O&A Disease management Wound care Med management IV therapy Other skilled need: ________	Eval and treat: Weight bearing status: ________ Precautions: ________	Eval and treat: ADL training Restrictions: ________ Other: ________	Eval and treat: Swallowing therapy Cognitive: ________	Eval and treat: • Long range planning • Community resources • Decision making	Assist with bath and personal care

Referral checked/accepted: ________ Assigned to: ________ Protocols: ________	Additional information needed: ________ Referral declined d/t:

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Timely Initiation of Care

Consumer Language	How often patients are seen for their start of care or resumption of care assessments on the date specified by the physician or within two days of the referral date or inpatient discharge date.
Type	Process Measure – Timely Care
Measure Description	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician specified date or within two days of the referral date or inpatient discharge date, whichever is later.
Numerator	Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within two days of the referral date or inpatient discharge date, whichever is later. For a resumption of care, per the Medicare Conditions of Participation, the patient must be seen within two days of inpatient discharge, even if the physician specifies a later date.
Denominator	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	None
OASIS Items Used	M0030 Start of Care Date or M0032 Resumption of Care Date M0100 Reason for Assessment M0102 Date of Physician-ordered Start of Care M0104 Date of Referral M1000 Inpatient Facility Discharge M1005 Inpatient Discharge Date

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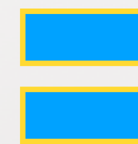
What Do We Need to Succeed?

Measure: Timely Initiation of Care

(M0030) Start of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year



(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
__ __ /__ __ /__ __ __ __
month / day / year
NA –No specific SOC date ordered by physician

OR

(M0030) Start of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year

< +2 days

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
__ __ /__ __ /__ __ __ __
month / day / year

OR

(M0030) Start of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __ /__ __ /__ __ __ __
month / day / year

< +2 days

(M1005) Inpatient Discharge Date (most recent):
__ __ /__ __ /__ __ __ __ UK - Unknown
month / day / year

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How Did My Agency Do?

Measure: Timely Initiation of Care

	Your HH Score	National Average
How often the home health team began their patients' care in a timely manner	______%	_95.7__%

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How Does Face to Face (FTF) Fit in Here?

- Technical and supports medical necessity!
- The FTF is the physician or NPP encounter- which reflects some of the clinical indications of why the patient needs home health
  - May discuss the increased s/s of CHF, COPD, Diabetes, other conditions
  - May discuss pain or new conditions
  - May discuss decreased function, falls, etc.
- The assessing clinician has the opportunity to provide more details to be incorporated into the FTF documentation
  - Details of lung sounds, level of exertion causing dyspnea, blood sugars
  - Details of wounds, pain assessments, medication compliance and understanding, side effects, etc.
  - Details of new risk for falls, inability to care for self due to declines
  - Included on 485 and when signed by certifying clinician, becomes doctor record for FTF

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Old vs New Certification: OLD

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT
24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

