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## IN THIS ISSUE


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***SPECIAL REPORT:***
Final 2013 PPS rule



## The 2013 PPS rule: Small payment change but big survey and case-mix impact

CMS' estimated payment reduction for agencies in 2013 is feather-light, but new sanctions for survey deficiencies and a major change to the diagnosis payment slot could hit agencies harder.

The final 2013 PPS rule, published Nov. 2, will reduce rates by only 0.01%, resulting in a $10 million reimbursement reduction next year, CMS estimates. That compares to 0.1% in the proposed rule.

The change reflects a slight drop in the market basket inflation update CMS originally anticipated and a revision to the fixed dollar loss (FDL) ratio which adds $50 million to the outlier payment pool. The FDL represents the amount of loss that an agency must experience before an episode becomes


*(continued on p. 7)*


## CMS finalizes new survey sanctions, raising the prospect of hefty penalties

Civil monetary penalties and payment suspensions for non-compliant agencies won't take effect until July 1, 2014, but CMS otherwise made only a handful of changes to its proposed survey sanctions in the final 2013 PPS rule.

On the suspension of payment for new admissions, CMS clarified that when this sanction is used, it would suspend payment only on new patients, not on existing patients with new episodes as proposed.


*(continued on p. 8)*

## Prepare for loss of case-mix points for resolved conditions

CMS has finalized its proposal to limit the use of the diagnosis payment slot (M1024) to *only* permit fracture diagnosis codes, which means you can no longer place resolved conditions there.

The financial impact on home health agencies could be significant, considering they infrequently get points for acute fractures but resolved conditions are coded in M1024 in about 60% of home health cases, says Trish Twombly, senior director for DecisionHealth, Gaithersburg, Md. These are conditions in which surgery or medical intervention may have resolved a condition but the patient still needs care.

The National Association for Home Care & Hospice (NAHC) estimates the change would translate into an average loss of $200 for affected episodes. That loss is due to patients dropping from C3 to C2 and from C2 to C1 status as a result of the M1024 limitation.

This essentially is a payment change without Congress' approval, says Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas. "It's an overreach on the part of [CMS]."

Even the Medicare Payment Advisory Commission (MedPAC) agreed that agencies would be "underpaid" if CMS finalized its proposal, the commission stated in its comments on the proposed rule.

CMS believes the impact will be less, stating it has found that more than 99.6% of assessments would continue to receive the same case-mix weight when the payment diagnosis field is restricted to fracture codes only, resulting in a 0.04% decrease in payments.

"I'm having a hard time believing that this estimate is correct," says Mary St. Pierre, NAHC's VP for regulatory affairs.

Here are the new guidelines for completing M1024, effective Jan. 1, 2013:

- Reporting a resolved condition in M1024 is permitted if the condition is related to the plan of care and may be significant in describing the patient, but you will *not* receive points for these conditions. They will be permitted to be listed in M1024 for risk-adjustment purposes only.

- When fracture aftercare V codes are reported as primary *or* secondary diagnoses, and paired with an eligible (numerical) fracture code in M1024, the grouper will award appropriate clinical points. CMS has provided a list of valid fracture conditions within its grouper paired with appropriate V codes (*see table 25 of the rule*).

- The grouper logic will score diagnosis codes when submitted immediately following a V code in the primary (M1020) or secondary (M1022) diagnosis fields the same as they are currently scored when a V code is reported in the primary diagnosis field and the supporting diagnosis code is reported in M1024. The points allocated are the same regardless of where the grouper

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looks for the diagnosis codes associated with the V codes, according to CMS.

### CMS: Coders not following guidelines

CMS' purpose for this change is two-fold. First, the agency plans to eventually eliminate the payment diagnosis field once ICD-10 is implemented, and second, it wants to ensure that agencies are in full compliance with coding guidelines, according to the rule.

The restrictions on the use of M1024 are a result of a CMS analysis that revealed home health agencies are not complying with the intention of Attachment D, and therefore are not "limiting the number of diagnoses assigned to the payment diagnosis field and are also reporting resolved conditions in that field."

If CMS believed that resolved conditions should never be placed in M1024, "why not fix it 10 years ago when home health first started using the payment slot," Rambusch says.

