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The Association of Home Care Coding and Compliance
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Diana Kornetti, MA, PT
Board Chair

August 29, 2014

VIA FEDERAL EXPRESS

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1611-P, Mail
Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments Regarding Home Health PPS 2015 Proposed Rule (CMS-1611-P)

To Whom It May Concern:

The Association of Home Care Coding and Compliance ("AHCC") is pleased to provide the following comments on the above-referenced notice of proposed rulemaking ("the Proposed Rule"). AHCC is the national membership organization for home health coding and compliance professionals throughout the country.

Home health agencies play a large and growing part in our nation's health care system. Home health agencies allow patients to receive skilled care at home. This not only leads to better outcomes for the patients, who are much more comfortable at home, but it saves Medicare a significant amount of money. For this reason, home health care is the lowest cost modality of care within the Medicare benefit.

Unfortunately, the home health benefit has been subjected to abuse by fraudulent providers and beneficiaries in recent years. To the federal government's credit, there have been many changes over the years designed to reduce the fraud committed upon Medicare. We would like to point out that this fraud only serves to put the solvency of the Medicare trust fund at risk, and adversely impacts those providers and beneficiaries who are acting in good faith. AHCC applauds the federal government's efforts and agrees that fraud and waste must be curtailed.

One effort that has been aimed at reducing such fraud and waste is the home health face-to-face rule. This rule is the result of a statutory change contained within the Patient Protection and Affordable Care Act ("PPACA"). Section 6407 of the PPACA added the requirement that a physician must have a face to face encounter, the subject of which is the basis for the need for

home health care, no more than ninety (90) days prior to admission to home health or no less than thirty (30) days after admission to home health care.

The rule promulgated by CMS required a physician to not only document the encounter, but to include a narrative. The purpose of the narrative was to explain why the patient's condition required home health. Providers have had significant difficulties with not only obtaining the narrative, but also obtaining a narrative that met the requirements of the regulation. This problem has been compounded by auditors who have applied extremely rigorous and often inconsistent standards when reviewing agency face to face documentation, which has led to significant audit problems for the industry.

1. ELIMINATION OF THE PHYSICIAN NARRATIVE REQUIREMENT.

COMMENT. AHHC applauds the elimination of the physician narrative requirement from the face to face rule. AHCC suggests that CMS make it clear that a home health agency will only be responsible for obtaining a signed and dated certification from the physician that states a qualifying face to face encounter occurred, the date of the face to face encounter and that the encounter occurred either ninety days prior to admission to home health or thirty days after admission to home health.

AHCC was heartened to see CMS acknowledge this problem. As noted in the comments to the proposed rule, the CERT program has identified a significant increase in the documentation error rate for home health. In 2013, the home health error rate jumped to 17.3%. This error rate is due almost entirely to alleged errors within home health agencies' face to face documentation. This error rate has led to almost \$3 Billion in recovery from home health agencies. We would like to emphasize that these recoveries do *not* necessarily represent money recovered for services that were provided inappropriately. They merely represent money recovered by auditors for face to face documentation that does not meet the auditors' criteria, regardless of the substance of the underlying claim for services.

Denying a home health agency reimbursement for legitimate services based upon a technical violation over which the agency has little control is extremely problematic. AHCC applauds CMS for recognizing the significant challenges this rule has created, the significant losses in reimbursement that have occurred, and for taking action to address the problem. CMS' proposal to eliminate the narrative requirement is well received and one that has the full support of AHCC and its more than 1,400 members.

However, we believe it would be in the best interests of both CMS and the home health industry if CMS would provide additional detail as to how it plans to rely upon the medical record of the patient. In the Comments, CMS states that:

In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, we would review only the medical record for the patient from the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home

health) used to support the physician's certification of patient eligibility, as described in paragraphs (a)(1) and (b) of this section.

79 Fed. Reg. 38376

It was not clear from the proposed regulation or the comments how CMS intends the review of the physician and/or facility records to work. Will home health agencies be required to obtain copies of the medical record from the physician and/or facility? Will auditors be required to submit requests to physicians and/or facilities in parallel with document requests to patients?

CMS must not take an approach, or direct its auditors to take an approach, that would make a home health agency's reimbursement contingent upon the medical records of the physician and/or facilities. Home health agencies have no means to influence a physician's or a facility's record keeping. In most cases, a home health agency is completely powerless to influence a physician and/or facility to modify the patient's medical record. We would recommend that the audits and other actions geared towards home health agencies would only look at the face to face documentation, meaning the place on the 485 or other related document where the physician has documented and certified that he or she had a qualifying face to face encounter with the patient, the date upon which it occurred and that it was within the appropriate time frame. In other words, the face to face certification should be treated like the physician's certification that the patient is confined to the home and has a medical need for the services. The appearance of an appropriate face to face certification should be the only piece an agency is required to have and maintain.

In the event that something in the home health agency's file causes the auditor to question whether a patient is indeed confined to the home and/or has a medical need for the services provided, the agency may then obtain additional documentation, including affidavits or otherwise, to submit to the auditor during an appeal of a denial.

If, however, it is CMS' intent that agency's will be responsible for the physician's medical record in the first instance, the elimination of the narrative requirement and replacement of the requirements with a reliance upon the physician's medical record may have made the face to face requirement more problematic.

2. SEPARATE AND DISTINCT/TITLE

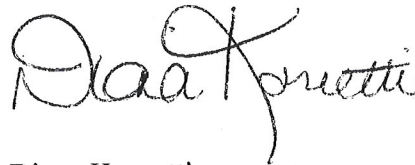
COMMENT: AHCC applauds the elimination of the requirement that the documentation of the face to face encounter be separate and distinct from the rest of the documentation and that it be titled.

A review of the proposed revised regulation indicates that in addition to eliminating the face to face narrative, CMS is proposing to eliminate the requirement that the face to face documentation be "separate and distinct" and that it be titled. AHCC and its members applaud this change as well. Allowing agencies to make the face to face certification a part of the "traditional" home health certification will further simplify the document collection process and help to ensure agency compliance.

Overall, AHCC and its members are very pleased to see the extensive changes found in CMS-1611-P. As discussed above, our understanding of these changes leads us to conclude that new rule will remove a significant burden from our industry. We look forward to your response to our comments seeking clarification so that we can better assist our members with achieving compliance with CMS' regulations.

Sincerely,

THE ASSOCIATION OF HOME CARE CODING AND
COMPLIANCE

A handwritten signature in black ink, appearing to read "Diana Kornetti". The signature is fluid and cursive, with the first name "Diana" written in a larger, more prominent script than the last name "Kornetti".

Diana Kornetti
Board Chair