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Home Health Targeted Probe & Educate Process: Responding to an Additional Documentation Request

3/31/2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Shelly Dailey MSN, BSN, RN, CPHM; Home Health & Hospice Provider Outreach Education Consultant

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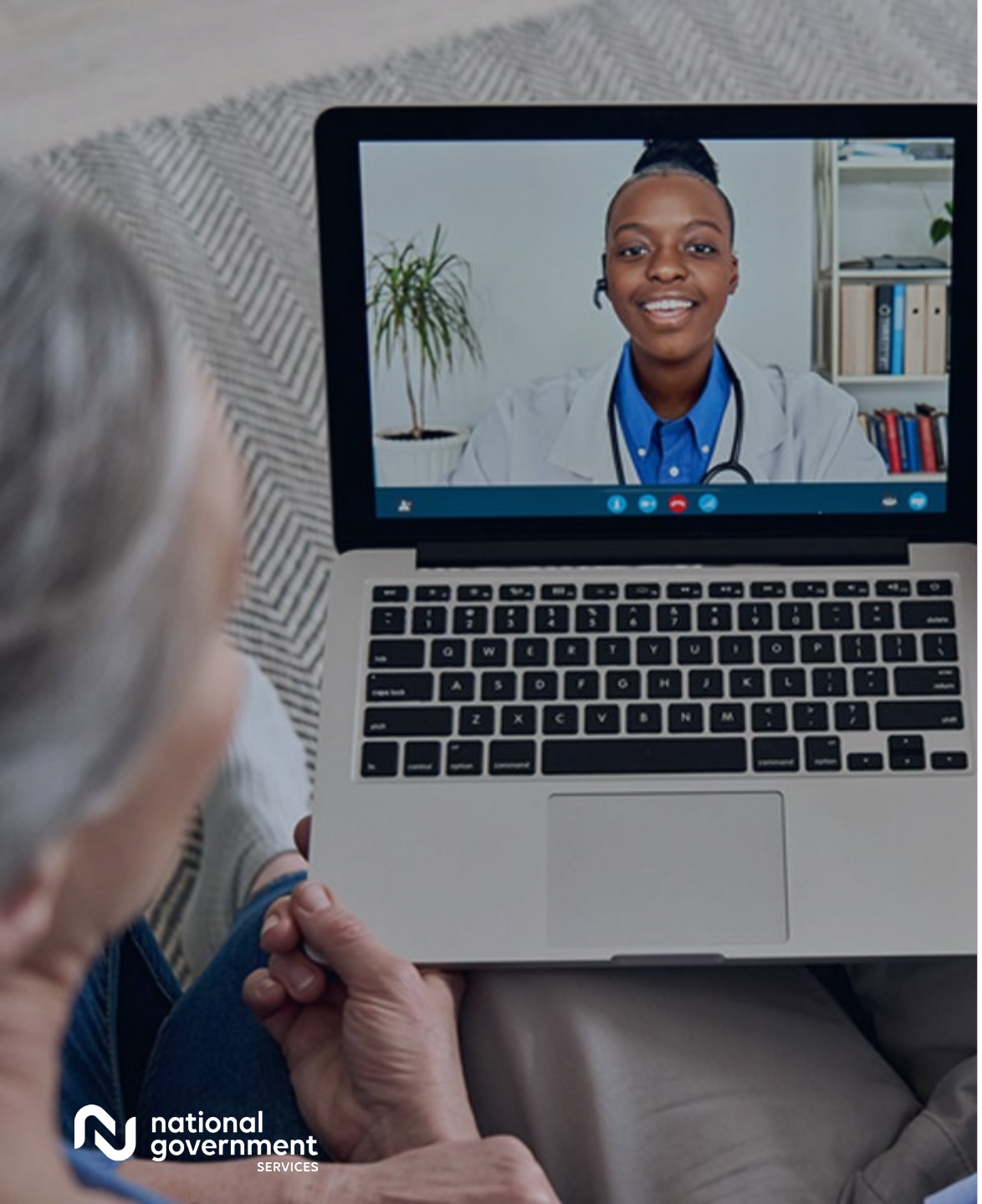

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Objectives

Explain the process of responding to an ADR as it pertains to the TPE process in Jurisdictions 6 & K; provide information regarding current TPE edits and denials, as well as describe the importance of home health medical record documentation collaboration amongst all providers delivering home health services.