But CMS believes the home health payment is based on resources required to care for patients in their current condition. And, if the patient has a resolved condition, the episode should receive points based on active co-morbid diagnoses plus clinical status, functional impairments and therapy needs.

Agencies currently are capturing points via the assessment, but CMS is not increasing the opportunity to capture case-mix points there to make up for the M1024 change, Twombly says. The fact remains that "in this rule, there is no way to capture clinical diagnosis points from a resolved condition." – *Maria Tsigas (mtsigas@decisionhealth.com)*

## CMS provides reassessment flexibility, but adds documentation burden

CMS has finalized a change that will limit when therapists can perform their reassessments, but provided additional flexibility in cases where ordered visit frequencies would make compliance hard for agencies.

CMS had proposed that, in multi-discipline therapy cases, therapists must perform reassessments on visits 11, 12 or 13 to meet the 13th visit requirement and on visits 17, 18 or 19 to meet the 19th visit requirement.

CMS has finalized that requirement, but says that in cases where physician-ordered frequencies make it impossible to comply without "providing an extra unnecessary visit or delaying a visit," a therapist may reassess the patient on a different visit. That visit would be the one which occurs "close to the 14th Medicare-covered therapy visit, but no later than the 13th Medicare-covered therapy visit." Similarly, therapists may assess close to visit 20, but no later than visit 19, to meet the 19th visit requirement.

Essentially, the change means that the reassessment can occur as early as visit eight if that's the closest to visit 14 for an affected discipline, says Mary St. Pierre, VP for regulatory affairs with the National Association for Home Care & Hospice (NAHC).

When a case like this occurs, agencies will need to document carefully to clarify that their situation fits CMS' exception, says Diana Kornetti, co-owner and administrator of Integrity Home Health Care in Ocala, Fla. For example, clinicians could note that the patient's frequency is once a week for the discipline and the reassessment was done outside the range, on visit 10, to maintain the ordered frequency and avoid an unnecessary visit, she says.

### CMS finalizes additional changes

CMS also finalized another proposed change, which provides that "if the required reassessment visit was missed for any one of the therapy disciplines for which therapy services were being provided, therapy coverage would cease only for that particular therapy discipline."

Only penalizing the therapy discipline that didn't complete the reassessment is a good idea, says Cindy Krafft, director of rehabilitation consulting services with Fazzi Associates in Northampton, Mass.

## LUPA rates: 2013 vs. 2012

Next year's national per-visit amounts for low-utilization payment adjustment (LUPA) episodes will be slightly above the final rates for 2012 across all disciplines, according to the final 2013 PPS rule.

| Home health discipline | 2013 | 2012 |
|---|---|---|
| Home health aide | $51.79 | $51.13 |
| Medical social worker | $183.31 | $180.96 |
| Occupational therapist | $125.88 | $124.26 |
| Physical therapist | $125.03 | $123.43 |
| Skilled nursing | $114.35 | $112.88 |
| Speech-language pathologist | $135.86 | $134.12 |
| *Source: Final 2013 PPS rule* | | |

However, another proposed change CMS has finalized could turn out to be more complicated. That change provides that coverage of therapy will resume during a late reassessment visit, rather than on the visit after. This could throw off your agency's visit count, Krafft believes.

Consider this example: You have a patient who receives occupational and physical therapy. The occupational therapy reassessment gets done on visit 13, but the physical therapist forgets and does the reassessment on visit 15. Despite the fact that this late reassessment visit will be paid, the visit that should have been the reassessment is not covered. As far as CMS is concerned, your total count of Medicare-covered visits is 14, not 15.

If you get this count wrong, your timing for subsequent reassessments will be incorrect, which could lead to non-covered visits, Krafft says.

### Prepare now for new therapy rules

Follow these additional tips to prepare your agency for the finalized therapy changes:

- **Take a look at the last several months of therapy activity,** Krafft says. This will help you determine how many of your reassessment visits land outside the required ranges, and if you need to make any changes in how visits are scheduled.

- **Communicate with your software vendor about the changes.** You need to make sure that your vendor is aware of the changes and when they should be implemented, Krafft says. Ask vendors which visits they are including in the Medicare-covered count to ensure they're in compliance with the rule, she says.

