Proposed 2013 payment cut is small, but other changes could be significant

If Medicare cuts in the 2012 PPS rule were a sledgehammer that knocked $640 million out of this year’s home health reimbursement, the proposed 2013 PPS rule’s cut of 0.1%, or $20 million, is more like a feather duster.

CMS also is proposing to give agencies more leeway on the burdensome face-to-face encounter and therapy requirements. But it’s not all good news: The proposed rule contains hefty penalties of up to $10,000 per day for agencies that score low with surveyors and a grouper change that could cost you case-mix points.

The much smaller reimbursement hit partly reflects a decision to stick with the 1.32 percentage-point reduction in the inflation update that CMS last year calculated would be needed in 2013 to offset case-mix creep (HHL 11/7/11). Based on more recent data, the case-mix adjustment next year actually should have been 2.18 percentage points, the July 6 proposed rule states.

(continued on p. 8)

CMS proposes fines up to $10,000 per day, other penalties for survey deficiencies

Getting a survey citation could become a lot more expensive: CMS’ 2013 proposed rule contains civil money penalties, payment suspensions and other sanctions for agencies with condition-level or repeat deficiencies.

Sanctions generally can’t be in place for more than six months, according to the proposal.

Currently, termination from the Medicare program is the only sanction available to CMS following survey deficiencies. CMS has been working on additional, intermediate sanctions since 1987 and issued a proposed rule on such sanctions in 1991, but that proposal was never finalized.

However, don’t expect a similar outcome this time. CMS is almost certain to finalize its proposals, owing to enforcement
pressure from the HHS Office of Inspector General and the Department of Justice, says Barbara McCann, chief industry officer for Interim Healthcare in Sunrise, Fla. (HHL 3/12/12).

Surveyors determine penalties

In its new proposal, CMS gives surveyors great individual discretion on which sanctions to impose, when to impose them and how quickly to lift them, McCann says. Surveyors also can choose whether they want to impose one or several kinds of sanctions and the amount of any civil money penalties.

Penalties range from $500 to $10,000 per day. They begin accruing when the surveyor identifies a condition-level or repeat deficiency and may continue until the agency has resolved its deficiencies.

The penalty amounts and their potential to add up quickly can easily put a small agency out of business, especially when paired with payment suspensions, McCann notes.

What's more, agencies have no way to let CMS know they have resolved deficiencies and think the sanctions should be lifted, she says.

Instead, CMS must conduct a revisit survey to determine whether condition-level deficiencies have been resolved, notes Mary Carr, associate director for regulatory affairs at the National Association for Home Care & Hospice. The deadline for revisit surveys is 45 calendar days from the original survey, but agencies have reported that in practice it is currently taking surveyors 90 days or more to come back, she says.

Add to that the fact that it can sometimes take more than two weeks for the survey office to issue your statement of deficiencies, says Rebecca Friedman Zuber, a Chicago-based consultant and former director of Illinois' state survey office. Meanwhile, your penalties will keep accruing but you're unable to get to work on fixing deficiencies, she says.

Waive appeal rights and get 35% off

CMS proposes to offer agencies the option to request an administrative hearing within 60 days of getting notice that money penalties have been imposed. (Note: This appeals process is in addition to the informal dispute resolution process CMS is proposing. For more on that process, see p. 3.) However, agencies would receive a 35% reduction to their penalty amount if they waive their right to a hearing.

In effect, this means that CMS is incentivizing agencies not to make use of their appeal rights, Friedman Zuber notes. But if agencies don’t challenge the penalty, it will become part of their compliance record and increase the risk of future repeat deficiencies.

That's problematic because repeat deficiencies also could be a cause for monetary penalties under CMS' proposal.
CMS proposes to define repeat deficiencies as those that are identical or similar to others that have occurred within the previous 365 days.

But it’s up to surveyors to decide what makes a “similar” deficiency, as CMS doesn’t define that term in the proposed rule, notes Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich.

