

# Home Health Application Information

Creneear Mims  
Director, Bureau of Health Services  
Division of Quality Assurance

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## Objectives

- Discuss the purpose of the web cast
- Define Home Health Agency
- Define Skilled Nursing
- The Department of Health & Family Services' Mission

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## Purpose of Presentation

- Increase in applicants
- Unfamiliarity with Home Health regulations
- Increased denials of Licensure and Certification

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## Definition of Home Health

- HFS 133.02 (3)
- HFS 133.10 (1)
- Not a Personal Care Agency
- Skilled Nursing

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## State-Licensed Only – Home Health Agencies

The Division of Quality Assurance  
Bureau of Health Services  
Jan Heimbruch

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## State-Licensed Only Agencies

- ◆ Optional decision by the applicant
- ◆ Medicare certification is not required
- ◆ Must maintain compliance with WI Administrative Rule HFS 133 and WI Stats., Chapter 50

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**What you should consider:**

- ◆ Develop a business plan
- ◆ Consider business start-up costs
- ◆ Recruit qualified staff
- ◆ Secure a “skilled level” patient population

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**Submitting Your Application**

- ◆ Know the regulatory requirements
- ◆ Develop your policies and procedures
- ◆ Validate the application is complete and thorough

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**Serving Patients with a Probationary License**

- ◆ Focus on admitting “skilled level” patients
- ◆ Develop patient’s plans of care and update as necessary
- ◆ Meet patient needs

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**Requesting the Initial On-site Survey**

- ◆ Must serve 10 “skilled level” patients
- ◆ Need survey completed within 90 days of issuance of probationary license
- ◆ Prepare your staff
- ◆ Review all regulatory requirements

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**What to Expect with the On-site Survey**

- ◆ Will be unannounced
- ◆ Is your opportunity to demonstrate provision of quality patient care through our on-site review of:
  - Patient medical records; closed and open
  - Interviews with staff and home visit observations; including patient interviews

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**After the On-site Survey**

**Recommendation to issue a regular non-expiring license**

- ◆ Must maintain compliance with all regulatory requirements
- ◆ Subject to future unannounced surveys; including complaint investigations
- ◆ Annual report and payment of yearly licensing fees

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**Summary: State-Licensed Home Health Agencies**

- ◆ Be an informed provider
- ◆ Maintain compliance with regulations
- ◆ Provide skilled-level services
- ◆ Department oversight
- ◆ Annual reporting requirements

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**Home Health Agency**

Application Process  
Tracy Ellingson,  
Licensing Specialist

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**Prior to Application**

- Read website  
[www.dhfs.state.wi.us/rl\\_DSL/HHAs/HHaintro.htm](http://www.dhfs.state.wi.us/rl_DSL/HHAs/HHaintro.htm)
- Demonstrate knowledge of website and understanding of definition of a home health agency
- Understand “primarily provides both skilled nursing and other therapeutic services”

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## General Information

- 12 page application
- Name and address of applicant
- Location of agency

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## General Information

- Description of the nature, type and scope of services to be provided
- The geographic area to be served

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## Ownership Information

- The date and state of incorporation
  - must submit a copy of articles of incorporation and tax status
  - if foreign corporation – evidence of authority to operate in WI [www.wdfi.org/](http://www.wdfi.org/)

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### Ownership Information – cont.

- Name, principal business address and percentage of ownership
  
- All officers, directors, or stockholders owning 10% or more of stock.