- **Begin training your staff now.** VNA of Care New England will begin training staff on the changes next week to ensure that therapy staff is well-versed in them by Jan. 1, says Jennifer Lee, rehabilitation manager at the agency in Warwick, R.I. In addition, you should get therapists on board by including them in any leadership meetings that discuss compliance strategies, Kornetti says. – *Danielle Cralle (dcralle@decisionhealth.com)*

## CMS adds new NPP role in face to face – but bigger problems remain

Once again the final 2013 PPS rule offers little relief for agencies struggling with the face-to-face encounter documentation requirement – leaving agencies to deal with recalcitrant physicians as best they can.

As expected, there was no major change between the proposed and final rule sections involving the documentation. Allowed non-physician practitioners (NPPs) at acute and post-acute facilities will now be able to do the face-to-face encounter at the facility and report it to a physician who has privileges at the facility and has attended to the patient.

That physician will then report the encounter to the certifying physician. (Allowed NPPs would be physician assistants, nurse practitioners, clinical nurse specialists and nurse-midwives who are certified by the laws of their state.)

Under the previous policy, only NPPs working in conjunction with the certifying physician were allowed to perform encounters (*HHL 7/16/12*).

### Change won't help deal with physicians

Agencies and consultants don't see the change as a big improvement.

Hospital NPPs will probably have no trouble working with their physicians, but getting the certifying physician to cooperate with another new procedure may be harder, says Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas.

"Doctors aren't thrilled with CMS in the first place," explains Rambusch. "Often their reaction to new regulations is, 'I'm not doing another thing. Medicare makes me jump through too many hoops as it is.'"

In fact, some physicians have started asking agencies for an "administrative fee" to complete documentation, says Robert Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis. "Some agencies might just want to go along, but if you do, you're paying a referral source" – which puts you at risk of violating the anti-kickback statute.

Richard Shroyer, administrator and president of Wellspring Healthcare Services in Woodridge, Ill., sees the benefit of allowing NPPs to perform the encounter, but doesn't like the extra hands on the document. "Passing information from one person to another can get confusing," he says. For one thing, it can slow down the progress of the encounter information to the certifying physician.

### No title/date? No problem

Also, CMS said it would "not be prescriptive as to what entity must date and title the face-to-face documentation" – meaning that if the doctor doesn't fill out that part of the documentation, the agency can do it.

That change is small but could be financially significant. About 45% of the 157 agencies who responded to a recent *HHL* survey said they'd had a denial based on face-to-face encounter documentation, including date and title issues – and of those agencies, one in four had lost between $1,000 and $5,000 in reimbursement (*HHL 10/22/12*).

The change is "a little bit of help, because it's been just one more thing to send back" to the certifying physician, says Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C.

### What to do to encourage compliance

If your agency is having trouble getting physicians to comply, Rambusch suggests you talk to them about it – and not just reactively whenever a certification stalls. "Tell them, 'We really love working with you, and we understand the burden of the paperwork – we're in the same boat. So what can we do to make this work for both of us?' Use your marketing and communications skills to get the physician on your side."

After all, though the doctor may not suffer directly from punting the documentation, he does get graded by CMS on his patient outcomes – and the better his home health follow-through, the less likely his patients are to be rehospitalized.

"There are benefits to him helping his patient access care outside the hospital environment," says Rambusch. "And they're on the private side, too, because all the private payers are also looking at quality indicators."

If all else fails, you may have to bite the bullet and stop accepting that physician's patients, Rambusch says. "If you can't get a physician to do the documentation in a timely manner, you can't bill," she says. "How long can you afford to give away free care?" – *Roy Edroso (redroso@decisionhealth.com)*

## CMS finalizes requirement for DME face-to-face encounters

The day before the final 2013 PPS rule, CMS released the 2013 physician fee schedule, which included a face-to-face requirement for DME supplies that may impact your patients.

Starting July 1, 2013, CMS will require doctors to submit an attestation that a physician assistant, nurse practitioner or clinical nurse specialist has performed a

## Final 2013 PPS rule's impact on home health agencies

Agencies in Alabama, Kentucky, Mississippi and Tennessee will feel the biggest impact from the final rule's policies, with an average payment decrease of 1.10%.