Surveyor judgment on what makes a condition-level or repeat deficiency can vary widely based on individual interpretations of the conditions of participation, she says.

Use these tips from Maxim to lower your agency’s risk for civil monetary penalties, payment suspensions and other survey sanctions:

• Audit 100% of your visit notes and plans of care for compliance with the applicable conditions of participation. It’s worth the effort when you consider that the vast majority of condition-level and repeat deficiencies are based on shortfalls in those documents.

• Make training on the conditions of participation an ongoing feature of in-services. Ideally, you should schedule in-service trainings on a monthly basis.

Alternative sanctions in detail

CMS proposes the following sanctions for survey deficiencies (for more on each of these sanctions, see p. 11):

• Civil money penalties. The amount of the penalty is based on the number and severity of deficiencies, as well as whether they have a direct impact on the quality of care. The surveyor also can consider the agency’s income and the availability of other agencies in the area. One-time penalties may also be imposed based on specific instances of non-compliance and could range from $1,000 through $10,000.

• Payment suspensions for new admissions and episodes. When this penalty is imposed, agencies will not receive payment for new admissions or new episodes for existing patients. Agencies may bill patients for the cost of care, but only if they can show that they informed the patient or caregiver both in writing and orally that Medicare may not cover their services.

• Temporary management. CMS could appoint a temporary manager, with input from the agency and the state survey office. The agency would pay the temporary manager’s salary and other expenses that result from the temporary management. This penalty may be imposed, for example, when the surveyor believes that “management limitations” make it difficult for the agency to remedy deficiencies, according to the proposal.

• Directed plan of correction. CMS or a CMS-appointed agency manager would draw up a targeted plan of correction to remedy specific deficiencies.

• Directed in-service training. When surveyors determine that staff performance issues resulted in deficiencies, they could require the home health agency to pay for targeted staff training by a recognized educational institution. – Tina Irgang (tirgang@decisionhealth.com)

CMS proposes informal dispute resolutions for survey deficiencies

If a surveyor found condition-level deficiencies at your agency and you disagree with the findings, you soon may be able to take advantage of a new resolution process outlined by CMS in the proposed 2013 PPS rule.

However, experts question agencies’ chances to actually get findings overturned. Under the proposed informal dispute resolution (IDR) process, agencies would have the opportunity to dispute one or several findings in a written statement that must be submitted within 10 calendar days after the agency receives its statement of deficiencies.

An IDR request wouldn’t delay enforcement of any sanctions the surveyor decides to impose on the agency. However, it would give the agency an opportunity to make its case directly to the surveyor, CMS notes.

What CMS doesn’t discuss, however, is how the IDR process would work after the agency has submitted its request, notes Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich. The federal Medicare agency may decide to implement a process similar to the recovery audit contractor (RAC) discussion period, during which providers have the opportunity to meet with auditors and discuss findings, she says.

Based on existing state IDR processes, the CMS process is unlikely to include a disinterested third party, such as an administrative law judge, says Robert Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis. Instead, IDR processes tend to be limited to discussions between the agency and the surveyor plus the surveyor’s
supervisor. Both the surveyor and the supervisor would have an interest in upholding the findings, dramatically limiting your chances of getting deficiencies overturned, he notes.

Tips to improve your chances of success

Follow these tips from Markette to improve your chances of benefitting from an IDR process:

• **Request a face-to-face meeting with the surveyor if possible.** An existing IDR process in Indiana gives the provider the option to handle all IDR communication in writing. However, a face-to-face meeting gives you the chance to make a good impression on the surveyor and drive home the personal impact of sanctions on you and your staff.