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### Ownership Information

- all members and partners
  
- all persons having authority or responsibility for the operation of the agency

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### Administration

- Administrator
  - Licensed physician  
Or
  - Registered nurse  
Or
  - Training and experience in health services administration and at least one year of supervisory or administrative experience in a HHA or related health program

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## Administrator

- Substitute Administrator
  - Same qualifications as the administrator

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## Fees

- \$300 non-refundable fee
  - Payable to Division of Quality Assurance
- Application will not be reviewed until fee is received
- After initial licensure, yearly fee is based on patient fee revenue

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## Fit and Qualified

- Survey and complaint history of other agencies owned and/or operated
- Adverse actions against any agencies owned or operated
- Denials, suspensions, civil money penalties or revocations
- Frequency of noncompliance

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## Fit and Qualified

- Convictions of abuse or neglect, assaultive behavior, wanton disregard for the safety of others
- Crimes related to the delivery of care
- Convictions relating to controlled substances
- Prior financial failures and bankruptcies

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## Financial Resources

- Sufficient financial resources to operate the agency for 90 days (recommend at least 6 months)
- Worksheet for guidance
- Letters from banks, income and expense statements, etc.

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## Caregiver Background Checks

- Each individual who is a signatory or a legal representative of the agency
- Any member who is an interested party having access to clients
- Complete HFS 64A and 69A
- Submit \$7.50 per person identified
  - Separate check from licensure fee

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## Caregiver Background Checks

- Websites:
  - <http://dhfs.wisconsin.gov/forms/HFS/HFS0064.pdf>
  - <http://dhfs.wisconsin.gov/forms/HFS/HFS0069.pdf>
  - [http://www.legis.state.wi.us/rsb/code/hfs/hfs012\\_app\\_a.pdf](http://www.legis.state.wi.us/rsb/code/hfs/hfs012_app_a.pdf)
    - (Underscores between 012\_app\_a.pdf)

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## Caregiver Background Checks

- May not license a person or entity who has been convicted of certain crimes
- [http://www.legis.state.wi.us/rsb/code/hfs/hfs012\\_app\\_a.pdf](http://www.legis.state.wi.us/rsb/code/hfs/hfs012_app_a.pdf)
- After licensure – agency is responsible for completing caregiver checks on its employees and contractors at the time of hire and at least every 4 years thereafter

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## Application Review

- First step – Application review
- Administrator qualifies
- Geographic location appropriate
- Fees paid

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## Next Step

- Policies and procedures will be reviewed by survey staff

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## Financial Requirements & Reimbursement

Marianne Missfeldt, RN  
Home Health/Hospice Nursing Consultant  
Division of Quality Assurance

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## Financial Solvency

- WI Administrative Code HFS 133
  - Sufficient for at least 90 days
  - Recommendation of 6 months
- Medicare requirement – CMS 855A
  - Reserve operating funds for 3 months
  - 50% of reserve funds NOT borrowed

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## Financial Solvency

- Medicaid requirement
  - No capital reserve required on application

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## Reimbursement

- Prior to licensure/certification
  - Medicare
    - No payment until Medicare sets effective reimbursement date
    - Payment is not retroactive
  - Medicaid
    - No payment until licensed/certified
    - Payment retroactive to effective date
  - Private pay
  - Insurance

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## Reimbursement

- After licensure/certification
  - Medicare
    - Through National Government Services (NGS)
  - Medicaid
    - Through EDS
  - Private Pay
  - Insurance

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## Reimbursement

- [http://dhfs.wisconsin.gov/medicaid/home\\_health\\_44/handbooks.htm](http://dhfs.wisconsin.gov/medicaid/home_health_44/handbooks.htm)

There are underscores after home\_ and after health\_

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## Regulations, Codes and Statute that Apply to HHAs

Mark Andrews  
DQA

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## Statute, Code and Regulation

- Wisconsin Statute Chapter 50
- Health Family Services Administrative Codes 12, 13 and 133
- Code of Federal Regulations Part 484
- Cross Reference for the State and Federal requirements

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## Wisconsin State Statute Chapter 50

- ❑ Provides the Department of Health and Family Services the authority to promulgate codes for home health agencies
- ❑ Contains the definition of what is a home health agency
- ❑ <http://www.legis.state.wi.us/statutes/Stat0050.pdf>

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## HFS Admin. Code 133

- ❑ Contains the State codes for home health agencies
- ❑ Compliance with the requirements listed in HFS 133 is necessary to become a State licensed home health agency
- ❑ For agencies wishing to become Medicare/Medicaid certified, state licensure is the first step
- ❑ [www.legis.state.wi.us/rsb/code/hfs/hfs133.pdf](http://www.legis.state.wi.us/rsb/code/hfs/hfs133.pdf)

