CHAPTER 12
SECTION 8

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - MEDICAL REVIEW REQUIREMENTS

ISSUE DATE:

AUTHORITY: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

To provide the needed information regarding medical review under the HHA PPS.

III. POLICY

A. Types of Medical Review. The contractors' medical review process will focus on whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented. This will be accomplished through a blend of pre-payment and post-payment reviews conducted on either a random/targeted basis.

1. Random reviews will allow the MCSCs to identify normal provider billing practice patterns as well as potential payment errors under the new system.

2. Targeted review may also be focused on areas such as:

   a. Identified program vulnerabilities

   b. Specific aberrancies

   c. Newly participating providers

   d. Other areas as they are identified

B. Documentation Requests. If a Request for Anticipated Payment (RAP) or final claim is selected for medical review, the medical reviewer will issue a request for medical documentation. The documentation request will identify a time frame to respond. An HHA

will not send medical records with the home health claim unless they are requested. Requested documentation may include, but is not limited to, the following information:

1. Valid Plan of Care (POC) (CMS 485). With the advent of the PPS, the POC must be reviewed and signed by the physician every 60 days unless one of the following occurs:

a. A beneficiary transfers to another HHA.

b. There is a significant change in condition (SCIC) resulting in a change in the case-mix assignment.

c. The beneficiary is discharged and returns to the same HHA during the 60-day episode.

2. Physician orders for services not included in the POC.

3. OASIS Assessment (If more than one OASIS assessment was performed during the episode, the additional assessment will be submitted with documentation. The additional assessments are to assist medical reviewers in validating SCICs).

4. Clinical notes for all disciplines.

5. Treatment and flow charts and vital sign records.

6. Weight charts and medication records.

7. Any other home health medical documentation to support payment and coverage.

C. Medical Review Responsibilities. Medical review is a multifaceted process used in determining the following:

1. Verification of eligibility and coverage requirements. The following information should be clearly reflected in the beneficiary's clinical records.

a. The beneficiary is homebound. The beneficiary's condition should be such that a normal inability to leave home exists, and consequently, leaving home requires a considerable and taxing effort. Absences from home are allowed, but they must be infrequent, of short duration, and/or to receive medical treatment.

b. The services must be provided under an established and approved physician Plan of Care (POC). The POC must include the following information:

(1) Pertinent diagnoses;

(2) All services, supplies and equipment anticipated during the beneficiary's episode of care; and

(3) Physician's orders that specify the type and frequency of professional services.

c. The services and supplies provided to the beneficiary must be medically reasonable and necessary for the treatment of the patient's illness or injury.

d. The HHA must be acting upon a physician certification that is part of a POC (CMS 485).

e. The beneficiary requires intermittent skilled nursing, speech-language pathology, physical therapy, or a continuing need for occupational therapy.

2. OASIS and Medical Necessity Validation. The medical review process will be of particular importance under the HHA PPS because of the lack of front-end validation of the OASIS assessment used in generating the HIPPS code for payment submission. Random post-payment reviews will be used to ensure that the HIPPS code generated by the HAVEN grouper software is reflective of the patient's true condition and that the services are actually rendered.

a. The validation process will guide medical review staff through the clinical records, allowing the reviewer to document whether or not the case-mix OASIS is reflective of the information contained in the medical records. Validation will be accomplished either:

(1) Manually through the use of The Home Health Resource Group (HHRG) Worksheet and accompanying OASIS instruction manual, or

(2) Through the use of an automated accuracy protocol designed to assist medical review of home health claims [The Regional Home Health Intermediary (RHHI) Outcomes and Assessment Information Set Verification Protocol for Review of Home Health Agency Prospective Payment Bills (ROVER)].

(a) The ROVER Protocol is a menu-driven Windows-based software application that runs under Microsoft (MS) Access.

(b) The program is designed for personal computer (PC) or laptop use, allowing reviewers to document their assessment of the correct response for each case-mix item and the validation source within the patient record, as well as to input text comments of their findings.

(c) The program guides contractor reviewers through entry of the appropriate data to identify the case being reviewed, their OASIS scores, and documentation sources.

(d) Edit checks, covering out-of-range and missing data, are used to alert the reviewer to incomplete or invalid entries.

(e) After all items are entered, the software can generate a paper report documenting the review, which then can be stored in a case file.

(f) The ROVER software also has an export/import/reporting module that will produce very basic reports to support program administration and providers.

(g) TRICARE expects the contractors shall use this protocol as a supplement to current medical review procedures.

b. A HHRG and HIPPS will be computed under either validation process (i.e., under either the manual or automated validation processes described above) based on the reviewer's responses and compared to the HHRG and HIPPS assigned by the HHA. The reviewer can then accept the HHRG billed by the provider, or adjust the claim as necessary. A new line-level pricing indicator will be used when a medical reviewer changes a HIPPS.

3. Common Ownership Determinations.

a. If, upon medical review, it is determined that common ownership exists in a transfer situation, the transfer claim will be rejected with a message that the second provider must seek payment under arrangement with the other agency.

b. Medical reviewers will use the automated authorization file (i.e., information on the authorization screen) to monitor discharges to related agencies.

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