• **Use the IDR process to learn more about the surveyor's concerns and help you remedy them.** Even if you can’t get findings overturned, the additional feedback from the surveyor during IDR may help you determine how you can address the deficiencies in a way that allows you to get sanctions on your agency lifted as soon as possible. – Tina Irgang (tirgang@decisionhealth.com)

Proposed rule provides greater face-to-face encounter flexibility

The face-to-face encounter requirement could be less burdensome for agencies thanks to a proposed change to who’s allowed to complete the encounter.

However, some agencies and consultants note that the proposed change still doesn’t create an incentive for physicians to complete the documentation.

CMS has proposed that non-physician practitioners (NPPs) working in an acute or post-acute care facility now can complete a face-to-face assessment in collaboration with a facility physician who treated the patient. That physician in turn would communicate the findings to the certifying physician, according to CMS’ proposed 2013 PPS rule.

Previously, only a facility physician, the certifying physician or NPPs working with the certifying physician were allowed to perform encounters.

CMS’ proposal is a move in the right direction, says Laura Montalvo, director of quality management for CHRISTUS HomeCare in San Antonio. The more options CMS can give agencies to complete the face-to-face encounter, the more compliance it will see, she says.

It could be that CMS wants to give agencies slightly more leeway due to the amount of face-to-face encounter-related denials and appeals, Montalvo believes.

“I’m totally for this,” says Thelma Bowen, CEO and owner of HealthCare Compliance Services in San Antonio. Non-physician practitioners in the past have done well on documenting the reason for home health and the patient’s homebound status, she says.

But not everyone is satisfied with CMS’ proposals.

There’s a new way for agencies to comply, but nothing that would increase physician compliance with face-to-face encounter documentation requirements, says Cheryl Adams, administrator for At-Home Health Care in Sparta, Ill.

Even under the proposed change, accountability for face-to-face compliance continues to lie solely with agencies, says Ann Rambusch, president of Rambusch Consulting in Georgetown, Texas.

CMS proposes titling flexibility

The proposed rule also states that agencies are receiving denials because face-to-face encounter documentation is not “clearly titled” by the certifying physician. CMS notes that its intent was to make the documentation clearly identifiable, but not to limit who can add a title.

As a result, CMS proposes “not to be prescriptive as to what entity must title the documentation.”

CMS didn’t respond to HHL’s request to confirm that this means agencies themselves may add the title.

Define a process to verify the encounter

Despite additional allowances from CMS that may simplify the process of collecting the documentation, make sure you have safeguards in place to ensure timely compliance:

• **Schedule a new encounter with the patient’s primary care physician if the face-to-face encounter from an acute facility doesn’t meet the requirement.** Tracking down the facility NPP or physician who worked with your patients several days or weeks earlier can be difficult and time consuming.

Instead, schedule an appointment with the patient’s primary care physician that will allow him or her...
to re-write the form. In many cases, the patient will already see the primary care physician within 10 days of discharge from an acute facility. Communicate to the physician that the face-to-face encounter to verify the need for home health needs to be completed at that time. In the event that a follow-up is necessary to correct documentation, the primary care physician is much more accessible, Bowen says.

- **Verify at the start of care that all face-to-face encounter documentation includes all required elements.** Many agencies simply scan the face-to-face encounter forms as soon as the patient is admitted, but those that do could later find their final claims are held up as they scramble to get the documentation corrected, Bowen says. – Karen Anderson (kanderson@decisionhealth.com) and Danielle Cralle (dcralle@decisionhealth.com)

### Careful what you wish for: Therapy changes may wreak scheduling havoc

A therapy change requested by the industry and included in the 2013 proposed PPS rule actually could add to the burden of agency schedulers.

CMS proposes that in multi-therapy cases, reassessments on the 11th, 12th or 13th visit would meet the 13th visit reassessment requirement. Similarly, reassessments on the 17th, 18th or 19th visit would meet the 19th visit reassessment rule.

The federal Medicare agency notes it made this change in response to multiple agency requests to define what it means that reassessments in multi-therapy cases can be “close to” visits 13 and 19.