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## Caregiver Background Checks

- ❑ HFS 12 – addresses the requirements of caregiver background checks
- ❑ <http://www.legis.state.wi.us/rsb/code/hfs/hfs012.pdf>

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### Reporting of Abuse, Neglect and Misappropriation

- HFS 13 – addresses the requirements for reporting of abuse, neglect and misappropriation
- <http://www.legis.state.wi.us/rsb/code/hfs/hfs013.pdf>

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### Code of Federal Regulations

- Part 484 contains the “Conditions of Participation” (CoP)
- The CoPs contain the Federal requirements to participate in the Medicare Program
- [http://www.cms.hhs.gov/GuidanceforLawsAndRegulations/downloads/som107ap-b\\_hha.pdf](http://www.cms.hhs.gov/GuidanceforLawsAndRegulations/downloads/som107ap-b_hha.pdf)

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### Comparison HHA Rules and Federal Conditions of Participation

- Allows the reader to compare both the State and Federal requirements for home health agencies using one document
- A valuable tool for those agencies currently working on becoming State licensed, but having the end goal of becoming Medicare certified

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## Conclusion

- ❑ For state licensure WI Stat. 50, HFS 133, 12 and 13
- ❑ For Federal Certification all the codes listed above and CFR Part 484

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## Pre-licensure Desk Review

Bobbi Stanford, RN  
Home Health Surveyor

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## Governance

- Send the names of your governing body members.
- Send copies of your policies with your specific agency name.
- Send a statement of services you are going to provide.
- Send a description of how the governing body will oversee the management of your agency.

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## Duties of the Governing Body

- Adopt written governing policies.
- Adopt a statement detailing services you are going to provide.
- Oversee the management of your agency.
- Appoint a qualified Administrator and Assistant Administrator.

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## Governing Body vs. Advisory Board

- The governing body is not the same as the Advisory Board.
- The Advisory Board must consist of the following:
- At least one practicing physician and one Registered Nurse, and appropriate representatives from other professional disciplines, whom the majority are not owners or employees of your agency.
- Send the names of these members along with their titles and or a description of who they are.

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## Administration

- Send the name of your Administrator and Substitute Administrator.
- Your Administrator can be a licensed physician, a Registered Nurse, or a person who has had one year of supervisory or administrative experience in home health care or related health programs.
- Send their qualifications.

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## Personnel Policies

- Send copies of the following written policies:
- A system of recruitment. How are you going to find adequate staff?
- Orientation. What your orientation plan is (see slides #56 and #57).
- Continuing education. All staff need continuing education, but Aides must have at least 12 hours annually.
- Plan for evaluation of staff in the performance of duties. You must evaluate performance of each staff member at least annually.

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## Employee Orientation

- Send copies of your orientation program, which must include the following:
- Policies and objectives of your agency.
- A description of specific job duties for each discipline. Such as the nurse will supervise nursing assistants at least every 2 weeks.
- Functions of how your staff will relate to one another in providing services. Such as, aides shall report to the nurse: changes in patient conditions, etc.

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## Employee Orientation

- Information about other community agencies, including emergency medical services.
- Work ethics.
- Confidentiality of patient information.
- Patient rights.



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## Disease Surveillance

- Send copies of your written policies for control of communicable diseases and infected skin lesions.
- When and how frequently are you going to test/screen staff for Tuberculosis?
- What will you do if staff reports for work with a contagious disease?
- What will you do if staff reports for work with an infected skin lesion?
- All staff having direct patient contact must have been screened for tuberculosis and found free from apparent communicable disease within 90 days prior to providing patient care. This must be in writing and can be done by a physician, a physician assistant, or registered nurse.

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## Program Evaluation

- Send us information on how your advisory Board/Group will evaluate your total program on a yearly basis.