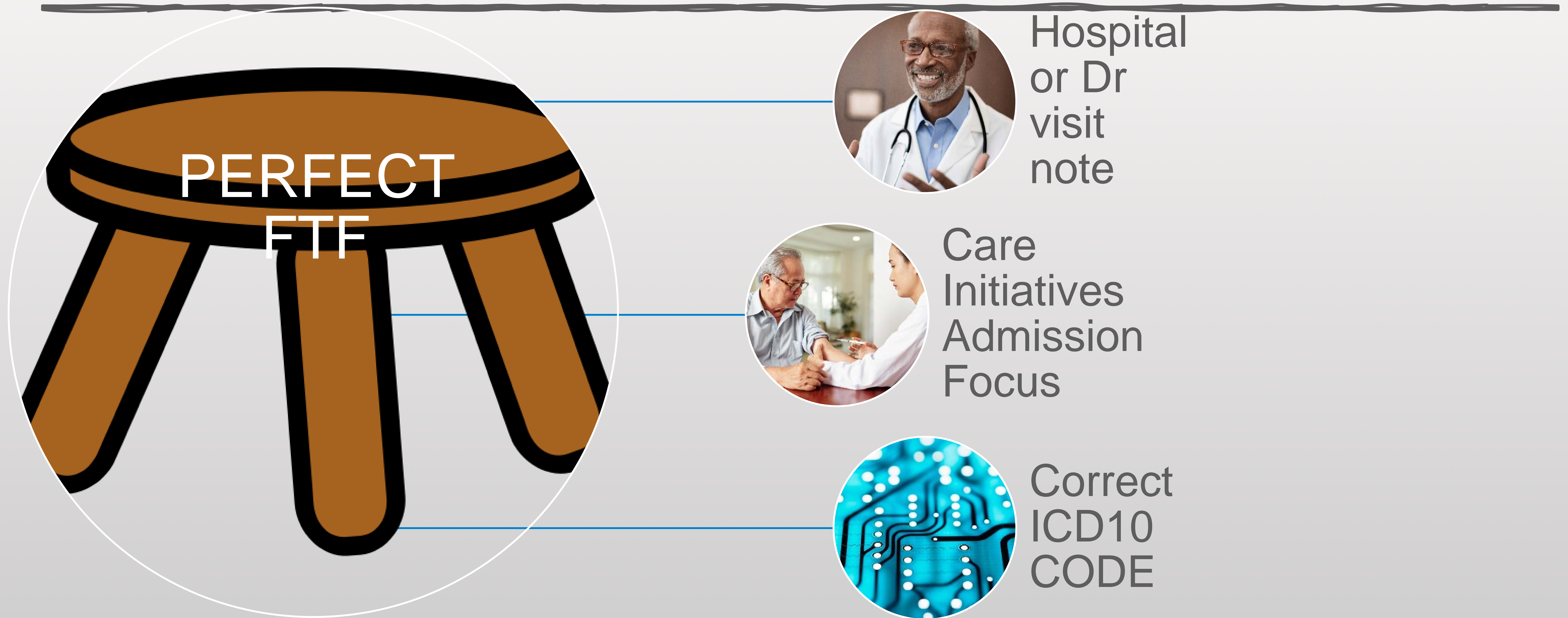
Old vs New Certification: NEW

- I certify/recertify that the above stated patient is homebound and that upon completion of the FTF encounter, on *(TYPE DATE HERE)* , has a need/continued need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnoses as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

FTF Process: Choose the Right Note

- Marketing/Intake- Ensure proper documentation is obtained from ordering provider
- Choose the “best” documentation available related to reason for home health
  - In a facility? Just needs to be a physician, NP, PA, CNS
  - Community admission? Needs to be documentation of visit by same provider who will be certifying
  - MUST be for same reason as referral- Home Health is a continuation
  - Must be within last 90 days (although closer is more supportive)
  - If using “telehealth”- MUST state audio and video
- ADMITTING Clinician- we MUST document to the focus of the FTF visit note FIRST- and THEN can elaborate on any other needs you have found
  - Example CHF at physician visit- but nurse finds a wound

Three-Legged Table- All Supports Each Other



Clinical Grouping (Primary Dx)

- Wound
- Neuro Rehab
- Musculoskeletal Rehab
- Complex Nursing Interventions
- Behavioral Health
- Medication management, teaching and assessment
  - MMTA — surgical aftercare
  - MMTA — cardiac/circulatory
  - MMTA — endocrine
  - MMTA – GI/GU
  - MMTA — infectious disease/neoplasms/bloodforming diseases
  - MMTA — respiratory
  - MMTA — other

Clinical Grouping

- CMS is using Primary Diagnosis from the claim
  - No longer mandated to match OASIS and POC- but this is how our EMR is set up to typically pull diagnoses to the claim!
- CMS defined groups by prior claims data and utilization
- The “Group” is indicative of historical data of costs– utilization, disciplines, supplies
  - Therapy utilization will not be a payment indicator separately from the “group”
  - CMS pays the episode, based on past data, but we provide care based on our assessment/orders
    - Patient may need therapy in “non- rehab” groups! This is included in the payment!
- Primary diagnosis should not be unspecified or a symptom code
  - If not on CMS list of “Grouped” codes- will “RTP” (Return to Provider” when billed and not process for payment

Primary Diagnoses per CMS

- The primary dx tells the story why patient needs home health
  - MUST match main reason on FTF
  - Excludes codes that don't support HH, such as dental codes
  - Exclude codes that are not following coding guidelines
    - Example if a manifestation codes is listed as a primary
  - CMS does recognize the operational difficulty with getting details from referral sources- states per 484.60 we would work with all providers to ensure we obtain information
- Avoid "unspecified"
  - Example: T14.90- "Injury- unspecified", or missing laterality where available

TOP 10 “Boomerang” codes make up 51% of all claims that RTP

- M62.81 Muscle Weakness Generalized 179,711
- R26.89 Abnormality of gait and mobility 49,095
- M54.5 Low back pain 38,716
- R26.81 Unsteadiness on feet 30,181
- R53.1 Weakness 28,706
- R26.9 Unspec abnormalities of gait and mobility 23,742
- R29.6 Repeated falls 23,578
- R26.2 Difficulty in walking not elsewhere classified 20,297
- M19.90 Unspecified osteoarthritis 16,544
- Z48.89 Encounter for other specified surgical aftercare 16,281

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Identify the FTF and Label It!