While it’s true that the industry requested a definition, the visit range CMS chose is so tight that it will be nearly impossible for agencies to comply, says Cindy Krafft, director of rehabilitation consulting services with Fazzi Associates in Northampton, Mass. “That kind of range even with two therapies will be a nightmare and three therapies will be a huge issue,” she says.

“I don’t think they understand that it’s very possible that in multiple therapy cases one of the therapies is at much lower frequencies than others and there wouldn’t be a visit scheduled between those ranges,” says Mary St. Pierre, VP for regulatory affairs with the National Association for Home Care & Hospice.

### CMS makes reimbursement concessions

The silver lining: CMS also proposes that therapy coverage will resume on the visit during which a therapist conducts a late reassessment. Previously, CMS had said that coverage resumes on the visit after the late reassessment.

It’s a change that would have prevented Kare-In-Home from missing higher-paying therapy thresholds in the past after reassessments were late or mistakenly performed by an assistant, says Corrie Hall, chief operating officer of the Gulfport, Miss. agency.

Finally, CMS proposes that in multi-therapy cases, coverage would continue for other disciplines when one discipline misses a reassessment. For example, if the physical therapist’s assessment is late, the occupational therapist’s visits still would continue to be covered.

### Change would add to scheduler’s burden

Nevertheless, the proposed visit ranges for multi-therapy assessments create an enormous additional tracking burden because schedulers will have to ensure all two or three therapists have a visit scheduled within the new range, Krafft notes.

What’s more, complying with the reassessment range might require a change in the physician-ordered visit frequency, St. Pierre notes.

**Tip:** Submit comments to CMS arguing that the visit range should be widened, Krafft says. Explain exactly why it will be difficult to adhere to such a tight visit range and suggest a specific change, such as visits eight to 13. Chances aren’t good on getting this proposal changed because CMS made it in response to industry requests, but a number of tightly reasoned comments may help, she notes. Comments are due Sept. 4. – Tina Irgang (tirgang@decisionhealth.com), with additional reporting by Burt Schorr (bschorr@decisionhealth.com)

### CMS proposes grouper change that could cost you points

In a move that could cost your agency earned reimbursement, CMS has proposed to further limit use of the diagnosis payment slot (M1024).

CMS has proposed to only permit fracture diagnosis codes to be placed in M1024, which means you can no longer place diabetes, skin 1 or neuro 1 case-mix...
diagnoses or, more importantly, resolved conditions in M1024, according to the proposed 2013 PPS rule.

The inability to assign resolved conditions in M1024 could have a significant financial impact on home health agencies since a considerable number of M1024 completions are due to resolved conditions, speculates Trish Twombly, senior director for DecisionHealth, Gaithersburg, Md.

For example, skin ulcers (not pressure ulcers) that are resolved by an amputation could no longer be coded in M1024.

“There go six to 12 case-mix points,” says Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas.

Consider that a loss of 12 case-mix points could mean a reimbursement reduction of up to $700 for that one case.

**CMS sees inappropriate use of M1024**

The federal agency’s rationale is that since acute fracture codes are not permitted in M1020 or M1022, they may be listed in M1024 when a fracture V code is listed in M1020, so that the home health agency can get its appropriate case-mix points.

However, the federal agency didn’t address whether home health coders also can list fracture codes in M1024 when a fracture V code is placed in the secondary slot (M1022).

These additional restrictions on the use of M1024 are a result of a CMS analysis that revealed home health agencies are not “limiting the number of diagnoses assigned to M1024,” which was CMS’ intention when it released Attachment D in 2008.

“Home health gets points for acute fractures so infrequently that making M1024 available only for acute fracture codes is almost an insult. What they are doing is removing other case-mix codes from consideration where the diagnosis has been resolved by surgery,” Rambusch says.

**HHAs could lose case-mix points**

A key issue that the federal agency completely failed to address in its proposed rule is what happens to resolved conditions if they can’t be placed in M1024, Twombly says. Coding guidelines prohibit them from being assigned to M1020 or M1022, she notes.