That's a larger decrease than predicted in the proposed rule, which projected a 0.91% cut. Agencies in most other parts of the country fared slightly better under the final rule.

| Type of agency | | Impact of 2013 policies |
|---|---|---|
| Freestanding | Nonprofit | 0.61% |
| | Proprietary | -0.21% |
| | Government | 0.07% |
| Facility-based | Nonprofit | 0.43% |
| | Proprietary | -0.08% |
| | Government | 0.01% |

| Area of the country | Impact of 2013 policies |
|---|---|
| New England (Conn., Maine, Mass., N.H., R.I., Vt.) | 1.24% |
| Middle Atlantic (Pa., N.J., N.Y.) | 0.64% |
| South Atlantic (Del., D.C., Fla., Ga., Md., N.C., S.C., Va., W.Va.) | -0.09% |
| East South Central (Ala., Ky., Miss., Tenn.) | -1.10% |
| West South Central (Ark., La., Okla., Texas) | -0.59% |
| East North Central (Ill., Ind., Mich., Ohio, Wis.) | -0.06% |
| West North Central (Iowa, Kan., Minn., Mo., Neb., N.D., S.D.) | 0.34% |
| Mountain (Ariz., Colo., Idaho, Mont., Nev., N.M., Utah, Wyo.) | -0.24% |
| Pacific (Alaska, Calif., Hawaii, Ore., Wash.) | 1.43% |
| Outlying (Guam, Puerto Rico, Virgin Islands) | -0.13% |

*Source: Final 2013 PPS rule*

face-to-face encounter for each new order of DME items. The encounter must occur within six months before the written order. The physician may submit the code G0454 for the encounter and reimbursement is generally estimated at $15.

"Ultimately, the agency isn't liable in this situation," explains Wayne van Halem, president of The van Halem Group in Atlanta, Ga. "It is the responsibility of the patient's physician to conduct the evaluation. If the claim gets denied, the DME supplier or the patient may be liable."

Contractors will be looking at these attestations for evidence of patient need, so if you recommend DME for your patients, it will help their case if your progress notes document the medical necessity of the equipment, van Halem adds. – *Roy Edroso (redroso@decisionhealth.com)*

## CMS finalizes claims-based ACH, details possible readmission measure

CMS is considering the adoption of readmission measures, the federal Medicare agency says in the final 2013 PPS rule.

One possibility is a 30-day measure that would count rehospitalizations for patients who come to home health immediately after an inpatient hospital stay, CMS says.

If that measure is implemented, accountable care organizations (ACOs) and other care transition projects are likely to use it to identify agencies they want to work with, believes Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich. This makes it more than ever crucial to implement best practices to prevent readmissions, she notes.

CMS also finalized its proposal to replace the OASIS-based acute care hospitalization (ACH) measure with a claims-based one on Home Health Compare.

The claims-based measure will include hospitalizations within the first 60 days of a patient's home health stay, regardless of that stay's total length. The OASIS-based ACH measure will continue to be reported in CASPER (*HHL 8/1/12*).

CMS also clarifies in the rule that observation stays which result in an inpatient stay will be included in the ACH measure, while observation stays that begin in the emergency department (ED) will be captured in the ED use without hospitalization measure.

While both ACH and ED use will now be based on claims data, neither measure will be removed from the OASIS, CMS says. Having information about hospitalizations and ED visits on the OASIS will allow agencies to "adjust care plans in response to changes in the patient's condition, medication regimen, and care needs," according to the final rule. – *Tina Irgang (tirgang@decisionhealth.com)*

## Other notable provisions of the final rule

- **CMS has extended reporting requirements for home health agencies and hospices.** Home health agencies will continue to receive a 2% reduction in payment if they fail to collect OASIS and Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) data. Meanwhile, hospices will receive a 2% reduction if they fail to report the two quality measures CMS currently requires. CMS didn't finalize any new measures for hospice quality reporting. However, hospices will no longer be required to provide a list of the patient care indicators in their quality assessment and performance improvement (QAPI) program as part of the structural measure.

- **CMS continues to research the implementation of a standardized patient assessment instrument for hospice,** but it's unclear whether this would happen as soon as 2014, a possibility raised in the proposed rule. Many commenters criticized CMS' proposal, arguing it wouldn't give providers enough time to prepare. In the final rule, CMS doesn't commit to an implementation date, but says it will "consider suggestions offered in comment to the proposed rule" as the data set is developed. CMS also is considering implementing an experience-of-care survey for hospice, but didn't specify a timeline for implementation in the final rule.