What was the reason for visit?

Face to Face Encounter

HISTORY AND PHYSICAL

Chief Complaint: Anxiety, Dementia, Depression

Past History:

Family History:

Allergies: Sulfa

Operations—Minor:

Major:

Physical Findings: BP 115/64 Temp. 98.5 Pulse 66 Resp. 19 Wt.

Head Normocephalic

Neck

Chest

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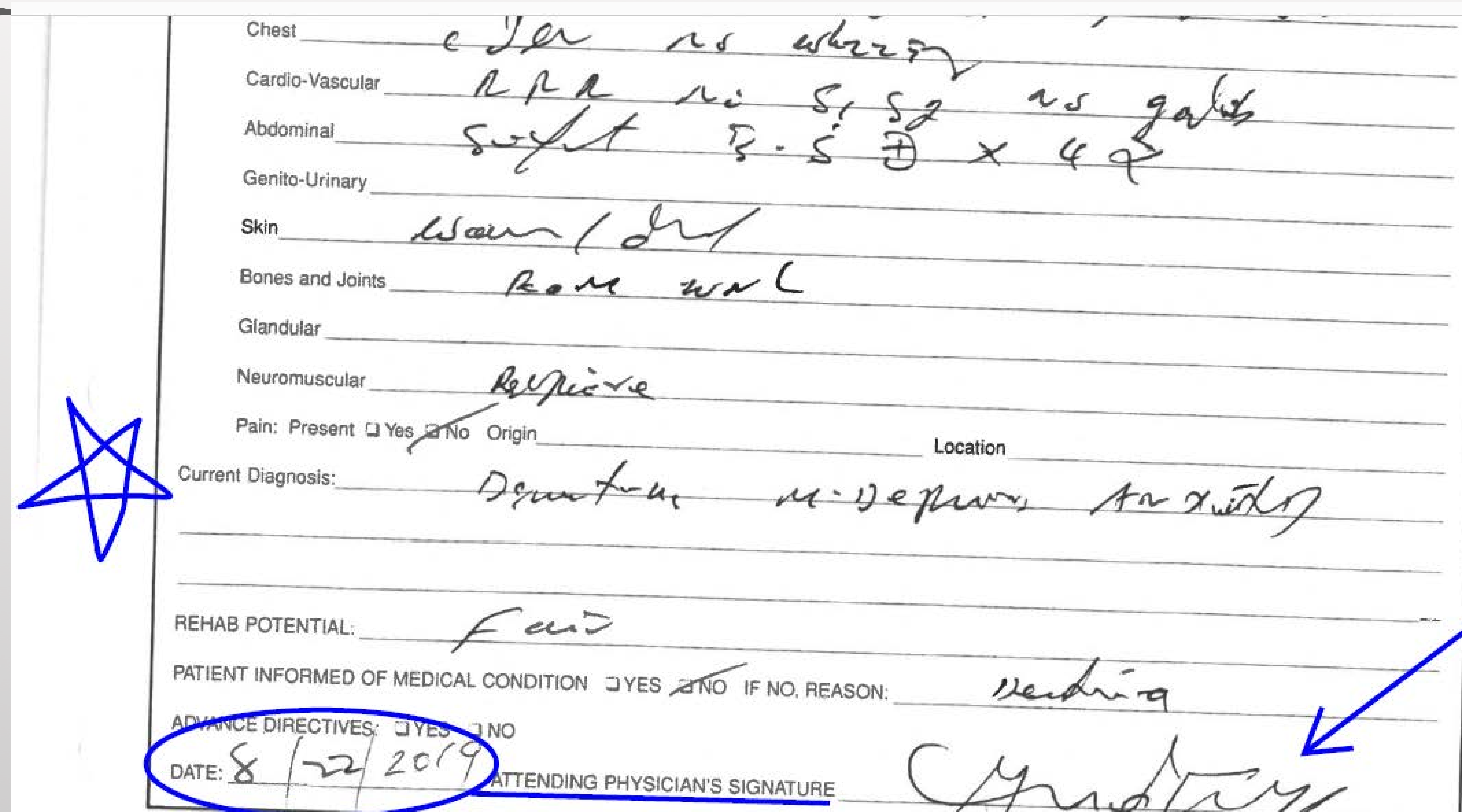
Note- Who, Where, When and What About?