Currently home health agencies are allowed to place resolved conditions in M1024 when a V code in M1020 or M1022 replaces a resolved condition that is case mix.

For example, any case-mix neoplasm diagnosis that was resolved with surgery and requires no further treatment could not be coded in M1024 if the rule becomes final as is, adds Rambusch.

“In this proposed rule, there is no way to capture clinical points from a resolved condition,” says Twombly.

However, the proposed removal of the diabetes, skin 1 and neuro 1 case-mix diagnoses from M1024 won’t impact agencies because CMS has proposed to make these categories the same number of case-mix points when placed in M1020 or M1022.

**CMS sticks to ICD-10 deadline for now**

Despite the proposed one-year delay of ICD-10 implementation to Oct. 1, 2014, CMS is planning to revise its PPS Grouper to utilize ICD-10-CM codes. “If determined to be appropriate, we plan to publish a draft list of ICD-10-CM codes for the HH PPS Grouper by the summer of 2012 for industry review and comment,” CMS says in its proposed rule.

Maria Tsigas (mtsigas@decisionhealth.com)

**CMS may implement new hospice assessment tool in 2014**

CMS is researching the creation of a standardized patient assessment instrument for hospices which may generate unified data for use in quality reporting.

The federal Medicare agency is seeking comment on the implementation of such an assessment tool in
calendar year 2014. The tool would include items already in use by other providers as well as items that are specific to hospice and would be used to calculate quality measures endorsed by the National Quality Forum (NQF).

For example, some of the items under consideration would help collect data for these NQF-endorsed measures:

- 1617: Patients treated with an opioid who are given a bowel regimen;
- 1634: Pain screening;
- 1637: Pain assessment;
- 1638: Dyspnea treatment;
- 1639: Dyspnea screening.

The proposed rule also extends current hospice quality reporting requirements for fiscal years 2014 and 2015. CMS may add requirements to report measures gleaned from the assessment tool in future rulemaking and is seeking comment on this possibility.

Finally, CMS is seeking comment on the possibility of reporting measures based on the Family Evaluation of Hospice Care Survey (FEHC) or another experience-of-care survey. – Tina Irgang (tirgang@decisionhealth.com)

Looking for CMS open-door forum coverage?

CMS says an outlier fix is imminent. Learn more at www.homehealthline.com.

Other proposed rule updates

- **Breaking news correction:** HHL’s breaking news email on the proposed rule stated that the facility non-physician practitioner (NPP) would be able to communicate face-to-face encounter findings directly to the certifying physician. In fact, CMS proposes that a facility physician would communicate the NPP’s findings to the certifying physician.

- **CMS will give more details on its ICD-10 transition plans in the final home health rule.**
  The federal Medicare agency doesn’t go so far as to say it will announce the final transition date in that rule, but does indicate it will share updates on how the transition would be impacted by the proposed one-year delay.

- **CMS extends the requirement to submit OASIS and Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) data** or lose 2 percentage points of your payments.
  The requirements are extended for reporting deadlines in 2013 and 2014. CMS emphasizes that home health agencies should monitor their HH-CAHPS vendors to ensure they submit data on time for all required reporting periods.

- **The proposed rule outlines a change to the descriptor of one of the therapy G codes.** The descriptor for G0158 would change from “services provided by a qualified occupational therapist assistant.”

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in the home health or hospice setting, each 15 minutes” to “services provided by a qualified occupational therapy assistant in the home health or hospice setting, each 15 minutes.”

**Proposed physician fee schedule includes DME face-to-face rule**

CMS’ proposed physician fee schedule aims to make face-to-face encounters a condition of payment for DME suppliers.

In an effort to gain physician buy-in, CMS suggests the implementation of a G code that would allow physicians to bill for the service and receive a $15 fee.