Agenda

- Home Health Benefit and Eligibility Criteria
- Additional Documentation Requests Process
- Targeted Probe and Educate Process
- Current HH TPE Edits & Denials
- Medical Record Documentation to Support HH Eligibility
- Submitting HH Documentation in Response to a TPE ADR
- References and Resources
- Question and Answer Period

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The Medicare Home Health Benefit and Eligibility Criteria

The Medicare Home Health Benefit

Services that the Medicare beneficiary (patient) may receive at home include:

- Skilled Nursing
- Home Health Aides
- Physical Therapy
- Occupational Therapy
- Speech Language Pathology
- Social Work

Home Health Eligibility Criteria

- Confined to the home (Homebound)
- Have a need for skilled services (in the home)
- Remain under the care of a physician and/or allowed practitioner (oversight)
- Receive services following a Plan of Care
- Had a Face-to-Face encounter

Additional Documentation Request Process

ADR

An ADR is a request for documentation to support a Medicare claim

- Providers can view ADRs:
  - FISS/DDE
  - NGSConnex
  - USPS (NGS Sends as a courtesy)

FISS DDE

- ADRs can be accessed by filtering the claims by status/location
- At the Claims Inquiry screen, type SB6001 in the S/LOC field and press <Enter> - all claims in the SB6001 status and location will be displayed
- At the desired claim, type S to the left of the claim under the SEL field and press <Enter>
- The ADR letter follows page 06 of the claim
- Please be sure to not press the <P9>/<PF9> key while viewing a claim in the SB6001 status—this will cause the claim to recycle and generate a second ADR letter
- Requested records are due to NGS within 45 days from the date the claim went to S/LOC SB6001 in FISS
- **FISS is the best way for all providers on TPE to know what claims are being requested**

FISS DDE

Records not received by day 45 will prompt the system to deny the claim and move it to S/L DB9997 on day 46

- Claim is assigned with reason code 56900 (denied for non-submission)
- If the records are received, the claim will move to S/L SM 5REC
- If the denial code appears and the records were submitted, wait a week and recheck the S/L
  - Call the provider contact center for assistance if necessary

NGSConnex

Free, secure, web-based application developed by NGS with a wide array of self-service functions, including:

- Obtain beneficiary eligibility information
- Query for your claims status
- **Submit documents for an ADR**
- Submit and review determination and reopening requests
- View your provider demographic information
- Query for your financial data
- Submit credit balance reports… and more!

NGSConnex: Homepage → ADR → HHH → Respond to an ADR

ADR

Incorporating policies and procedures regarding ADRs will assist in ensuring:

- Appropriate documentation is obtained from outside entities
- All home health eligibility criteria have been met
- Medical records are reviewed for accuracy by multiple people prior to submission
- All proper documentation is included in the medical record prior to responding to an ADR
- Proper claims payment (revenue stream)

ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart.
- Information within the ADR provides helpful hints for appropriate claims payment.
- Keep in mind the ADR does not provide an all-inclusive list of what should/should not be included for medical record submission.
- It is up to each provider to review the medical record documentation to ensure the contents support all eligibility criteria, and matches the claim submitted for services rendered to the patient.

ADR

- Many methods and techniques are often utilized to create an agency process and/or policy to ensure proper medical record documentation is collected and submitted upon receipt of an ADR.
- Incorporation of such practices may also assist in a decrease of payment denials and appropriate payment of home health claims.

Mock Charts

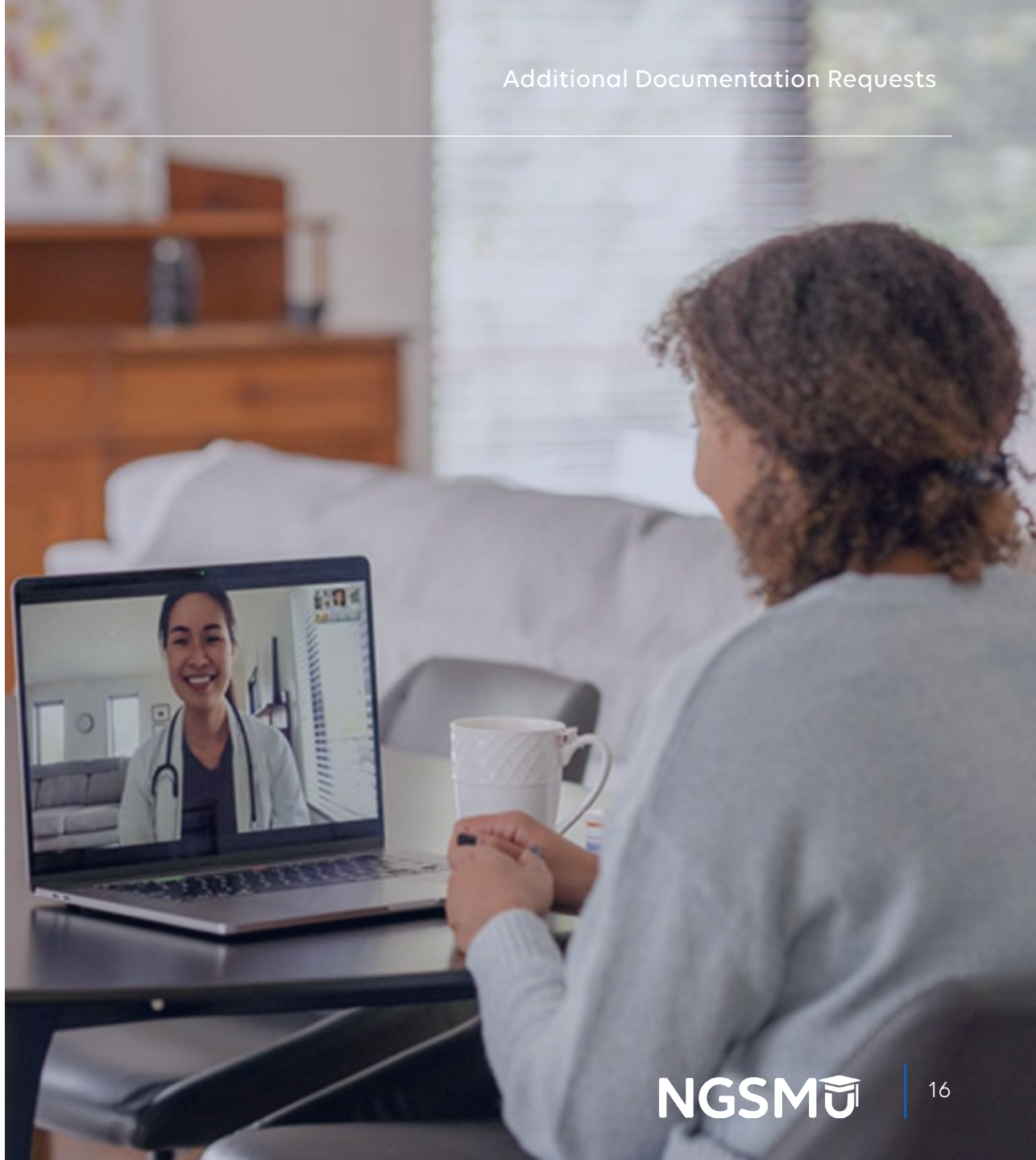
A model of a medical record to provide an example of the documentation to be submitted.