- **The final rule corrects a wording error in the proposed rule which implied that agencies are responsible for overseeing their patient satisfaction vendors.** CMS clarifies in the final rule that while agencies should make sure vendors submit their data on time, they don't have any other oversight duties relating to the compliance of their vendors with CMS requirements.

## Small payment change

*(continued from p. 1)*

eligible for outlier payments. The extra dollars will bring outlier payments up to the target 2.5% of total payments, CMS says.

### More case-mix adjustments to come?

CMS also reduces the home health update by the 1.32 percentage point case-mix adjustment it originally proposed, even though additional data for 2010 justifies a 2.18 percentage-point reduction, according to the final rule. Future case-mix adjustments will take the difference into account, CMS indicates.

The bottom line: a national standardized 60-day episode payment rate of $2,137.73, effective Jan. 1, 2013, compared with the current $2,138.52. (Both figures are before patient case-mix and local wage-index adjustments.)

But unless re-elected President Obama and congressional Republicans can agree on a new budget bill, next year's reimbursement outlook could be much darker than that. Without an agreement, the sequestration requirement, approved originally as a stopgap, will clip all Medicare reimbursement by 2%, notes Bill Dombi, VP for law with the National Association for Home Care & Hospice.

### Survey sanctions a 'seismic event'

Like the proposed rule, the final rule provides gradations in the civil monetary penalties agencies must pay if they fail to correct condition-level or repeat survey deficiencies in the time allowed. The maximum penalty is $10,000 for each day a deficiency remains uncorrected. (*For more details, see story p. 1.*)

The monetary penalties are one reason "the 2013 final rule will change home care as we know it," believes consultant Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich. To her, the new penalties are a "seismic event" for home health.

Another major negative for agencies: the rule limits use of the diagnosis payment slot (M1024) to fracture codes only, adds Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C. The change removes case-mix points for resolved conditions and could cost agencies some $200 per affected episode. (*See the story on p. 2.*)

Other provisions made final by the rule:

- **Face-to-face encounters:** Non-physician practitioners now may perform encounters in acute and post-acute facilities, with findings passed along to the certifying physician through a physician who has privileges at the facility and has treated the patient. (*See p. 4 for details.*)

- **Therapy reassessments:** CMS has relaxed the rules on when therapists can perform reassessments in certain multi-discipline cases. (*See the story on p. 3.*)

– *Burt Schorr (bschorr@decisionhealth.com)*

***Editor's note:*** *Find the final rule at www.gpo.gov/fdsys/pkg/FR-2012-11-08/pdf/2012-26904.pdf.*

## Survey sanctions

*(continued from p. 1)*

CMS also has finalized a proposed informal dispute resolution (IDR) process with a 2014 effective date. The process would allow agencies to submit additional documentation to the surveyor in an attempt to get deficiency findings overturned. All other survey-related provisions will take effect July 1, 2013. (*For more on IDR, see next week's issue.*)

The fact that sanctions other than termination from the Medicare program will now be available is a good thing, says John Gilliland, an attorney with The Gilliland Law Firm in Indianapolis. However, many of the new sanctions, especially civil monetary penalties, will have a "terrible" impact on affected agencies, he believes. Small agencies in particular don't have much extra cash in hand, meaning even a lower-range penalty could exhaust their resources, he notes.

CMS will implement four different kinds of civil monetary penalties:

- **Upper-range penalties** between $8,500 and $10,000 per day until the deficiency is resolved. This level will be reserved for so-called "immediate jeopardy" situations that led to actual or potential patient harm.
- **Middle-range penalties** between $1,500 and $8,500 per day. These penalties are for situations where a condition-level or repeat deficiency was identified that related to poor patient care, but didn't result in immediate jeopardy to patient health and safety.
- **Lower-range penalties** are between $500 and $4,000 each day until the deficiency is resolved. They are intended for condition-level or repeat deficiencies that don't affect the quality of care directly.
- **Per-instance penalties** between $1,000 and $10,000. These are one-time penalties which can be imposed for condition-level deficiencies that were corrected during the survey.

In addition to the substantial penalty amounts, a lack of preparedness will hit many agencies hard, believes Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich.