Instituting a similar fee for home health face-to-face encounters would help compliance tremendously, believes Cheryl Dott, administrator for The Thorne Group, Inc. Home Health Services in Youngwood, Pa.

The proposed rule also notes that the physician would only be able to bill the G code once, even if there are multiple DME orders per visit.

**CMS requires encounter with doc or NPP**

The rule would require DME suppliers to have documented proof of a face-to-face encounter that occurred between a physician, physician assistant, nurse practitioner or clinical nurse specialist and the beneficiary no more than 90 days before or 30 days after the order is written.

“We believe that requiring a face-to-face encounter that supports the need for the covered item of DME would reduce the risk of fraud, waste, and abuse since these visits would help ensure that a beneficiary’s condition warrants the covered item of DME,” CMS says in the proposed fee schedule.

In addition, documentation of the face-to-face encounter must support the need for every covered item of DME for each individual visit.

The fee schedule proposes three options for physician face-to-face documentation:

- A physician attestation that confirms that a face-to-face encounter has been conducted by an allowed physician or non-physician practitioner (NPP);
- A physician or NPP signature on the pertinent section of the patient’s medical record;
- A physician would initial the history and physical exam for the date of the face-to-face encounter, “thereby documenting that the beneficiary was evaluated or treated for a condition relevant to an item of DME on that date of service.”

CMS has not yet decided which of the three options it will choose. – Danielle Cralle (dcralle@decisionhealth.com)

**Editor’s note:** To view the entire fee schedule, go to http://tinyurl.com/77dag2q.

**Proposed 2013 cut**

(continued from p. 1)

The final rate also was impacted by updates of both the wage index and the home health market basket used to calculate the inflation adjustment. Changes to the market basket include the identification of four additional cost categories:

- Administrative and support services;
- Financial services;
- Medical supplies; and
- Rubber and plastics.

That brings the total number of categories up to 16.

Bottom line: A proposed national standardized 60-day episode payment rate of $2,141.95 for 2013, up a small fraction from this year’s $2,138.52.

That’s good news to Corrie Hall, chief operating officer of Kare-In-Home in Gulfport, Miss. This year’s wage index changes, for example, were a major reason why Mississippi and other states in its region are projected to average only a 0.9% reimbursement reduction compared with this year’s projected drop of 6.3%, Hall notes (see table, p. 9).

Hall also likes CMS’ proposals for easing therapy coverage rules. The pending rule would allow late reassessment visits to be covered by Medicare. (See p. 5 for other proposed therapy changes.)

**Don’t write off sequestration cuts**

The dark cloud for home health agencies and other providers, however, is the deficit reduction legislation Congress passed last year to avoid a first-time-in-history default on U.S. Treasury bonds (HHL 12/5/11). Unless Capitol Hill Republicans and Democrats can agree on some deficit reduction alternative, the law requires a 2%
cut (or sequestration) for all categories of government spending by year end, including Medicare.

Presumably such a withhold would be in addition to payment reductions caused by the pending PPS rule, says Bill Dombi, VP for law with the National Association for Home Care & Hospice.

**Other proposed rule provisions**

- **Sanctions for non-compliant agencies:** The proposed rule would create civil monetary penalties of up to $10,000 per day as well as various other sanctions for survey citations. CMS is offering agencies an informal dispute resolution process to overturn citations and end sanctions. One improvement the Visiting Nurse Associations of America wants is a time limit for the resolution of sanctions under the procedure, says Margaret Terry, VP for quality and innovation. (See p. 1 for details.)

- **Face-to-face encounters:** Non-physician practitioners would be permitted to 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.)

- **Grouper changes:** These would restrict use of the diagnosis payment slot (M1024) and could mean lost case-mix points. (See p. 5 for details.) – Burt Schorr (bschorr@decisionhealth.com)


### Proposed 2013 PPS rule’s impact on home health agencies

Agencies in Alaska, California, Hawaii, Oregon and Washington would see a 1.06% payment increase in 2013, the best deal under CMS’ proposed policies.

