Home Health Face-to-Face Denial Prevention

THE PROVIDER PERSPECTIVE

Laura Montalvo, BSN, RN, COS-C, HCS-D
Chief Clinical Officer Select Data

June 18, 2014

DECISIONHEALTH

Disclaimer

- Information made available from this section of the webinar should not be considered legal advice. It is for educational purposes only and does not provide all available information on the subject. Information shared is not a promise or warranty/guaranty (expressed or implied). The opinions expressed, discussions undertaken, and materials provided do not represent any official position of Select Data or CHRISTUS HomeCare.

DECISIONHEALTH

Objectives

- Understand the impact of industry Face-to-Face (FTF) denial rates/patterns to drive positive change in your organization's FTF content improvement program
- Learn what FTF denial prevention strategies/solutions did *not* work well in a group of home health agencies
- Learn what FTF denial prevention strategies/solutions have been successful in a group of home health agencies
- Incorporate a free training tool into your FTF weapons arsenal

THE FACE-TO-FACE CALAMITY

- Merriam-Webster defines calamity as *"a disastrous event marked by great loss and lasting distress and suffering."* This is a very fitting description of the state of home health over the past year with regard to FTF.
- A good question to ask ourselves as a industry is have we done what is required to ensure physician's core competency of documenting FTF per Medicare requirements?
- Adult learning theory tells us that adults are relevancy oriented. Tell a meaningful story quickly about how the FTF denial problems directly affect or impact them
- If the external customer (MD/Rep) or internal customer (Marketing/Admin Staff) do not "buy in" to the need to change documentation then reversing a 40%-60% FTF denial rate will be difficult to achieve

NAHC F2F LAWSUIT UPDATE

- Three claims are included in the NAHC lawsuit:
  - The Centers for Medicare & Medicaid Services (CMS) does not have the authority to require the physician narratives as the authorizing statute passed by Congress only requires that a physician document that the encounter occurred;
  - to the extent that CMS can require the narratives, the Constitution and Medicare law require CMS to promulgate standards for compliance that affected parties can understand and meet; and
  - Medicare cannot deny a claim solely on the basis of the face-to-face encounter documentation, instead the whole record must be considered.

WAITING ON THE FTF LAWSUIT?!

- It is strongly advised that agencies continue working on their FTF documentation improvement projects while waiting on the outcome of the FTF lawsuit results
- Proactive efforts will insulate agencies from further denials no matter which way the lawsuit results swing

FTF Denial Prevention Strategies/Solutions that did NOT work well

- Not formally revising or re-launching the FTF program at our agencies based on the MAC denial examples
- Not naming an Executive Champion to lead the FTF documentation improvement charge
- Not following up with MD's/MD office staff on FTF forms received with insufficient documentation to support reimbursement once MAC's published specific denial examples.
- Using teaching tools that provided a list of short phrases acceptable to meet homebound requirements versus specific narrative examples.
- Continually verbalizing or focusing on the "difficulty" of obtaining valid face-to-face documentation by various members of staff (clinical liaisons, DON's, account executives/marketing staff, intake, etc.)

Did Not "Formalize" the FTF Improvement Campaign

- Lost opportunity to gage buy-in/barriers to change at each office
- Without formalizing the campaign, some staff may have thought the problem with FTF documentation does not include my office *(it is a problem in another part of the country).*
- MAC denial training letters may have been interpreted incorrectly by some offices
- Some offices may not have implemented the revised forms or support tools timely (or at all)
- Without a documented timeline, specific action plan with goals and reevaluation steps, the project would could be lost among competing projects or never properly initiated/measured.

Did Not Name an Executive FTF Champion to Lead the Charge

- Why is an Executive Champion Important?
  - Sends a message to the organization that this project is mission critical and has the support of the top leaders of the organization
- Who could serve as an Executive Champion?
  - CEO, COO, CCO, CFO or other high level leader
- What should an Executive Champion do if the expected results are not materializing?
  - Steer the project team to analyze the milestones and results and revise the plan as needed

No Action Taken on Insufficient F2F Documentation Received

- Gatekeeper staff (final person or persons in your agency that decide if the FTF meets *known content* criteria) should be versed on the specific MAC denial examples in your region
- Gatekeeper staff should also be trained to deliver tactful communication with MD/MD office representative(s) to facilitate FTF documentation training, resolve content issues prior to billing, etc.
- FTF denial risk is not mitigated if gatekeeper staff do not address FTF documents that are inadequately completed
- If the record is selected for review by RAC, ADR, SMRC, etc., then the inadequately completed FTF will be denied with a high degree of certainty
- Consistent surveillance on the front end, will reduce denial management work on the back end