Checklists

Print the model checklist offered on the NGS website to assist in creating a checklist.

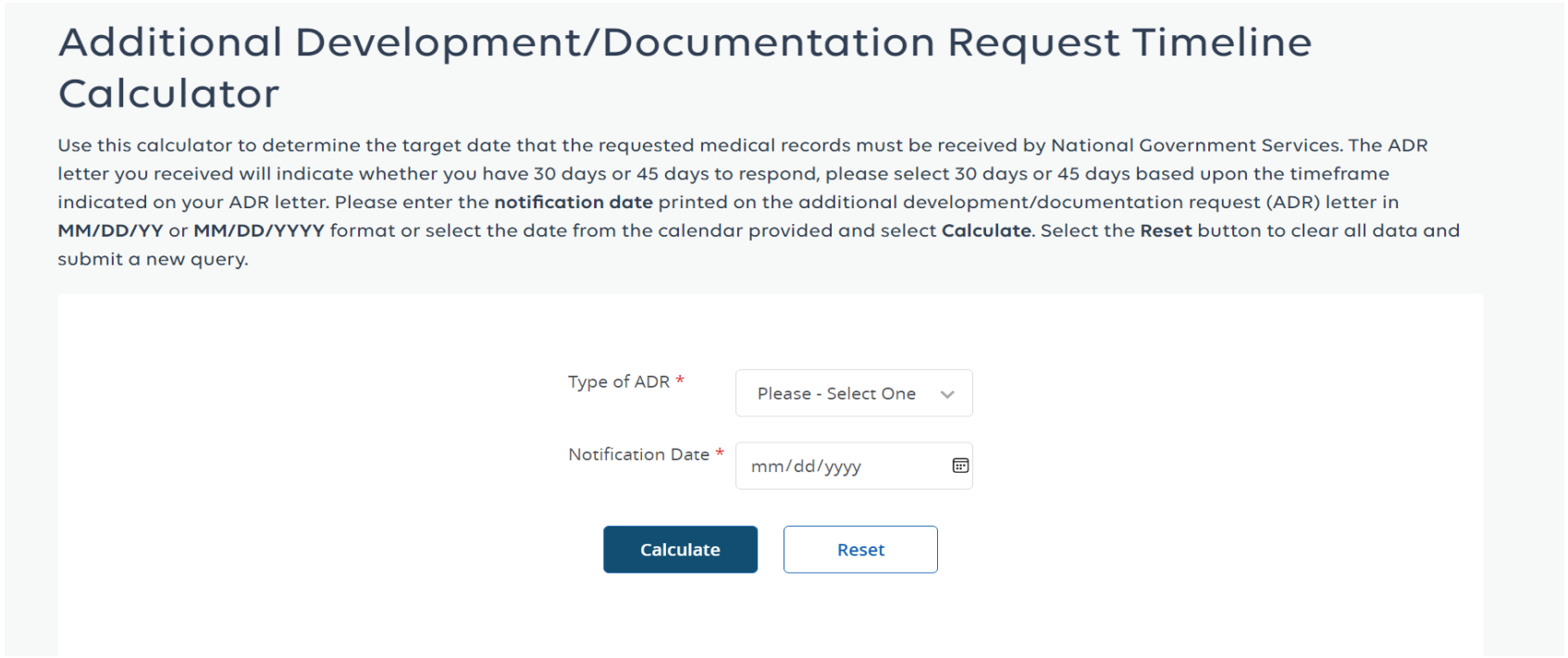
Staff Involvement

Multiple staff member involvement for collection and review of medical records prior to submission.



