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Home Health Agencies Prepare for Pre-Claim Review Chaos

Article By:

Health Care at Much

Government is predictable. It is even more so when it comes to federal healthcare agencies. For example, when one segment of healthcare enjoys surges in profits, the ***Centers for Medicare and Medicaid Services*** will intervene to adjust reimbursement. When one type of healthcare delivery system experiences outlier levels of fraud or noncompliance, the U.S. ***Department of Health & Human Services' (HHS) Office of Inspector General (OIG)*** will ramp up enforcement mechanisms.

History is now repeating itself, as home health agencies (HHAs) are again coming under increased fire by HHS and their enforcers, Medicare administrative contractors (MACs). On June 8, 2016, and again on June 24, 2016, HHS gave notice about a "Pre-Claim Review Determination in five states" beginning in Illinois on August 1, 2016. This pre-claim review looks to be brutal. A review of the events that put HHAs in the crosshairs of the HHS enforcement apparatus can help providers prepare for the coming storm.

A Short History of Home Health Agency Regulation

HHAs are ubiquitous in the U.S. healthcare system and have been included in our current regulatory model since the dawn of Medicare (a.k.a. the passage of the Older Americans Act of 1965). There is no dispute that as the country's population ages, the need for HHA services grows. As the needs grow, so do the program costs and the resulting impact on overall healthcare spending.

Over time, ever-increasing home health agency program costs drew regulatory attention. HHS began requiring supporting documentation to justify the need for homecare-based services. With the passage of the Affordable Care Act in 2010, a face-to-face (F2F) evaluation by a physician became a requirement for payment of services delivered to HHA-admitted patients. Although this requirement is easily understood and justifiable, the documentation has proven to be a moving target and has caused a significant amount of lost reimbursement and tension on the part of providers over the last five years.

HHA Admission Requirements Evolve

In general, Medicare Home Health Care Program participation requires that the patient:

1. Be temporarily or permanently homebound;

2. Have a need for skilled services;

3. Be under the care of a physician;

4. Receive services under a plan of care established and reviewed by a physician; and

5. Have a face-to-face encounter with a physician or allowed non-physician practitioner.

Predictably, each of these five requirements further establishes a number of additional conditions that HHAs must satisfy before CMS approves payment. Most recently, the challenge for HHAs has involved documentation: what must be documented, and by whom? The Affordable Care Act has further complicated this problem, and findings by the OIG in 2014, that 32 percent of F2F encounters were not documented sufficiently to prove compliance with Medicare standards, resulted in increased scrutiny of HHA billing.

Enter a Physician Narrative Requirement

From 2011 through the 2014 OIG investigative report, HHS required F2F documentation to include a physician narrative that provided “an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services.” (See 42 C.F.R. Sec. 424.22.) It should surprise no one that this generic request for a “physician narrative” justifying hundreds of millions of federal Medicare dollars would cause problems. CMS has used the narrative requirement to deny payments, and pressured HHAs to rally around template narrative language that increased the likelihood of reimbursement. This outcome benefited neither HHAs nor HHS and failed to help detect outright fraud or abuse.

Recent Changes: Simplification, or Exacerbating the Problem?

Beginning in 2015, HHS removed the physician narrative requirements, and instead developed a new standard. HHAs must now authenticate F2F evaluations through preexisting physician documentation such as progress notes, discharge summaries, and the like. Presumably, HHS increasingly viewed narratives as generating inauthentic clinical evaluations designed to substantiate home health services. HHS appears to have concluded that doctors would already have medical records that include the necessary substantiation. The government apparently saw the use of documentation that already exists as the fix for a problem that it had created in the first place. This is where Isaac Newton becomes our guide.

Newton’s Third Law

Newton’s brilliant observation — for every action there is an equal and opposite reaction — is proven true every day, particularly when it comes to government intervention. Actions by the government often create an equal and opposite reaction, especially in the healthcare industry. The cycle has become all-too familiar:

1. Government creates a new requirement for reimbursement.

2. Government creates a standard for verification of the requirement (expecting a sophisticated, diverse, highly regulated industry to adjust and comply).

3. Chaos ensues.

4. Industry reacts and attempts compliance by relying on the plain language of the regulations and guidelines, consulting with peers and industry groups, and working to educate and ensure compliance by staff and medical professionals.

5. In an effort to comply with the standards, providers start providing template language to their medical staff; in this case, for use in the F2F narrative.

6. Government becomes concerned about costs and isolated incidents of abuse, and begins to artificially restrict and recover government payments.

7. New regulations are introduced to streamline the previously problematic narrative requirements.

8. More ambiguity and confusion jeopardizes provider reimbursement and government compliance.

9. Chaos continues.

Lather. Rinse. Repeat.

Pre-Claim Review: A Pandora’s Box or an Actual Solution?

There is no doubt that this five-state pre-claim review will cause serious problems, as unanswered questions remain about the types of documentation and procedures that will satisfy HHS requirements. For example: How soon must HHAs authenticate supporting documentation after an F2F encounter? How may a provider ensure that non-employed physicians properly document the F2F encounter? Exactly how can a non-treating physician provide addenda to the medical record to satisfy a treating physician’s F2F encounter documentation requirements?

We have tried to contact government representatives and Medicare administrative contractors for assistance and clarification. True to form, the government staff believed that existing guidance was clear and that no further clarification was necessary.

All HHAs should be prepared for this new pre-claim review period. Consult with legal counsel, prepare your staff and physicians, and get ready for a bumpy ride.

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