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## Patient Rights

- Send a copy of your written patient rights statement that you will provide to each patient prior to providing services.
- Patient rights can be found at the following web site:  
[dhfs.wisconsin.gov/forms1/oqa.2646](http://dhfs.wisconsin.gov/forms1/oqa.2646).
- Send your patient rights policies.

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## Complaints

- Send your complaint policies.
- You must have policies of how you are going to report to the state any alleged abuse, neglect, and misappropriation of property allegedly done by your staff. You will need to include how you will investigate and protect patients during the investigation.
- Your policies need to include what you will do when a patient or family member voices a complaint.
- Send a copy of the State of Wisconsin complaint form. This form can be found at the following web site: [dhfs.wisconsin.gov/forms/1/oqa.2069](http://dhfs.wisconsin.gov/forms/1/oqa.2069). This form identifies how patients can register a complaint with the State of Wisconsin.

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## Service agreement/Acceptance and discharge of patients

- Send copies of your written policies for acceptance and discharge of patients.
- A copy of your service agreement which includes the following:
  - Services provided.
  - Fees for the services provided.

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## Services Under Contract and Qualifications

- Send a copy of each of the contracts, which includes the following:
  - A statement that patients are accepted for care only by your agency.
  - A list of the services to be provided.
  - Agreement to conform to all agency policies.

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### Services Under Contract

- A statement of the contractor's responsibility for participating in the development of patient plans of care.
- A statement regarding how services will be controlled, coordinated, and evaluated by your agency.
- Procedures for: submitting clinical and progress notes, scheduling visits, and periodic patient evaluations.

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### Services Under Contract Qualifications

- It is your responsibility to ensure that contract staff are qualified.

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### Plans of Care

- Send a copy of patient plans of care for: nursing and home health aide.
- Send a copy of patient plans of care for: therapy or personal care worker (if these services are provided).

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### Plans of Care

- Send your policies on the plans of care, which include:
- Initial plan developed within 72 hours of acceptance.
- Plans will be incorporated in patient records.
- Plans signed by physicians within 20 working days of the patient's admission.

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### Plans of Care

- Patient plans of care must:
- Include measurable goals with bench mark dates for review.
- Be individualized, specific to each patient.
- State methods for providing care. Such as, dressing changes to abdominal wound 3 times per week using clean (sterile) technique.
- State frequency of visits for each discipline.
- Indicate which discipline is responsible for which tasks.

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### Content of Plans of Care

- List primary and pertinent diagnoses.
- List medical supplies provided by you.
- List current medications and treatments.
- Identify start of care date.
- Identify certification period.
- Identify discharge plan.
- Identify other pertinent information: such as address and telephone number, impairments, etc.

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## Examples of Plans of Care Goals

- If the patient has pain, you need to establish what degree of pain the patient can live with. Your goals could be:
  - Patient’s pain will be controlled at 0 to 2 by 1/10/08 as evidenced by patient report.
  - Patient’s pain will be controlled at none to mild by 1/10/08 as evidenced by no facial grimacing.



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## Examples of Plans of Care Goals

- If the patient has a wound, your goals could be:
  - Patient’s wound will be healed by 1/1/08 as evidenced by tissue granulation and closure.
  - Patient’s wound will show evidence of healing by 1/1/08 as evidenced by decreased size and depth.

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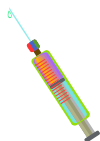
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## Examples of Plans of Care Goals

- If the patient has diabetes, you need to establish what blood sugar parameters are appropriate for the patient. Your goal could be:
  - Patient’s blood sugars will remain between 120 to 150 for this certification period.



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## Medical Records

- Send copies of your written policies regarding patient medical records. Your policies need to reflect the following:
- Records are complete, accurate, legible, systematically organized, and readily accessible.
- How records are safe guarded against loss, destruction, and unauthorized use.

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## Medical Records

- How you are going to control use and removal of records.
- Identify conditions for release of information.
- Send a copy of your accepted abbreviation list.

