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Kennedy Health Law News

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A NEW TYPE OF INVESTIGATION IS BEING CONDUCTED IN HOME HEALTH CARE

by Lurese A. Terrell, Esq.

Governmental agencies have discovered yet another place to investigate home health agencies for monies that they claim have been paid in error for home health care. The investigation is simple and the results may be harsh.

TrCenturion, the payment safeguard contractor is looking at the HIPP codes used in the billing for individual patients. The HIPP codes that are classified as "D" codes are the more complex patients. TriCenturion investigators are investigating the billing submitted for the "D" coded patients. Those home health agencies that have a high percentage of "D" HIPP codes in their submitted billing are being investigated. CMS has authorized Palmetto to suspend the RAP (Request for Anticipated Payments) payments, until TriCenturion completes their investigation and has determined the billing is correct. Suspension of RAP is not appealable. You will be advised to continue to file final claims with the RHHI and they will be paid based on Medicare coverage, allowable services and qualifying beneficiaries.

Most of the "D" HIPP coded patients will have complex medical issues. "D" coding occurs often when the patient has more than one medical issue, such as insulin dependency due to diabetes, AND necessary wound care. If a high percentage of your patients have "D" HIPP codes, you are now a prime suspect. Your patient records and bills should reflect the complex nature of the medical care given to these patients.

This is an easy thing for the governmental agencies to check. You have a "D" code, but your patient records and billings do not indicate the complexity of your care for that patient. It will be assumed by TriCenturion and Palmetto you have billed incorrectly, and/or coded incorrectly. The result will be error as the higher amount paid on a "D" coded patient will not be supported by the records. The governmental agency can easily charge you with fraud and withhold the payments for the episode.

You must make certain your paperwork supports your billing. You may need to augment your paperwork, or you may need to downgrade your patient's HIPP code. You must be able to justify whichever is applicable for your home health agency and its patients.

HOME HEALTH IS UNDER FIRE FROM SURVEYORS

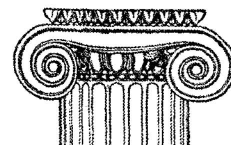
by Lurese A. Terrell, Esq.

It has come to my attention that surveyors are now going directly to the patients and asking them questions that lead the surveyors to suspend payments, and demand payment be disgorged by the home health agency (overpayments) due to the "condition" of the patient.

As you know, some patients move in and out of being "homebound" during their treatment episodes. Depending on their injury/illness, and future treatment, a patient can recover during an episode, and no longer require home health prior to the end of the 60-day period. Other patients can get better, go in for another surgery, and then require home health again during a single episode.

I have been told by another health care attorney (an accurate source) some home health patients are receiving visits from surveyors who ask them a few questions. The questions are not the most accurate way to assess whether the patient is homebound or not. If the surveyor asks "can you drive," the answer from the patient may be "yes," but if the surveyor asks "when was the last time you drove a car," the answer will probably be "oh, not since the surgery."
Surveyors have been determining from these type of visits that patients are not homebound. While it is arguable as to exactly when the patient was no longer homebound (if they truly are no longer homebound), the surveyors are demanding repayment for the entire episode.

You must make certain your field nurses note when the patient is no longer homebound, if they in fact have improved before the end of the episode. The field nurses notes are your only proof of whether a patient is homebound and qualifies for continued treatment by the home health agency. The home health care agency cannot be paid for service to a patient who is not homebound.



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