Meanwhile, agencies in Alabama, Kentucky, Mississippi and Tennessee would see the biggest reduction at -0.91%.

In addition, nonprofit agencies would see a slight payment increase in 2013, while proprietary and government agencies would see a reduction.

<table>
<thead>
<tr>
<th>Type of agency</th>
<th>Impact of 2013 policies</th>
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<tbody>
<tr>
<td><strong>Freestanding</strong></td>
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<tr>
<td>Nonprofit</td>
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<td>Proprietary</td>
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<table>
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<tr>
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<tr>
<td>New England (Conn., Maine, Mass., N.H., R.I., Vt.)</td>
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<td>Middle Atlantic (Pa., N.J., N.Y.)</td>
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<td>East North Central (Ill., Ind., Mich., Ohio, Wis.)</td>
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<td>Pacific (Alaska, Calif., Hawaii, Ore., Wash.)</td>
<td>+1.06%</td>
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<tr>
<td>Outlying (Guam, Puerto Rico, Virgin Islands)</td>
<td>-0.25%</td>
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</table>

_Source: Proposed 2013 PPS rule_
**Tool: Proposed 2013 home health rule at a glance**

The *HHL* team has compiled this quick-reference tool to help you evaluate the major provisions of CMS’ proposed rule. The following changes would take effect in 2013 if the rule is finalized as proposed.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Content</th>
<th>Section</th>
</tr>
</thead>
</table>
| Payment update                   | -0.1% Includes:  
  • +1.5% market basket update (+2.5% less the 1% reduction required by health care reform)  
  • -1.32% case-mix adjustment  
  → Standardized episode rate of $2,141.95                                                                                                         | III.A-C |
| Market basket rebasing and revision | • Results in a labor-related share of 78.535% and a non-labor related share of 21.465%.  
  • Moves base year for market basket update from CY 2003 to CY 2010.  
  • Adds four new cost categories (administrative and support services; financial services; medical supplies; and rubber and plastics). | III.C   |
| OASIS and HH-CAHPS reporting     | CMS extends existing reporting requirements, including 2 percentage point payment reduction for noncompliance.                                                                                    | III.C   |
| Face-to-face encounters          | • Non-physician practitioners (NPPs) 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.  
  • CMS will no longer prescribe who may title the face-to-face encounter documentation.                                                             | III.D   |
| Therapy coverage                 | • Coverage will resume on the visit during which a late reassessment is conducted.  
  • In multi-discipline cases, coverage will continue for other disciplines when one or more disciplines miss a reassessment.  
  • In multi-discipline cases, 13th visit reassessments will be considered timely on the 11th, 12th or 13th visit; 19th visit reassessments will be timely on the 17th, 18th and 19th visit. | III.E   |
| Hospice quality reporting        | CMS extends existing reporting requirements and informs the industry of its intent to add further quality measures in future as well as create a unified patient assessment instrument. | IV.C-E  |
| Home health grouper              | CMS will restrict M1024 to only permit fracture diagnosis codes to be listed in M1024 when a fracture V code is listed in M1020.                                                                  | III.G   |
| Survey changes                   | See p. 11.                                                                                                                                                                                              | V.B-D   |
## Tool: Proposed survey changes at a glance

The HHL team has compiled this quick-reference tool of the major survey provisions in this year's proposed rule. The following changes would take effect if the rule is finalized as proposed.

