

Compliance Review Services, Inc.

Consulting & Training Services

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An electronic version of this newsletter is available
at www.ComplianceReviewServices.com



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Construction Update



Construction is going well, and we will move into our new office building on September 8th and 9th. Please note our new information:

Compliance Review Services, Inc.
11201 Steeple Park Drive
Houston, TX 77065
Phone: (832) 237-2525
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Calendar of Events

- 8/11 Supervising Nurse Certification Course**
4-day course: 8/11, 8/16, 8/30 & 9/1
9:00 a.m.–4:00 p.m.
- 8/18 How to Run Your Home Health Agency**
10:00 a.m.–4:00 p.m.
- 8/23 CBA Program Review** **NEW!**
10:00 a.m.–4:00 p.m.

Call (713) 776-3566 to request a registration form, or go to www.ComplianceReviewServices.com to download one.

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**COMPLIANCE
REPORT**

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**Compliance Review
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Consulting & Training
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We're moving
into our new
office building
on 9/8 and 9/9!
See the back
page for more
information.

“I PASSED MY MEDICARE INITIAL SURVEY...

By Kimberley Kelly, RN, BSN, CLNC

There are two different situations that determine what you—the agency—are expected to do once you have passed your Medicare survey. I am going to outline these steps for you.

You Passed and Had No Deficiencies

Congratulations! The surveyor should give you at exit (or close after exit) your “Medicare date.” This is the date that your agency will become Medicare certified. You should do a new OASIS assessment for all of your active Medicare patients and 485. The date for the 485 will reflect that you are able to bill because it is on or after the date the surveyor gave you.

Palmetto will give you your Medicare Provider number by mail after you have passed your survey. We are told by clients this takes two to five weeks to happen.

Once you receive your Medicare Provider number, you can begin billing. Remember, once you bill Medicare, they will send you ADRs (additional data/documentation requests) before they will pay the initial claims. You will have to copy your chart and send it to them, and you will want to do that in a very timely manner! If you need our help, call and we can set up a consultative visit with you.

You Passed and Had Standard Level Deficiencies

Congratulations! The surveyor will give you within 10 business days of exit your statement of deficiencies (Z tags) for state. You will have 10

NOW WHAT?”

calendar days to submit a plan of correction. Another set of deficiencies (G tags) may come in the mail from the federal government (Palmetto), and you must promptly submit a plan of correction for those, too.

After the state and federal government review your plans of correction and accept them, then you will get your “Medicare date.” This is the date that your agency will become Medicare certified. You should do a new OASIS assessment for all of your active Medicare patients and 485. The date for the 485 will reflect that you are able to bill because it is on or after the date the surveyor gave you.

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Have more questions?
Call us at (713) 776-3566

Excluded Imposters

By Troy Brooks
Sheehy, Serpe & Ware, P.C.

Most healthcare providers who employ nursing staff are familiar with the concept of an imposter. An imposter is someone who claims to be licensed as an RN or LVN, but in reality is not. While it may seem far fetched to some that imposters may actually be employed as a nurse it occurs frequently. So frequently in fact that each quarter the Texas Board of Nurse Examiners (BNE) publishes a list of imposters who have gained employment as nurses.

Another problem for providers is nurse employees subject to professional disciplinary action. If, for instance, a nurse's license is suspended or revoked while they are employed by a healthcare provider, this may cause the healthcare provider to be out of compliance with state and federal healthcare regulations. If that healthcare provider is receiving money through Medicare or Medicaid, then payments related to that nurse's services could be considered an overpayment.

An action against a nurse's license may also trigger exclusion from Medicare or Medicaid, or both. Exclusion means that items or services

furnished, ordered, or prescribed by a specified individual or entity will not be reimbursed. In other words, if an employee happens to be excluded from Medicare or Medicaid then any services that employee provides are not reimbursable through that particular program. Over the past year, there have been several known instances in which providers have unknowingly employed excluded individuals and were later forced to repay any payments related to that individual's services.

While most providers verify licensure on a regular basis, most never check the exclusion lists. As one can determine from the issues discussed above, annual verification may not be frequent enough. Below are web sites that make the verification just a click away.