ADR

Utilize the NGS ADR Timeline Calculator to determine the target due date for medical record submission.



ADR

Reminders:

- Check for ADRs (in FISS or NGSConnex) on a daily basis
- Check PECOS on a routine basis to ensure that all providers involved in patient care are up-to-date with Medicare certification
- Review medical record documentation for home health eligibility and certification/recertification prior to submission:
  - Homebound status
  - Need for skilled service in the home
  - Plan of care
  - Physician and/or allowed practitioner oversight
  - Face-to-face encounter
- Submit all medical record documentation in a timely manner.

Targeted Probe and Educate Process

TPE

CMS's TPE program is designed to help providers and suppliers reduce claim denials and appeals via 1:1 assistance/education:

- The goal of the TPE program to assist providers with quick improvements
- MACs work with providers in 1:1 sessions to identify errors and issues within medical record documentation
- Many common errors are easily corrected – such as a missing documentation
- TPE reviews can be either prepayment or post-payment and involve MACs focusing on specific providers/suppliers that bill a particular item or service

TPE

TPE provider determination:

- CMS instruction to determine the targeted items, services, devices, and/or providers
- Data analysis: utilization patterns, trends, and billing comparisons
- Improper payment strategy

TPE

- Upon selection for TPE providers receive a notification letter offering details about the TPE process
- A **point of contact** from each home health agency is requested within the Notification Letter
  - This will ensure that the NGS clinical review team can contact the provider as needed for intra probe questions regarding the medical record documentation, etc.

TPE

Initial Probe (Round One)

- Intro/probe education as needed
- Provider notification via ADR
- Record submission
- Review and calculation
- Results letter
- Provider request for education
- 1:1 education with nurse reviewer

Round Two

- Intro/probe education as needed
- 45-56 days following education - provider notification via ADR
- Record submission
- Review and calculation
- Results letter
- Provider request for education
- 1:1 education with nurse reviewer

Round Three

- Intro/probe education as needed
- 45-56 days following education - provider notification via ADR
- Record submission
- Review and calculation
- Results letter
- **Referral to CMS (as applicable)**

TPE

Referrals to CMS may result in:

- Additional rounds of TPE
- Referral for revocation
- Corrective action
- Extrapolation
- Referral to Unified Program Integrity Contractor (UPIC)
- Referral to the Recovery Auditor (RA)
- 100% Pre-pay review

TPE

Additional Rounds of Review occur when there is a:

- PER **is greater than 15%** of total paid claims
  - 1,000 medical records reviewed and 500 paid incorrectly = 50% PER
- Providers **must request education** with Medical Review department staff
  - Call the telephone number on the results letter to schedule educational session
    - ✓ NGS will not contact you to schedule the educational session

TPE

- To be released from TPE review each provider **must have a PER of 15% or less.**
- If the PER is 15% or greater (this includes 15.2%) the provider will be moved into the next round of TPE.

TPE

Helpful Hints:

- Notification letter includes the reason for review
- ADRs for TPE are generated via the usual process
- MAC requests 20 – 40 claims
- Do not send medical record documentation until an ADR has been received for each claim
- Providers must respond within 45 days (suggest 30)
- Providers that do not submit medical records upon receipt of an ADR (56900 denial) may be referred to the RA or UPIC
- Records are reviewed by the MAC within 30 days of receipt.
  - Results letter offers 1:1 education

TPE

Medical review includes analysis of the submitted medical record documentation for:

- **Technical Components (examples):**
  - Dates of service
  - PECOS
  - Physician orders
- **Eligibility Requirements (examples):**
  - Homebound Status
  - Medical necessity
  - Documentation to support services billed
  - Face-to-face encounter timeliness
  - Certification/recertification of eligibility criteria

TPE

Detailed results letter at the conclusion of each round includes:

- Outline of the TPE process
- Reasons for denials
- Medicare regulation information to support each denial
- **PER**
  - Release or retention of TPE process (Information regarding additional rounds as applicable)
    - ✓ Must have a **PER of less than 15% (<15%)** to be released from additional TPE rounds
    - ✓ Contact information to schedule 1:1 Education information

TPE

- The process for appealing denied claims has not changed with the TPE process.
- Results of an appeal will not change the **PER** of the TPE audit results.