- Was the FTF in a facility?
  - If not, then the FTF must be completed by the ordering/POC provider
  - Circle or NOTE WHERE this FTF was- and by WHOM
  - Was this within the last 90 days for the same reason the patient now needs HH?

Identify and Label the Who, When and What!



Chest

Cardio-Vascular

Abdominal

Genito-Urinary

Skin

Bones and Joints

Glandular

Neuromuscular

Pain: Present ❑ Yes ❑ No Origin Location

Current Diagnosis:

REHAB POTENTIAL:

PATIENT INFORMED OF MEDICAL CONDITION ❑ YES ❑ NO IF NO, REASON:

ADVANCE DIRECTIVES: ❑ YES ❑ NO

DATE: 8/22/2019 ATTENDING PHYSICIAN'S SIGNATURE

What's Missing?

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Then on the POC…

Primary Diagnosis

Code	Description	Date
F03.91	Unspecified dementia with behavioral disturbance (O)	11/12/2019

Surgical Procedures

Code	Description	Date
--	--	--

Secondary/Other Diagnosis

Code	Description	Date
F41.9	Anxiety disorder, unspecified (O)	11/12/2019
F32.9	Major depressive disorder, single episode, unspecified (O)	11/12/2019
R33.9	Retention of urine, unspecified (O)	11/12/2019
R13.11	Dysphagia, oral phase (O)	11/12/2019
G47.00	Insomnia, unspecified (O)	11/12/2019
F17.210	Nicotine dependence, cigarettes, uncomplicated (O)	11/12/2019
Z91.81	History of falling (O)	11/12/2019

Mental Status	Other
Oriented, Disoriented	--

Additional Orders
to self only

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Matching the Date…

PT Goals
Patient will Improve ability to safely complete bed mobility with Max A to Min/CGA to allow patient to move in bed and prevent pressure injuries within 5 minutes (Goal Term: long, Target Date: 1/10/20)
Patient will Decrease risk of falls as evidenced by No ER/hospital visit due to madication errors. score of . to allow patient to . (Goal Term: long, Target Date: 1/10/20)
Patient will improve ability to safely transfer from bed to Wheelchair with CGA to allow patient to move in bed and transfer and prevent pressure injuries (Goal Term: long, Target Date: 1/10/20)
Patient will improve strength of BLE and trunk from 2/5 to 4-5/5 to allow patient to move in bed and prevent pressure injuries (Goal Term: long, Target Date: 1/10/20)

Rehab potential: Poor to achieve stated goals with skilled intervention and patient's compliance with the plan of care.
Discharge plans: Discharge when medical condition is stable and patient is no longer in need of skilled services.
Discharge to caregiver.
Discharge when goals met.

Nurse Signature and Date of Verbal SOC Where Applicable Digitally Signed by:	Date 11/12/2019

I certify that this patient is confi[redacted] ent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred 8/22/19 within time frame requirements and it is related to the primary reason the patient requires home health services.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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What Do We Do Now?

- Patient referred to the agency for a wound, but the only FTF visit note does not mention the wound
  - Inquire if other documentation that includes wound
  - Schedule a telehealth where RN can be present to show Dr the wound?
  - Re-review the FTF- and see if HH can be provided for the primary issue during that note also
    - Clarify with referring Dr to ensure orders
    - Handoff clarity to admission RN to ensure she documents the focus is what is on FTF, and the wound is not first issue documented/focused on

What Do We Do Now?