Beware of teaching tools that provide only a short list of acceptable phrases

- Found that physician's took one short phrase from the list and wrote no additional specific facts as to the patient's homebound reasons in quantifiable terms.
- Then when our agency staff would follow-up requesting patient-specific details and the physician/office staff would counter, *"But it was on your list as acceptable…"*
- We meant the list to be a starting point and the expectation was for the physician/representative to add the specific details for each patient, but our training tool was taken literally.
- Discovered that some of the single short phrases did not meet the CMS expanded definition of "confined to home" criteria 1 and criteria 2. Our tools needed revamping.

CMS "Confined to Home" Definition

- Confined to the home – Describe why the patient is homebound. An individual is considered "confined to the home" if **both** of the following **two criteria** are met:
  - Criteria 1--The patient must either:
    - Because of illness or injury, need supportive devices such as crutches, canes, wheelchairs, and walkers; special transportation; or another person's help to leave his or her residence, **OR**
    - Have a condition such that leaving his or her home is medically contraindicated
  - Criteria 2--There must exist:
    - A normal inability to leave home; **AND**
    - Exertion of a considerable and taxing effort needed to leave the home

Examples of short homebound phrases that do not meet CMS "Confined to Home" Definition

- Homebound reasons:
  - Needs help of another person or assistive device to leave home *(Risk=this statement alone does not explain taxing effort in measurable terms)*
  - Disoriented to person and place and requires supervision at all times *(Risk=this statement alone does not explain taxing effort in measurable terms)*
  - Open wound to abdomen and should not leave home until wound heals *(Risk=this statement alone does not explain inability to leave home or taxing effort in measurable terms)*

The "This is Not Possible" Mentality

- Continual group focusing and verbalizing of how difficult or impossible a task is to accomplish can be a barrier to successful change and is counter-productive. Negative attitudes of key staff members can thwart efforts to execute a FTF performance improvement project
- Once obstacles to obtaining valid FTF documents are explored and documented by the team, then movement should be made toward solutions identification and development
- Engage key staff members to be an integral part of leading and driving the *solutions* train
- Reiterate if Physician's are getting denied on FTF documentation 49.8% of the time (Palmetto May 2013), then they are also getting approved 50.2% of the time. If we can get it right 50.2% of the time, then we can get it right 100% of the time!!! Focus on the positive!!!

Legitimate Barrier and Response

- Legitimate Barrier/Problem: Hospitalists often turn over quickly in hospitals so I am constantly losing the physicians that have been trained on FTF documentation to new ones with no knowledge of the denial issues.
- Response to Problem: Train new marketing staff that turnover is likely and continual training with new physician's, residents, and physician representatives is key to FTF compliance and a requirement of their position.

FTF Denial Prevention Strategies that Have Worked

- Leveraging MAC Denial Letters, MLN articles with correct and incorrect FTF documentation examples, and CMS FTF Q&A's as credible sources for driving documentation improvement
- Providing disease-oriented and/or mobility-related ADL examples of correct/specific homebound documentation for Physician/Physician Representative training
- Combining FTF encounter progress notes to FTF forms with title and pagination
- Providing FTF focused documentation training delivery in varied ways: short group education sessions, one-on-one training sessions, electronic training via fax and phone, and using electronic/paper/visual education aides

MAC's Provide Credibility to Support Change in FTF Documentation Content

- CGS, Palmetto, and NGS have information on their MAC websites regarding Face-to-Face denials or Q&A's that can assist HHA's communicate with Physicians when FTF documentation submitted to the agency does not meet Medicare requirements
- Credible source documentation makes the problem of lacking/incomplete FTF content ***real*** to the physician

PALMETTO

- J11 Home Health and Hospice Medicare Advisory June 2013 specifically cited the following as examples of inadequate homebound status:
  - Diagnosis alone, such as osteoarthritis
  - Recent procedures alone, such as total knee replacement
  - Recent injuries alone; such as hip fracture
  - Statement, 'taxing effort to leave home' without specific clinical findings to indicate what makes the beneficiary homebound
  - 'Gait abnormality' without specific clinical findings
  - 'Weakness' without specific clinical findings
- The face-to-face documentation must also include clinical findings to support the need for skilled services, i.e. skilled nursing or therapy