Current Home Health TPE Edits & Denials

Current Home Health TPE Edits & Denials

- JK Current HH Edits: **Obtain from MR Prior to Webinar to ensure current edits**
- J6 Current HH Edits: **Obtain from MR Prior to Webinar to ensure current edits**

- JK Current Top HH Denials: **Obtain from MR Prior to Webinar to ensure current top denials**
- JK Current Top HH Denials: **Obtain from MR Prior to Webinar to ensure current top denials**

Avoiding Home Health TPE Denials

- Submit medical record documentation in a timely fashion
- Review medical records for quality prior to submission
- Ensure appropriate medical record documentation is included (face-to-face encounter, plan of care, etc.)
- Ensure medical record documentation supports all home health eligibility criteria
- Ensure dates and signatures are appropriate and timely
- Questions regarding TPE or ADRs: j6probeandeducate@anthem.com or jkprobeandeducate@anthem.com

Medical Record Documentation to Support Home Health Eligibility

Medical Record Documentation to Support Home Health Eligibility

- Documentation from the acute/post-acute care facility and certifying physician and/or allowed practitioner must support all home health eligibility criteria.
- Documentation from the home health agency medical record must support all home health eligibility criteria, including:
  - Homebound status
  - Need for skilled services
  - Physician and/or allowed practitioner oversight
  - Plan of care
  - Face-to-face encounter

Homebound Status

- No mandatory form or format requirement
- Found anywhere in the medical record from the referring physician and/or allowed practitioners office or the acute/post-acute care facility record documentation
- Documentation that supports the definition of "confined to the home" as per CMS regulations (CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30)
- Documentation must be patient specific as per federal regulations
  - Do not utilize check boxes or canned statements
  - Explain why the individual cannot leave home due to the current injury or illness as it relates to the principal diagnosis for which the patient requires home health services

Need for Skilled Services

No mandatory form or format requirement

- Found anywhere in the medical record from the referring physician and/or allowed practitioners office or the acute/post-acute care facility medical record documentation
- Documentation regarding the need for skilled services must be patient specific as per federal regulations
  - Do not utilize check boxes or canned statements
  - Explain why the individual cannot leave home to receive skilled services on an outpatient basis

Under the Care of a Physician and/or Allowed Practitioner (Oversight)

- Documentation from the acute/post-acute care facility certifying patient eligibility **must provide the name of the physician and/or allowed practitioner who agrees to monitor home health services in the community at the time of the referral** when/if the certifying physician or allowed practitioners will not be providing oversight of home health services (hospital, SNF, IRFs or outpatient surgery center referrals).

Plan of Care

No mandatory form or format requirement

- Discharge plan from the acute/post-acute care facility at the time of the patient discharge prompting referral to home health
- Initial plan of care written by the referring certifying physician and/or allowed practitioner at the time of the patient's office visit that prompted the referral to home health
- The initial plan of care, as well as the POC for the period under review should always be included upon receipt of a HH TPE ADR

Face-to-Face Encounter

The face-to-face encounter is not an attestation form completed by the home health agency, it is the actual:

- **Discharge summary** from the acute or post-acute care facility written at the time of patient discharge prompting referral to home health services; or an actual.
- **Progress note** from the physician and/or allowed practitioners office at the time of the patients one on one visit with the physician and or allowed practitioner in the office prompting referral to home health services.

Face-to-Face Encounter

Remember, the face-to-face encounter:

- Must be related to the primary reason the patient requires home health services and the condition must be addressed within the encounter. (A listing of the diagnoses and medication will not meet the requirement.)
- Does not require a mandatory narrative except in the instances when skilled oversight of unskilled care is ordered.
- May be completed and signed by an allowed practitioner without a physician counter signature.
- Must be completed within 90 days prior to the HH start of care or within 30 days after the start of care.

Initial Certification of Eligibility Criteria

Required for all new start of care admissions:

- No mandatory form or format requirement
- Statement from the certifying physician or allowed practitioner acknowledging that all five eligibility criteria have been met
- Dated signature below the statement from a Medicare enrolled physician or allowed practitioner

Recertification of Eligibility Criteria for Subsequent HH Episodes

- Follows the initial certification of eligibility.
- When requested for review by the MAC, the initial SOC certification must be included.
- Completed by the community physician and/or allowed practitioner that has been monitoring home health services
- No mandatory form or format requirement.
- All documentation regarding initial certification and continued eligibility must be included
  - The initial plan of care, as well as the POC for the period under review should always be included upon receipt of a HH TPE ADR.
- Date of the face-to-face encounter at the time of initial certification.
- Statement from the community physician or allowed practitioner overseeing home health services acknowledging that all five eligibility criteria continue to be met.
- Dated signature of a Medicare enrolled provider or allowed practitioner below the recertification statement.
- Mandatory narrative regarding skilled oversight of unskilled care (when ordered).