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## Readiness for Regular Licensure Survey

Marianne Missfeldt, RN  
Home Health/Hospice Nursing Consultant  
Division of Quality Assurance

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### Patients Served

- HFS 133.03(4)(b)3
  - Admitted/cared for 10 skilled patients
  - Must have 7 active skilled nursing when full-operations letter submitted
  - Must have 3 skilled nursing patients at the time of the on-site survey

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### Full Operations Letter

- Written notification includes:
  - Served appropriate patient census
  - CMS 855 completed if applying for Medicare
  - Capitalization requirements completed
  - Fiscal intermediary approval received

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### Full Operations Letter

- Include:
  - Copies of plans of care for 10 skilled patients
  - Copies of medication lists for those 10 skilled patients

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## THE SURVEY PROCESS



### Division of Quality Assurance

LouAnn Brown, RN  
Beverly Samplaski, RN  
Mary Jo Sutton, RN  
Home Health Surveyors

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## PRE-SURVEY

- Served 10 Skilled patients (BQA Memo 99-029)
- OASIS: confirm test transmission if seeking Medicare Certification as well



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## ENTRANCE CONFERENCE

- Survey staff always present identification
- Meet with Administrator or designee
- Introductions, type of survey
- Surveyor Requirements are
  - Place to work & access to key staff members
  - Requested documents will be
    - # of skilled unduplicated admissions
    - List of current clients
    - List of all employees- direct and contracted
    - Home visit schedule of all disciplines
    - List of discharged clients



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## HOME VISITS

- Purpose of the visit
- Patient Consent
- Focus of the Surveyor
  - Observations & Interviews
  - Patient Rights and Satisfaction
  - Implementation of the Plan of Care
  - Infection Control practices
  - Medications, Diet, Teaching, & Assessments
  - Continuity and Co-ordination of services
  - Goals, Outcomes, & Supervision



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## CLINICAL RECORD REVIEW

- Done on all home visit patients
- Review open and closed records
- Entire clinical record is reviewed - filing must be current
- Surveyors have a module to fill out on each record



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## PERSONNEL RECORD REVIEW

- Staff qualifications (license, certification, etc. for all staff, including contracted)
- Orientation and performance reviews
- Background checks
- Health information
- Continuing education



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## DAILY COMMUNICATION



- “No Surprises” survey
- Done throughout the survey
- After all home visits are completed
- At the end of each day, if agency wishes

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## INFORMATION ANALYSIS

- We review all gathered information
- Are regulatory requirements met?
- Outcome, or *potential* outcome
- Degree of severity
- Frequency and trends
- Preliminary results



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## EXIT CONFERENCE

- Agency can decide who attends
- Preliminary findings are presented
- State violations and/or Federal deficiencies
- Frequent areas of difficulty
  - Plan of Care
  - Medical Records
  - Infection Control
  - Skilled Nursing



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## PLAN OF CORRECTION

- Time lines:
  - SOD= 10 working days
  - POC = 10 calendar days
- POC must include *what, how, who, and when*, & be signed and dated
- Accepted or Rejected? Contact will be made by the surveyor
- KEY: Develop, Achieve, Sustain



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## REFERENCES

- State Operations Manual with Appendices
- Survey Guide for Home Health and Hospice
- WI Administrative Code HFS 133
- 42 CFR 484
- Survey Forms may be found at:  
<http://dhfs.wisconsin.gov/rlds/HHAs/hbaApplicatn.htm>

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## Medicare Certification

Marianne Missfeldt, RN  
Home Health/Hospice Nursing Consultant  
Division of Quality Assurance

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## Centers for Medicare & Medicaid Services

- Certifies
- Determines effective date
  - S & C memo 01-02
  - State Operations Manual, Section 2780

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## Required Forms for Medicare Certification

- Submit to DQA
  - CMS-1572
  - CMS-1561
  - Expression of Intermediary Preference
  - Medicare Certification Civil Rights Information Request Form