- For Texas Medicaid exclusions: <http://www.hhsc.state.tx.us/OIE/exclusionlist/exclusion.asp>
- For Medicare exclusions: <http://oig.hhs.gov/fraud/exclusions.html>
- For Texas nurse license verification: <https://www.bne.state.tx.us/olv/olverif.htm>

Troy Brooks is a former Texas Department of Aging & Disability Services (DADS) attorney. ❖

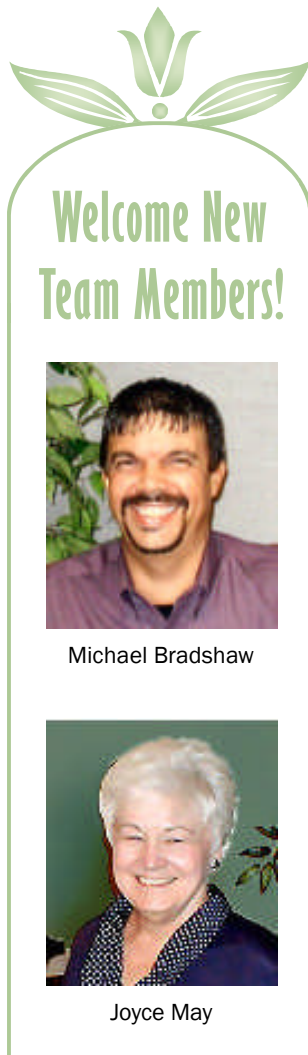
PLEASE WELCOME Our New Staff

Michael Bradshaw, RN, has worked as a Nurse Surveyor for the Department of Aging & Disability Services in Houston, Texas, for the past five years. Previously, he was a Director of Nursing for a home healthcare agency in The Woodlands, Texas. Michael has an Associate in Applied Science from Angelina College in Lufkin, Texas.

Joyce May, RN, BSN, began her nursing career at the first NICU in the Dallas area. After

many years in hospital staff nurse positions, Joyce worked as a Nursing Specialist for the Texas Department of Health/Department of State Health Services from 1990 to 2004. She obtained her Associate in Applied Science from El Central College in Dallas, Texas and her Bachelor of Science in Nursing from Texas Tech University in Lubbock, Texas.

We're excited to have Michael and Joyce as part of our team! ❖



Michael Bradshaw

Joyce May

SPOTLIGHT ON Key Provider Updates

Warning to Agencies with LHH and PAS in Their License about Separate Entities and Medicare Requirements

In a recent state survey, an agency was cited because it did not supervise its provider every two weeks with an RN. The agency had Licensed and Certified, Licensed Home Health, and PAS on its license. Because the agency was not operating a separate entity, the surveyor held it to the Medicare requirement, which is supervision of nonskilled personnel by an RN every two weeks. If you are doing PAS/PHC services, please make sure that you implement a separate entity ASAP! Similarly, if an agency with Licensed Home Health patients does not establish a separate entity, then those patients on the same license as Licensed and Certified (e.g., pediatric and OT-only patients) will be held to Medicare rules! If you need help implementing a separate entity, please call our office. We have a special two-hour "Separate Entities" class that we offer based on demand.

New Form for PDN Prior Authorization

HHSC has developed a new form for PDN prior authorization. For your convenience, we have posted the form on the Special Bulletins page at www.ComplianceReviewServices.com.

CBA Providers: Nurse May Refer to Dentist

Effective July 1, 2005, a Home and Community Support Services (HCSS) registered nurse may refer a current CBA consumer needing dental treatment to a dentist without obtaining prior authorization from the case manager.

PHC Providers: Pilot Expands to San Antonio

DADS is expanding the Service Responsibility Option (SRO) pilot in the PHC program to San Antonio! The pilot will begin in August

2005. For more information, contact Elizabeth Jones at 512-438-4855.

Medicare Providers: CMS Posts Final Expedited Review Forms and Other Documents

CMS posted on its website the OMB approved final versions of the Generic and Detailed Notice forms required under the new Expedited Review process that will go into effect on July 1, 2005. This new process applies to both home health and hospice. You can download these forms, instructions for the forms, questions and answers, and other information regarding the new expedited review process from the Special Bulletins page on our website at www.ComplianceReviewServices.com.

Other key information:

- The Quality Improvement Organization (QIO) for Texas is the Texas Medical Foundation (TMF), and their phone number for beneficiary appeals is 1-800-725-8339. This must be provided on the Generic Form.
- Hospice providers should receive in the mail a Memorandum of Agreement (MOA). Most home health agencies have already signed an MOA with TMF and will not be required to sign another one.

Can a PTA Discharge a Patient from Home Health Services?

Our firm contacted DADS and CMS and asked if a PTA could discharge a patient from home health services. DADS stated that a PTA could discharge a patient; however, Jackie Brown from the CMS Dallas office (214-767-6401) said a PTA could not.

A PTA can conduct the last visit on a patient as long as the PT handles the discharge, updates the plan of care, and completes the discharge summary. ❖



You ask me why I do not write something...

I think one's feelings waste themselves in words, they ought all to be distilled into actions and into actions which bring results.

—Florence Nightingale, in "Florence Nightingale," by Cecil Woodham-Smith (1951)