Referral and Order for HH Services

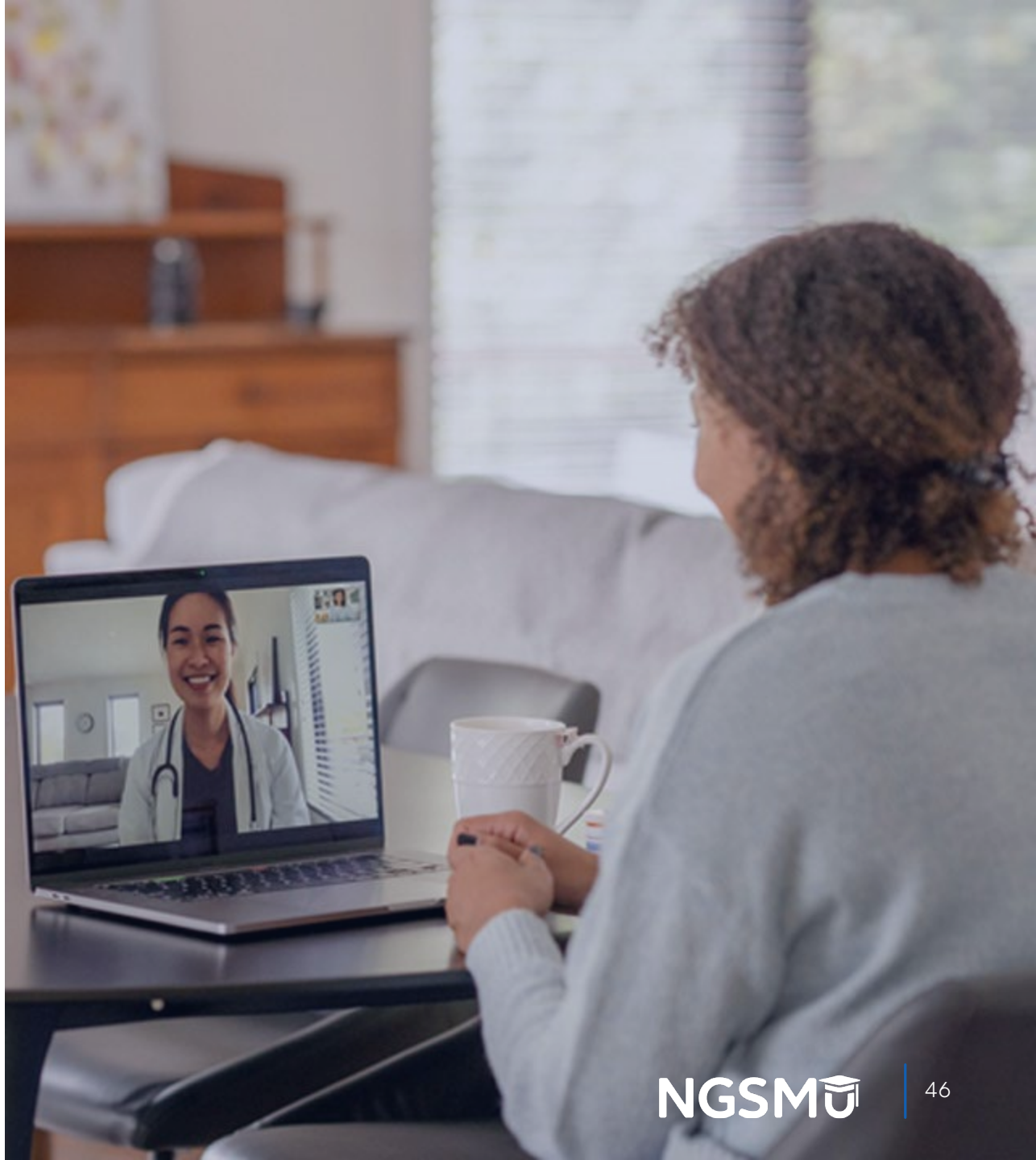
- **Must be:**
  - Written and signed by the certifying and/or referring physician or allowed practitioner.
  - For the patients current primary diagnosis as witnessed during the time of the face-to-face encounter visit prompting the referral to home health.

Dates of Service

- Ensure the medical record documentation submitted is for the correct dates of service (DOS) on the ADR.
  - When the DOS are for a subsequent home health episode, ensure the initial certification statement is included within the medical record documentation submitted.
  - Ensure the correct visit notes are for the DOS under review.
  - Send a visit note for each service date billed for the claim under review.
  - Additional notes from other claim periods are fine; however, the visit notes for the claim DOS must be included.

Medical Record Documentation to Support Home Health Eligibility

- The certifying physician and/or allowed practitioner must review and sign any medical record documentation incorporated in to the patient's medical record that is used to support the certification/recertification of eligibility criteria.
- If medical record documentation is used for verification of eligibility criteria, it must be signed and dated prior to submission of the claim.



Medical Record Documentation to Support Home Health Eligibility

- Medical record documentation should include documentation from any other agency, establishment, office, and/or facility that has provided care or services for the patient before or during the home health episode.
- Documentation from the home health agency must be corroborated by medical record entries from other providers and align with the time period in which services were rendered.