CGS

- CGA website has several Q&A's that address FTF content
- **Question:** "A typical example of what we see from physician's is 'has heart failure-needs CP assessment and HF teaching'; homebound status documented as 'DOE' (dyspnea on exertion). Does this not satisfy the requirement for clinical findings and homebound status documentation?"
- **Answer:** "Simply listing a condition does not meet the requirements for the home health face-to-face encounter. Additional details would be needed to determine what about the patient's condition (heart failure) requires that home health services are needed now. Likewise, the homebound status documented as "DOE" would need to be quantified as well."—Updated: 03.01.14

CGS

- **Question:** My agency received a denial from a CERT for FTF. Reason: Physician did not fully explain why the patient was homebound, just said "Ambulatory Dysfunction" and the full claim was denied. We want to appeal but how do we provide additional documentation since it is the physician whose explanation was not sufficient? We have enough problems just getting the doctors to sign orders—now how can we go back and get further documentation?
- **Answer:** It is important for HHAs to ensure they are performing a QA check on the FTF documentation prior to billing Medicare. If the FTF documentation is lacking, HHAs should resolve those issues prior to sending the final claim to Medicare for payment. Your agency may want to request the physician's FTF documentation in addition to the form that was completed as there may be additional information that is available there, which was not included on the FTF form.

NGS

- NGS website instructs: If the (FTF) denial notes the narrative was not descriptive enough to support homebound status or skilled service:
  - Submit the **dated** physician's progress note from the visit used for the FTF. The date should be the same as the FTF certification form. These notes often have the clinical findings supporting homebound status and the need for home health services.—Last modified: 10/18/13

DECISIONHEALTH

But beware the CMS and MAC tools Are Not Perfect

- The CMS and MAC Face-to-Face training tools also have their problems:
  - The majority are very long documents
    - MLN SE1405 = 11 pages long
    - MLN SE1219 = 4 pages long
    - MLN SE1038 = 4 pages long
    - CMS Home Health Face-to-Face Q & A's = 17 pages long
    - Suggested Electronic FTF Template Elements = 6 pages
  - If the tools are too long to read then they may never be utilized at all
  - If the tools are too long to read then the ability to absorb quickly may not occur and application of learned concepts may not materialize

DECISIONHEALTH

Show Them ***How*** It Should Be Done

- Cannot overemphasize the importance of ***teaching*** physicians/physician representatives ***how*** to properly document homebound status and home health need
- Adult learning principles:
  - Adults need to be involved in their instruction
  - Experience (including mistakes) provides basis for learning activities
  - Adults are most interested in learning about subjects that have immediate relevance to their job or personal life
  - Adult learning is problem-centered rather than content-oriented

Providing Several SPECIFIC Homebound Documentation Examples

- By taking 5 typical home health patient scenarios and drafting specific homebound examples onto a ***1 page training tool***, the physician now had a concrete mold to follow versus a list of short, quick phrases to pick from.
- The patient-specific homebound narratives conveyed to physician's that "cookie cutter" and "canned phrases" were not the expectation. The training examples sent the clear message that non-specific phrases like "taxing effort to leave home" would no longer cut the mustard.
- We saw MD offices actually begin to provide more specific homebound documentation after training with the 5 example tool and incorporate segments of the descriptive language from the examples into their completed FTF forms when relevant to their individual patients.
- This approach was especially effective at medical specialty office groups/clinics (ortho, cardiology specialists, etc). The specialty groups often see a particular patient type over and over again and the homebound specific statements were repeated supporting physician FTF documentation competency.

Five Example Tool Snap Shot

Examples of Valid, Patient-Specific Face-to-Face Homebound Documentation

Please note: Examples list multiple conditions and symptoms that specifically explain "why" each patient is homebound.

Example #1: GAIT/SOB/FALLS/CV DISEASE EXAC.
Patient is homebound due to inability to ambulate for more than a few minutes or few feet without falling due to poor balance and extreme fatigue/weakness; very SOB with minimal exertion and patient must stop to sit and rest every few minutes or he/she cannot go on. Patient has had multiple falls with injury in recent past and also requires the assistance of another person to ambulate at all times due to unsafe gait pattern and cardiopulmonary disease exacerbation.

Example #2: DEMENTIA/SAFETY/FALLS
Patient is homebound due to end-stage dementia and cannot be left unattended due to wandering behaviors and extremely poor cognition. Patient has wandered away from home and been lost in the past resulting in injury. The patient is now too disoriented to safely leave home alone and requires frequent prompting and redirection of another person to keep the patient from harm. The patient also exhibits poor balance and falls easily if not supported by another person during all attempts at ambulation.