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CMS 1572

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

HOME HEALTH AGENCY SURVEY  
AND DEFICIENCIES REPORT

1. Agency Name: \_\_\_\_\_

2. Agency Address: \_\_\_\_\_

3. Agency City: \_\_\_\_\_

4. Agency State: \_\_\_\_\_

5. Agency Zip: \_\_\_\_\_

6. Agency Telephone: \_\_\_\_\_

7. Agency Fax: \_\_\_\_\_

8. Agency Email: \_\_\_\_\_

9. Agency Website: \_\_\_\_\_

10. Agency Type: \_\_\_\_\_

11. Agency Status: \_\_\_\_\_

12. Agency License Number: \_\_\_\_\_

13. Agency License Expiration Date: \_\_\_\_\_

14. Agency License Issued By: \_\_\_\_\_

15. Agency License Issued On: \_\_\_\_\_

16. Agency License Issued For: \_\_\_\_\_

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## Required Forms for Medicare Certification

- Submit to NGS
  - CMS-855A

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### Tips to Facilitate the Medicare Enrollment Process for Institutional Providers (CMS-855A)

- To ensure that your Medicare enrollment application is processed timely, you should:
- 1. Submit the 2006 version of the Medicare enrollment application (CMS-855).**

Effective May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) revised the CMS-855 Medicare enrollment application. Providers and suppliers must submit the appropriate 2006 version of the CMS-855 Medicare enrollment application. The application version can be found in the lower left corner of the application.

If an applicant submits the 11/2001 version of the CMS-855, the Medicare contractor will return this application without further review.

An electronic copy of the current CMS-855 Medicare enrollment application follows this tip sheet.
  - 2. Submit the correct application for your provider or supplier type to the Medicare fee-for-service contractor working your State or location.**

The Medicare contractor that serves your State or practice location is responsible for processing your enrollment application. Applicants must submit their applications to the appropriate Medicare fee-for-service contractor. A list of the Medicare fee-for-service contractors by State can be found in the download section of <http://www.cms.hhs.gov/MedicareProvidersEnroll/>.
  - 3. Submit a complete application.**

When completing the CMS-855 for the first time, each section of the application must be completed in ink (blue preferable). When reporting a change to your enrollment information, complete each section listed in Section II of the CMS-855.

**Note:** If you are enrolled in Medicare, but have never submitted the CMS-855, you are required to submit a complete application. Providers and suppliers should follow the instructions for completing an initial enrollment application.

The attachment at the end of this document provides tips for completing certain sections of the CMS-855.
  - 4. Request and obtain your National Provider Identifier (NPI) number before enrolling or making a change to your Medicare enrollment information.**

CMS requires that providers and suppliers obtain their National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare. A Medicare contractor will not process your enrollment application without the NPI and a copy of the NPI certification letter received from the National Plan and Provider Enumeration System or from the organization requesting your NPI. The NPI certification is required with each CMS-855 application you submit.

If you do not have an NPI, please contact the NPI Enumerator at <http://nppes.cms.hhs.gov> or call the Enumerator at 1-800-465-2226 or TTY: 1-800-992-2226.

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## Outcome and Assessment Information Set (OASIS)

- Basics
  - What is it?
  - Adult, non-maternity Medicare, Medicaid patients receiving skilled care
  - Transmission of OASIS data
    - Dedicated computer
    - Must demonstrate ability to transmit prior to certification survey

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## Outcome and Assessment Information Set (OASIS)

### ■ Resources

- OASIS Implementation Manual
- Chris Benesh, OASIS Automation Coordinator
  - 608-266-1718

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## Billing Medicare

- After certification survey
- After receiving effective date
- Through NGS

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## Summary

- Purpose
- Definition of Home Health
- Skilled Nursing
- Compliance
- Home Health Application
- Initial Survey
- Regulations

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## Summary

- Thank you for your attention. If you have questions please contact the following:
- Marianne Missfeldt-Home Health Nurse Consultant (715) 836-4036
- Janet Heimbruch-Section Chief (608) 266-0371
- Mark Andrews –Section Chief (608) 266-0269
- Lora Quinn-Section Chief of Licensing (608) 266-7485

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