### General changes

<table>
<thead>
<tr>
<th>Survey types</th>
<th>CMS codifies existing definitions of terms including “standard survey,” “partial extended survey” and “extended survey.”</th>
</tr>
</thead>
</table>
| Informal dispute resolution (IDR) | CMS proposes a process for informal resolution of disputes about survey findings:  
- The agency may dispute one or more condition-level findings cited in its statement of deficiencies.  
- A request for IDR must be submitted within 10 calendar days of receipt of the statement of deficiencies. It must be in writing and include the specific deficiencies disputed.  
- A request for IDR will not delay the effective date of sanctions or other enforcement action. |

### Sanctions for non-compliant agencies

CMS may decide to impose one or several of the sanctions below for condition-level or repeat deficiencies. Sanctions will be imposed for a period of no more than six months. The choice of the sanction reflects the impact of a deficiency on patient care and/or the presence of repeat deficiencies.

CMS is seeking comment about possible public notices when sanctions are imposed on agencies.

<table>
<thead>
<tr>
<th>Type of sanction</th>
<th>When is it imposed?</th>
<th>What happens?</th>
<th>When is it lifted?</th>
</tr>
</thead>
</table>
| Termination from Medicare | The agency:  
- Failed to remedy an immediate jeopardy situation within 23 days.  
- Failed to correct any deficiencies within six months.  
- Failed to submit a plan of correction.  
- Resumed management control during a temporary management period without CMS approval. | The agency loses its Medicare billing privileges. | N/A |
| Temporary management | The surveyor finds:  
- The agency had one or more condition-level deficiencies and management limitations impair the agency’s ability to correct deficiencies.  
- An immediate jeopardy situation. | CMS appoints a temporary manager, with input from the agency and the state office. The agency must pay the temporary manager’s salary. The temporary manager has authority to hire, fire and reassign staff. | When the agency:  
- Is in compliance and can show that it will remain so.  
- Was terminated.  
- Resumes management control without CMS approval. |
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Suspension of payment for new admissions and episodes</td>
<td>The agency has one or more condition-level deficiencies.</td>
<td>Agencies will not receive payment for any new admissions or new episodes that start on or after the sanction effective date. The agency may not charge patients for services unless it can demonstrate that patients/caregivers were informed orally and in writing that Medicare may not cover services.</td>
<td>When the agency has corrected all deficiencies or upon termination.</td>
</tr>
<tr>
<td>Civil money penalties</td>
<td>The agency has one or more condition-level or repeat deficiencies.</td>
<td>Amounts are based on:</td>
<td>Per-day penalties accrue until the agency has corrected deficiencies or been terminated.</td>
</tr>
</tbody>
</table>
|                                                     | Penalties cannot exceed $10,000 and can be imposed on a per-day or per-instance basis. Per-day penalties begin when the surveyor identifies the deficiency. Per-instance penalties are imposed for specific instances of noncompliance the surveyor has identified. Increases or decreases in penalties are possible based on failure or good-faith effort to correct deficiencies. | • The size of the agency and its resources.  
• The availability of other agencies in the region.  
• Medicare cost reports, claims information and other sources of information about the operations of the agency.  
• Evidence of an effective quality assessment and performance improvement system at the agency.  
Amounts:  
• $8,500 to $10,000 per day for immediate jeopardy to health and safety.  
• $2,500 to $8,500 per day for repeat or condition-level deficiencies that did not result in immediate jeopardy, but do relate to quality care.  
• $500 to $4,000 per day for repeat or condition-level deficiencies that did not result in immediate jeopardy and did not directly relate to quality care. | Note that you may request an administrative hearing or inform CMS that you waive that right. The decision to waive will result in a 35% reduction of the penalty amount.  
Once the final payment is computed, it is due within 15 days. |
| Directed plan of correction                          | The agency has one or more condition-level deficiencies.                           | CMS or a temporary manager appointed by CMS creates a targeted plan of correction to remedy specific deficiencies.                                                                                       | If the agency achieves compliance within the timeframes specified in the directed plan of correction. |
| Directed in-service training                         | The surveyor determines that staff performance resulted in deficiencies and that the deficiencies can be remedied through staff training.            | The agency must pay for in-service trainings by established learning institutions.                                                                                                                          | When staff demonstrate competencies that enable compliance in the future.          |
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