Example #3: PAINFUL AMBULATION/PAIN MED SIDE EFFECTS/ASST. DEVICES
Patient is homebound due to unsteady, painful ambulation with extremely poor balance and current use of narcotic pain medications to address pain issues. Side effects of the narcotic pain medications being exhibited by the patient are disorientation, drowsiness, and dizziness; all increasing patient's fall risk and making it very difficult and unsafe for the patient to leave home. Patient requires supportive devices of wheelchair and special transportation, as well as the assistance of another person at all times when attempting to leave home for medically-required appointments.

Example #4: OBESITY/SOB/02 DESATS/FALL RISK
Patient is homebound due to morbid obesity, unsteady and unsafe ambulation, very poor balance and weakness from recent surgery. Attempts to leave the home exacerbate the patient's COPD with extreme SOB and uncontrollable coughing resulting. The patient's oxygen saturation levels also fall below 90% and it takes several minutes for coughing to subside and oxygen levels to return to above 90% after stopping and resting. Patient is at very high risk for falls with serious injury due to problems with oxygenation and leaving home is medically contraindicated for all the reasons cited above.

Example #5: LOWER EXTREMITY WOUND AFFECTING GAIT/INFECTION RISK/DM
Patient is homebound due to complex surgical wound to __ foot. The patient is non-weight bearing on __ foot resulting in new mobility, balance, and transfer limitations which increase patient's fall risk. Leaving the home also presents risks of complication such as infection and delayed healing for this diabetic patient. It is medically contraindicated for the patient to leave home until wound heals.

DECISIONHEALTH®

We are actually teaching physician's *HOW* to document FTF and we can always do more

- MAKE IT BETTER IDEA—shorten and focus the use of the 5 Specific Examples Tool:
  - Take each of the specific examples and place each on its own small FTF card (pocket size) and then marketing staff can pull the card that best fits the patient being referred to assist the physician/representative with FTF narrative.

DECISIONHEALTH®

Home Health Need

- Train MD/Rep to ask the home health need question, *"Why home health, why now?"*
  - The patient may have had CHF or DM for many years. What has changed for this patient that now requires them to receive home health care?
  - Focus on skills needed: Observation & assessment, medication teaching/monitoring, teaching & training; IV therapy or complex wound care; skilled therapy interventions like gait training, fall prevention, etc.
  - Train MD/Rep to stay away from terms like: needs help; no one to do IV/wound care; lives alone; post-hospital stay or post-op

Combining the FTF form with the Encounter Progress Note

- Some agencies have found success with combining the FTF form with the actual MD progress note that corresponds to the Encounter date (a requirement) to expound on homebound status and home health need
- Forms are properly titled to ensure compliance with FTF rules. Recommend pagination as well
- The CMS HH FTF Q&A's allow HHA's to title the FTF forms (revised Q&A's released May 9, 2014, #16)

There's More Than One Way To Skin A Cat!

- Varied training delivery modes have proved effective in securing compliant FTF documentation
- Leverage technology whenever possible to assist in training delivery
- Leverage teaching tools that can keep on training after the educator has left the physician's side
- Don't leave out potential physician representative groups that may be a FTF gold mine

Multiple Training Delivery Modes

- Short group education sessions to residents, discharge planners/case management staff, or RN's on the floor, etc.
- One-on-one training at the point of patient referral at the hospital, wound clinic or physician office, etc
- Electronic training via fax transmissions and telephone calls from intake or FTF agency staff to hospital staff, wound clinic or physician office, etc
- Use of visual/paper training aids that the physician/physician representatives keep for future reference

Technology and Tools

- As described earlier by Diane, the hospital and physician offices have the option to develop electronic face-to-face documentation forms and templates that will promote FTF documentation compliance
- Visual aids should be brief, tell a story quickly to engage the adult learner and be problem oriented
- Don't be afraid to blow it up and try again!

Face-to-Face Gold Mine: It Takes a Village

- Look for potential physician representatives to recruit for FTF training/data extraction assistance (this list is not all-inclusive):
  - Discharge planners
  - Social Workers
  - RN's on the floor facilitating discharge
  - Case Management
  - Therapist's for therapy only referral patients
  - Medical assistants, LVN's in MD offices
- Make sure your tools are flexible to train a variety of physician representatives while focusing on the core competency you are seeking to develop
- Keep asking the entire physician representation team for assistance to promote effective transitions of care!