- Patient referred for therapy, but recent H&P was all about CHF exacerbation? Or Cancer?
  - Due to PDGM, we can't typically use a "therapy diagnosis" like we used to- such as "Weakness" or "Abnormality of gait"
  - Medical diagnoses (such as CHF exacerbation, COPD, Cancer) are allowed and SHOULD be used for therapy
- If the medical diagnoses doesn't make sense for therapy, may need to:
  - Clarify with Dr if nurse care is also needed to reflect the FTF reason
  - Schedule a telehealth

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“Under the Care of a Physician”

- As of 3/27/20, this could be under the care of a physician or an NP, or a PA
  - Community provider
  - Not a hospitalist
  - Must agree to home health and agree to follow and provide POC and orders
- This is the community Dr/NPP– not just the referral source

Your Assessment Ensures Compliance

- Determine eligibility for the Medicare or other payer's home health benefit
  - Need for skilled intermittent nursing
  - Need for PT or SLP
  - Homebound
  - Physician ordered
  - Payer checklist

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Medicare Must Knows…

- CMS Medicare Benefit Policy Manual
    - www.cms.gov/manuals/Downloads/bp102c07.pdf
- Nursing ordered? Why does patient need?
    - Observation/Assessment- show recent changes in condition, medication or treatment
    - Technical skilled service- have appropriate diagnosis for injections, catheter changes, infusions, complex wound care
- Therapy ordered?
    - Show recent changes in functional ability
    - If not, may establish a maintenance program

How Do We Know?

- These skills and criteria must be taught
  - At orientation
  - Preceptorships
  - Ongoing case management meetings and education
- The “Initial Assessment” is a huge responsibility- not just a paperwork
  - Ensuring safety
  - Ensuring patient fits “home health” acceptance
  - Ensuring coverage by insurance

Medicare Eligibility

What is Medicare?

Medicare is a health insurance coverage given to all individuals who are 65 or greater in age or disabled.

Does Medicare cover Home Health Care? **Yes, under certain conditions.**

What are the conditions?

- Patient must be under the care of a physician
- Patient must have appropriate Face to Face
- Patient must be homebound
- Patient must have a qualifying skill
- Care must be reasonable and medically necessary
- If SN is qualifier, SN service must be intermittent.

Update on Homebound

Statement “1” must first be met:

1. The patient must either need physical assistance leaving the home

Then, both “2” and “3” must be met:

2. There must also be a normal inability to leave the home

AND

3. Leaving the home must require a considerable and taxing effort

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Homebound

- Documentation must support throughout
  - Amount needed varies by type of patient
- Beware of vague descriptions
- Utilize objective, measurable language

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Proving Homebound through Documentation

Patient is homebound due to:

- Requires assistance with caregiver to leave home
- Patient only ambulates ___ feet, and must rest due to pain
- Patient only ambulates ___ feet, and must rest due to dyspnea
- Patient unable to ambulate without assist due to poor balance and unsteady gait
- Dementia, patient cannot safely leave their home.
- Patient being bed bound and cannot leave home.
- Patient uses walker and has difficulty walking in the community
- Patient requires a wheelchair for mobility
- Patient’s COPD requires oxygen and leaving home is very difficult
- Patient’s Hip/knee replacement requires walker and it takes considerable effort due to

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Poll Question: Two Little Ladies

- 90 year old walks with cane on uneven surfaces, good balance, denies pain, and is alert and oriented x4. She never leaves her home.
- 24 year old quad, needs full assist for ADLs and IADLs. Once in wheelchair, she is independent with mobility. She leaves the home on a daily basis, but there is clear taxing effort.
- Is either homebound?
  - 90 year old
  - 24 year old
  - Both
  - Neither

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Medicare Criteria

What are the 6 conditions?

- Patient must be under the care of a physician
- Patient must be homebound
- **Patient must have a qualifying skill**
- Care must be reasonable and medically necessary
- If SN is qualifier, SN service must be intermittent.
- Patient had a qualifying FTF for same reason as HH need

Qualifying Skill

After homebound status is determined, the Agency must identify if the patient has a "qualifying skill" to bill Medicare.

3 qualifying skills: SN, PT, ST

Once a patient has qualified for home health, with SN, PT or SLP needs- then OT can stand alone

Medical Necessity- A Qualifying Criteria

- Must show WHY the patient NEEDS the skills
- Covers all disciplines
  - Nursing
  - Physical therapy
  - Occupational therapy
  - Speech language pathology
- When denial for nursing, top skill denied observation/assessment
- FTF does NOT have to say the patient will have home health, or request for SN/PT, etc- It just needs to make CLINICAL sense

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3 Qualifying Skills For Nursing

- Observation/Assessment of exacerbated diagnosis or when the likelihood of change in a client's condition requires skilled nursing personnel to identify and evaluate the client's need for possible modification of treatment; or initiation of any additional medical procedures until the client's treatment is essentially stabilized.