Medical Record Documentation to Support Home Health Eligibility

Medical Record Documentation Collaboration:

- Medical record documentation regarding any and all eligibility criteria should be shared by the referring entity/provider with the home health agency at the point of referral.
  - Medical records from the patients actual face-to-face encounter visit.
  - The initial certification statement from the start of care associated with the claim under review, as well as the certification statement for the dates of service on the ADR.
- The home health agency should continue to document eligibility throughout the home health medical record.
- Medical record documentation from the physician and/or allowed practitioner office providing oversight, certification, and recertification should also be included within the home health agency medical record.

Submitting Medical Record Documentation for a HH TPE ADR

Documentation Preparation

- **Prior to submission of documentation, it is imperative that all medical record documentation is completely reviewed to ensure:**
  - All pages are for the appropriate patient
  - All pages are legible (not faded, not bleeding ink into portions of the document)
  - PECOS – Validation for all physicians involved in the patient's care for all DOS in the period of care
  - Appropriate OASIS submission
  - Any and all therapy evaluations and reevaluations are included
  - The patient's name is on each page (front and back where appropriate)
  - The correct dates of service for the claimed period of care
  - Dates and signatures are clear and appropriate

Documentation Preparation

- Identifiable signatures and credentials for each clinician signature
- Signature logs
- Legibility of all documentation
- Accuracy of documentation
- All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
- Pages are not folded over, cut off or crinkled during copying, printing, and/or faxing
- Highlighter is not utilized/blank ink copies best
- ADR is placed on the top of the medical record
- Home Health agency contact name and telephone number

Documentation Preparation

- Copy both sides of the documents
- Organize the documents
- Paginate each page
- Cover letters are at the discretion of the provider
- Do not bind the records, use sticky notes, or alter the records
- Ensure documentation to support each of the five eligibility criteria
- Attach the ADR on top of each medical record
- Copy all pages as one PDF
- Return records to the MAC within 45 days

Documentation Preparation

When responding to a multiple MAC Medical Review ADR request:

- Respond to each ADR separately
  - ✓ When medical records are submitted together and not clearly separated, this can cause denials.
  - ✓ Submitting medical records separately will decrease denials for non-submission of medical record documentation (56900).

Jurisdiction 6

Medical Record Submission
Electronic Submission: NGS Connex or esMD
U.S. Postal Service: National Government Services, Inc. PO BOX 6474 Indianapolis, IN 46206-6474
FedEx/UPS: National Government Services, Inc. 6345 Castleway Court Indianapolis, IN 46250 ATTN: Mail & Distribution
FAX: 315.442-4154

Always check NGSMedicare.com for the most up-to-date information.

Jurisdiction K

Medical Record Submission
Electronic Submission: NGS Connex or esMD
U.S. Postal Service: National Government Services, Inc. PO BOX 7108 Indianapolis, IN 46206-7108
FedEx/UPS: National Government Services, Inc. 6345 Castleway Court Indianapolis, IN 46250 ATTN: Mail & Distribution
FAX: 315.442-4390

Always check NGSMedicare.com for the most up-to-date information.

TPE Email Inquiries

Jurisdiction K: JKAcasemanagement@elevancehealth.com

Jurisdiction 6: J6Acasemanagement@elevancehealth.com

Home Health References and Resources

CMS Home Health Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies
  - HH PPS web page
  - Home Health Agency (HHA) Center
  - MLN® Publication, "Home Health Prospective Payment System"
  - The Medicare Learning Network®