Face-to-Face Stats

- Based on April 1,2011-December 31, 2011, 2012, 2013 Medicare Completed Episodes for CHRISTUS Enterprise

Medicare Episodes	RAC FTF Denials	FTF Denial Rate
8203	21	0.26%

FTF Denials are currently under appeal with MAC; pending redetermination
RAC Request Dates: May 2013-February 2014 for total of six home health offices in TX/LA
Source: SHP Financial Executive Advantage Reports with permission from CHRISTUS HomeCare

Putting it all Together: Free Face-to-Face Tool

- As a result of the research performed for this webinar, I developed a tool to facilitate physician/physician representative FTF documentation compliance based on the following:
  - Adult learning principles—tells a story quickly to engage the adult learner and is problem oriented to deliver core competency
  - Slim, focused design utilizing more color for story-telling effect/impact
  - Focuses more on MAC denial language as we continue to see incorrect documentation phrasing despite sharing MAC denial information (seeking to change an engrained behavior)

CMS Home Health Face-to-Face Made Easy

PERCENT OF DENIALS FOR FACE-TO-FACE = 49.8% Source: Palmetto GBA, May 2013

Targeted Training: Documentation of Homebound and Home Health Need

DENIED

- *"Taxing effort to leave home"* (non-specific CMS definition)
- *"Weakness" or "Tires easily"* (insufficient alone; specific clinical findings needed to explain/support)
- *"Cannot drive" or "No transportation available"* (insufficient homebound reasons)
- *"Gait abnormality alone" or "Gait dysfunction alone" or "Decreased mobility alone"*

DENIED

- *"Diagnosis alone"* (e.g., Hip fracture or Dementia) *or "Procedure alone"* (e.g., TKA)
- *"No one available to do wound care/IV therapy"* (insufficient; specific skilled requirements needed)
- *"Patient (or family) needs help"* (insufficient; specific skilled requirements needed)
- *"Patient post-hospital stay alone"* (insufficient; specific skilled requirements needed)

CORRECT

- *"Patient temporarily homebound with new onset of painful ambulation due to right hip fx and ORIF surgery. Patient now ambulates with walker; human assist for stairs. Patient weak with poor balance due to narcotic pain med use; increased risk for falls. Patient requires skilled nursing for instruction, observation and assessment of post-op incision/care and medication teaching/management. PT for gait training to restore safe independent functional ambulation in community."*

Call XXX-XXX-XXXX with Questions on Face-to-Face Specific Content Requirements

DECISIONHEALTH

Final Thoughts

- Don't give up!
- Keep studying your FTF program/tools and act when necessary to revise the program/tools to yield FTF compliance (think Plan, Do, Study, Act)
- Create a culture that supports the continual challenge of each staff member to come up with their own new ideas on how to solve problems or make their jobs more efficient and effective (think LEAN, Kaizen, Six Sigma)
- *Our industry holds the answers to the face-to-face problem within our own ability to create solutions*

DECISIONHEALTH

Questions?

KEEP CALM
AND
FACE-TO-FACE ON

DECISIONHEALTH

References

- CMS Internet Only Manual (IOM), Publication 100-2, Medicare Benefit Policy Manual, Chapter 7, Section 30.5.1.1
- Code of Federal Regulations, Title 42, Part 424, Subpart B, 424.22
- Medlearn Matters article SE 1405, SE 1219, SE 1038
- CMS Home Health Face-to-Face Q & A's, May 9, 2014
- NAHC FTF Lawsuit retrieved from http://www.nahc.org/NAHCReport/nr140401_1/
- CMS Suggested Electronic Clinical Template Elements of a Progress Note Documenting a Face-to-Face Examination for Home Health Services, *DRAFT v3.1 (02/02/14)*
- J11 Home Health and Hospice Medicare Advisory, June 2013
- CGS Home Health Face-to-Face (FTF) FAQ's retrieved from http://www.cgsmedicare.com/hhh/education/faqs/FTF_FAQs.html
- NGS Appeals for Home Health Certification and Face-to-Face Documentation Denials retrieved from http://www.ngsmedicare.com/ngs/wcm/connect/ngsmedicarecontent/ngsmedicare/review+process/comprehensive+error+rate+testing/appeals+for+home+health+certification+and+face-to-face+documentation+denials
- Adult Learning, retrieved from http://epltt.coe.uga.edu/index.php?title=Adult_Learning

DECISIONHEALTH

Contact Information

Laura Montalvo, BSN, RN, COS-C, HCS-D
Chief Clinical Officer Select *Data*
4155 East La Palma Avenue, Suite 250
Anaheim, CA 92807
(800) 332-0555

DECISIONHEALTH®