Many will rely on the fact that the monetary penalties won't kick in until 2014, she believes. However, the penalties you'll see then will depend on deficiencies you're getting now, even if they're only at the standard level, she notes. That's because monetary penalties are based not only on condition-level deficiencies, but also repeat deficiencies.

CMS defines a repeat deficiency as "a condition-level citation that is the same as, or similar to, a previous *standard* [emphasis added] or condition-level deficiency" during the most recent survey.

### CMS to look for industry feedback

One concession CMS made: It will allow industry stakeholders to give feedback on interpretive guidance surrounding the sanctions. Rather than additional rulemaking, the feedback process probably would involve policy discussions between CMS and the National Association for Home Care & Hospice (NAHC), says Mary St. Pierre, NAHC's VP for regulatory affairs. The delayed implementation of monetary penalties as well as the feedback process go some way toward addressing concerns about the sanctions, she says.

Another clarification in the final rule concerned situations where each penalty level would be appropriate. For example, the highest possible penalty can only be imposed when a patient actually came to harm as a result of an immediate jeopardy situation. In the proposed rule, CMS said only that any immediate jeopardy situation could warrant such a penalty.

One example of a situation that CMS might define as "immediate jeopardy" would be the administration of medication without a doctor's orders, believes Betty Gordon, a principal with Simione Healthcare Consultants in Westborough, Mass.

CMS also lowered the minimum amount in the "middle range" of penalties from $2,500 to $1,500.

All penalty amounts can increase or decrease based on whether CMS believes that the agency is making progress in remedying deficiencies.

One concern voiced by NAHC and other commenters on the proposed rule: Revisit surveys to determine whether an agency has achieved compliance on a citation often are delayed. Meanwhile, penalties keep accruing.

CMS' response: It will "develop guidance" for its State Operations Manual to ensure revisit surveys are scheduled "in a timely manner," according to the final rule.

In addition to penalties and payment suspensions, CMS also finalized the other sanctions it had proposed: temporary management by a CMS-appointed

individual, directed plans of correction for specific deficiencies and directed in-services in cases where CMS determines a deficiency is due to a lack of staff education. Termination from the Medicare program also will continue to be an option when an agency fails to correct deficiencies within six months (or 23 days for immediate jeopardy situations).

### Who will decide sanctions?

CMS provided more detail in this final rule about how sanctions would be determined. Sanctions will be vetted at CMS state and regional levels and the final determination on whether a sanction will be imposed will be made by the CMS regional office, according to the rule. Several commenters on the proposed rule had been concerned that the imposition of sanctions would be left up to individual surveyors.

Nevertheless, the penalties still may be subject to different interpretations, Gordon says. A citation that one jurisdiction might think is worth a steep penalty could result in a lower penalty or none at all in a different jurisdiction, she fears.

This fear is well-grounded in past experience with surveys, Maxim believes. Interpretations of the conditions of participation vary so widely that agencies in some states never see condition-level deficiencies, while those in others have seen a big uptick under the new survey protocols that took effect in 2011, she notes.

### Tips to help you prepare for sanctions

Use this expert advice to prevent sanctions on your next survey:

- **Take a page out of the playbook of accredited agencies.** Some accredited agencies will coach their staff on how to talk to surveyors on a regular basis, Gordon notes. She cites the example of one agency which prepared staff for conversations with surveyors by posting signs in its bathrooms which listed questions staff might be asked. Another good idea might be to take 15 or 20 minutes during your next staff meeting to talk your employees through some of the questions surveyors will ask them, she suggests. Those questions can be found in CMS' survey protocols.

- **Implement unannounced, supervised home visits.** How often you conduct those visits depends to some extent on your outcome and patient satisfaction scores, Gordon says. A low score on an outcome or Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) question may indicate a problem that you won't want to wait for a surveyor to find. Considering the independent nature of home health care, it's crucial for supervisors to observe clinicians in the home occasionally and to compare the care they provide with the care they document, she says.