NGS Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance

Medicare University website

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- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received.
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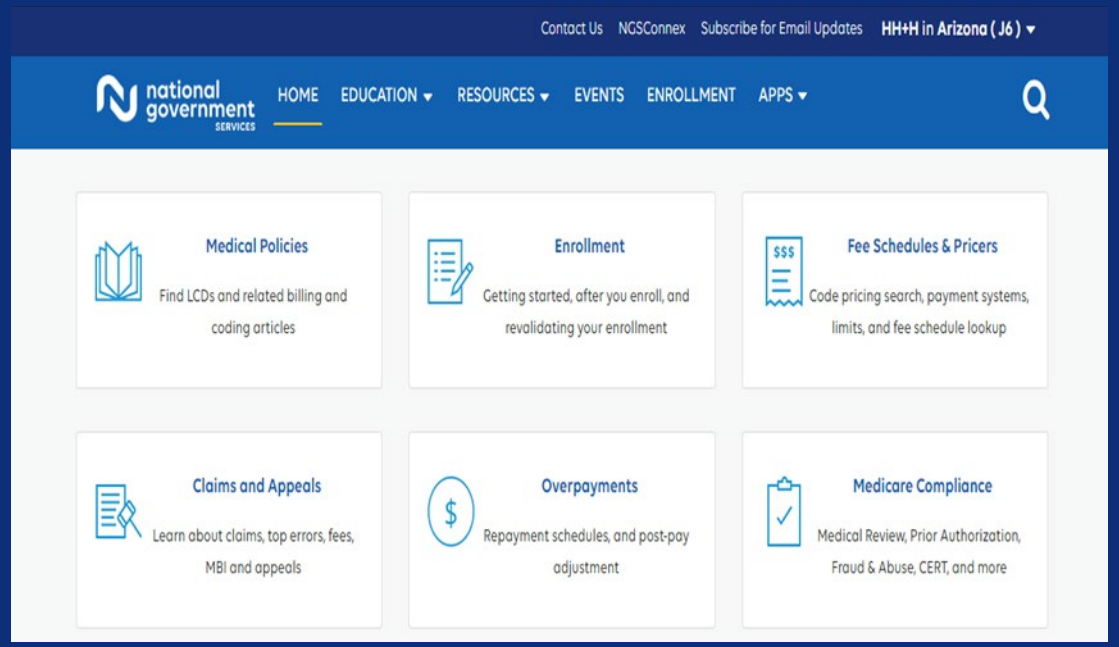
AK, AZ, CA, HI, ID, NV, OR, WA, AS, GU, MP	MI, MN, NY, NJ WI, PR, USVI	CT, ME, MA, NH, RI, VT
Interactive Voice Response (IVR) Unit: 866.277.7287 Provider Contact Center (PCC): 866.590.6724	Interactive Voice Response (IVR) Unit: 866.275.3033 Provider Contact Center (PCC): 866.590.6728	Interactive Voice Response (IVR) Unit: 866.275.7396 Provider Contact Center (PCC): 866.289.0423

Provider Contact Center Procedures

- First option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries
- Contact number and hours available on our website
  - Resources > Contact Us > Provider Contact Center

NGS Email Updates

- Subscribe to receive the latest Medicare information



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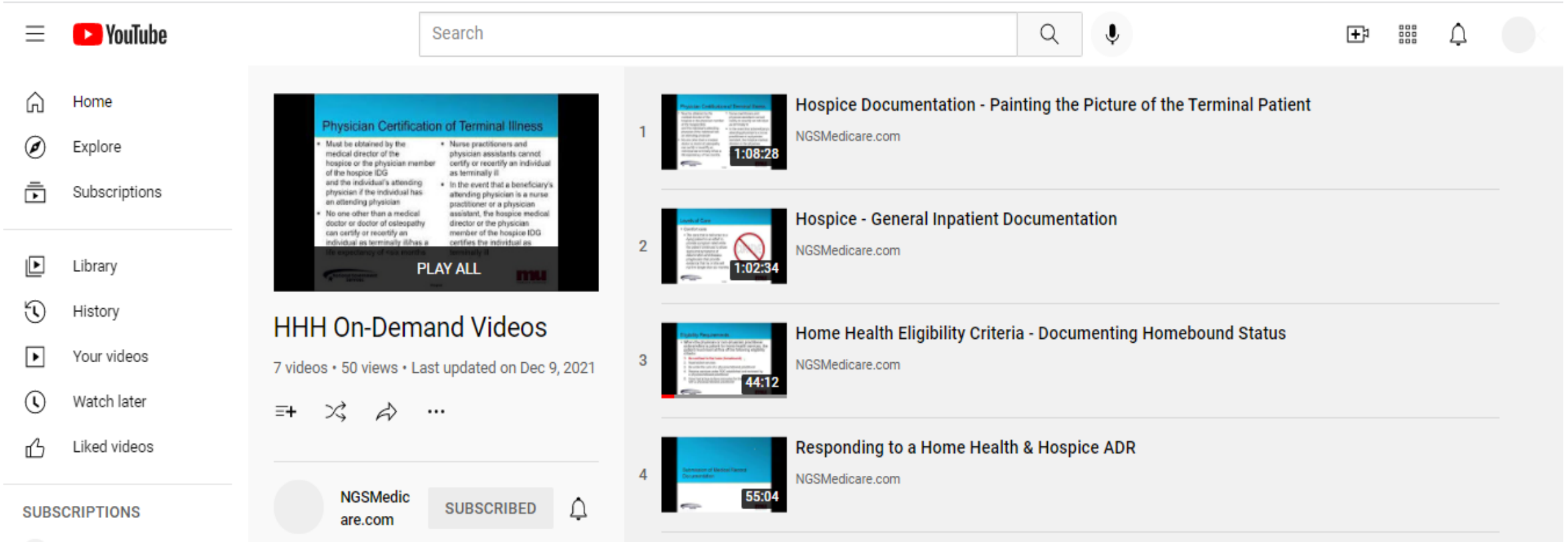

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Save the Date

September 13, 14, 15

Flamingo Las Vegas Hotel & Casino

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Las Vegas, NV 89109

Early Bird Registration $249

Includes 3 full days of education

Rooms: $95/night

Group Name: 2023 HHH Medicare Summit

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