- Teaching and Training activities that require skilled nursing personnel to teach a client, the client's family, or caregivers how to manage the treatment regimen would constitute SN services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. SN visits for teaching and training activities are reasonable, necessary, and appropriate to the client's functional loss, illness, or injury.

- Skilled Procedures

Medical Necessity Documentation

- Documentation should answer question “Why Home Health, Why Now?”
  - Objective clinical evidence of patient’s individual need for care
  - Progress or lack of progress
  - Medical condition
  - Functional losses
  - Treatment goals

Assessment

Medicare Benefit Policy Manual, Publication 100-2, Chapter 7, Section 40.1.2.1

- “O&A of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized.”

Three Week Window

- Skilled observation services are covered for three weeks
  - If reasonable potential of a complication or further acute episode, needing changes to POC
  - Paid even if no further acute episode or complication
  - Extended if there remains a reasonable potential for complication or acute episode

Clinical Indications

- When clinical indications show assessment will likely result in changes to the POC, services would be covered
  - Indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment

Exceptions to Indications
(or When is it Reasonable?)

- Assessment by a nurse is not reasonable and necessary if:
  - Indications are part of a longstanding pattern of the patient's condition
  - And/or there is no attempt to change the treatment to resolve the clinical indications

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Front Loading

- Improves outcomes
- Decreases hospitalizations
- Protects payment

Example: Patient admitted after a new diagnosis of diabetes, and was started on an oral hypoglycemic. Pt understands diet and medications- BS is 85-110 consistently within the first three weeks.

- Our orders were 1w9.
- What if our orders were 3w1, 2w2, 1w5?

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Documenting the Skill

- Example for strong documentation
  - Start your narrative for BILLABLE part of visit
    - The patient condition + skilled intervention
  - Follow up on loose ends from last visit(s)
    - Was there a new med? New c/o?
    - Showing continuity/coordination of care and impact of HH
  - O&A on other secondary dx/risks
    - Include best practice teaching/assessments here
  - Explain the details- what foods, side effects, contraindications did you teach on? What CHF s/s did you assess and teach about? (Not just general terms such as "taught on s/s of CHF")

Showing the Need through Documentation

Clinical Indications that Support Need for Home Health

- Patient has a new diagnosis of ____
- Patient recently had an exacerbation of symptoms related to ________
- Patient recently had the following changes in medications and/or treatments ______ ____
- Patient recently hospitalized for _______________________________________
- Patient has a wound ____
- Patient has an infection requiring antibiotics ____________________
- Patient recently had a decline in function related to ______________
- Patient recently had a decline in safe ability to perform ADLs ________
- Patient recently had a change in speech and/or swallowing _________

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How Our Processes Protect Our Payment

- Marketing
- Intake
- Admission assessments/Evals
- Case conferences
- Recertification* (see tool)
- QA

Recertification for Nursing Need

- Is there still a “hands-on” skill that the patient needs?
    - Ongoing skilled wound care
    - Vitamin B12 or other IM injections
    - IV medication administration
    - Foley catheter changes
- For ongoing assessment or teaching:
    - Has there been a **medication or treatment order change** in **last three weeks?**
    - Has there been a new or exacerbated condition in last three weeks (requiring medication or treatment changes)

Recertification for Therapies

- Are there still skilled modalities, such as ultrasound, that the patient needs?
- Are the other manual modalities (therapeutic exercises, gait training, ADL training, balance work) **advancing with the professional assessment and adjustments of plan of care? (not repetitive each visit)**
  - Note: Due to Jimmo vs Sebalius case, we do not need to see improvement to qualify for home health- but it is NOT considered to take skills of therapist to simply perform repetitive modalities that could be taught to non- therapist
- Has there been a change in setting? Caregiver? Function?
- Is it reasonable to meet goals?

Not Just at Recert!

Prior to new 30-day episode- ask “Is the focus of care going to remain the same? Any new co-morbidities to add to the claim?”

a. “No new focus or diagnoses”- will carry over codes from past comprehensive assessment/coding
b. If a new focus, ask “Was this related to a major decline not expected in the POC?” If yes, do SCIC. If no, proceed to change diagnoses to reflect the focus of care

Thank You! Questions?

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