- **Look at the results of your most recent survey and review the steps you've taken to correct any deficiencies.** Considering the fact that repeat deficiencies can trigger penalties, you want to make sure the surveyor will find you in top form on any conditions or standards that were cited the last time around, Maxim says. – *Tina Irgang (tirgang@decisionhealth.com)*

***Editor's note:*** *Look to next week's issue for a tool summarizing all finalized survey changes.*

## Discharge notes

- **CMS is implementing a change that ensures you'll get the full payment you're owed** when partial episode payment (PEP) adjustments are erroneously applied to dual eligibles' claims. The change will be effective for home health episodes ending on or after Jan. 1, 2010 and will be implemented on April 1, 2013, according to a transmittal published Nov. 2. To prevent underpayments on Medicare episodes which overlap a later demand bill episode, CMS plans to implement an automatic adjustment that will ensure full payment of the initial episode. Learn more at *http://homehealthline.decisionhealth.com/Articles/Detail.aspx?id=514236*.

- **Online training on data entry for hospice quality reporting will be available the week of Nov. 12,** CMS announced on its "spotlights & announcements" page Nov. 2. Hospices can access the training at *www.qtso.com*. Hospices will learn how to create an account and report data for the two required quality measures. The training will be available through April 2013 and can be accessed an unlimited number of times. Learn more at *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Spotlight.html*.

## Tool: Final 2013 PPS rule at a quick glance

*HHL* has boiled down the 298-page final rule into a quick reference tool to help you determine the impact of each change on your agency. For each change in the rule, this tool provides the section of the rule which contains it, as well as the proposed version of the change for a side-by-side comparison.

| Provision | Content | Section of rule | Proposed rule version | Impact |
|---|---|---|---|---|
| Payment changes | -0.01%. Includes:<br>▸ +1.3% market basket update (+2.3% less the 1% reduction required by health care reform)<br>▸ -1.32% case-mix adjustment<br>▸ Fixed dollar loss ratio of 0.45 | III.A-C | -0.1%. Includes:<br>▸ +1.5% market basket update (+2.5% less the 1% reduction required by health care reform)<br>▸ -1.32% case-mix adjustment | CMS expects payments will remain "virtually unchanged" in 2013. |
| Home health grouper | The grouper will award points when fracture codes in M1024 are paired with aftercare V codes in M1020 or M1022. M1024 also will permit the reporting of resolved conditions, but points will only be awarded to fracture conditions. | III.G | CMS will restrict M1024 to only permit fracture diagnosis codes to be listed in M1024 when a fracture V code is listed in M1020. | The change will result in a significant loss of case-mix points for patients with conditions that have been resolved through surgery. Coding experts believe up to 60% of home health episodes could be affected. |
| Face-to-face encounters | ▸ Non-physician practitioners (NPP) may conduct encounters in acute or post-acute facilities in collaboration with a facility physician who has privileges and treated the patient. The facility physician may inform the certifying physician of the NPP's findings.<br>▸ CMS will no longer prescribe who may title the face-to-face encounter documentation. | III.D | Finalized as proposed. | Work to ensure that communication occurs between facility practitioners and the certifying physician. |
| Therapy coverage | ▸ In multi-discipline cases, 13th visit reassessments will only be considered timely on the 11th, 12th and 13th visit; 19th visit reassessments will only be timely on the 17th, 18th and 19th visit. However, when agencies would need to schedule an unnecessary visit to comply, it's acceptable to reassess on a visit close to (but not on) visits 14 and 20, respectively.<br>▸ Coverage will resume on the visit during which a late reassessment is conducted.<br>▸ In multi-discipline cases, coverage will continue for other disciplines when one or more disciplines miss a reassessment. | III.E | ▸ In multi-discipline cases, 13th visit reassessments will only be considered timely on the 11th, 12th and 13th visit; 19th visit reassessments will only be timely on the 17th, 18th and 19th visit.<br>Other changes are finalized as proposed. | The clarification on reassessment ranges means agencies must document carefully that their case falls within the exception provided by CMS. |
| Survey changes | All proposed sanctions were finalized, but some (civil monetary penalties, payment suspension on new admissions) won't take effect until July 1, 2014. All others will take effect July 1, 2013. | V | CMS proposed several alternative sanctions for agencies out of compliance with the conditions of participation:<br>▸ Civil monetary penalties<br>▸ Payment suspensions<br>▸ Temporary management<br>▸ Directed plans of correction and/or in-services | Work to correct previous survey deficiencies. Implement staff training on conditions of participation. |

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