Home Health Agency
Annual Statistical Report
January 1 through December 31, 2016

The Annual Statistical report is not optional; all home health agencies are required to submit this data.

Please read all instructions before completing this report.

Responses are DUE by January 31, 2017

Submit this 2016 Home Health Agency Annual Report electronically to:
homehealthannualreports@health.mo.gov

After the Bureau of Home Care & Rehab Standards receives the data the information will be sent to the Missouri Alliance for Home Care to be compiled into the annual report.

Bureau of Home Care & Rehabilitative Standards will only accept Home Health Agency Annual Report Electronically!

HOME HEALTH AGENCY ANNUAL REPORT
DEFINITIONS AND INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ANNUAL REPORT. All information given in this Annual Report should be for services rendered to patients in Missouri. Please do not include data on patients residing in states other than Missouri.

GENERAL DEFINITIONS

- **Agency Name and Address -** (reported on page 1) – Select your agency name with the CMS provider number from the drop down. The address and county will automatically fill in below. Select only the name and location of the **licensed** agency in Missouri for which this data is reported. Do not select the home office/corporate headquarters if that is not the licensed agency submitting this data. The data in the drop down list is current as of December 1, 2016. If the agency for which you are reporting data has had an address or name change after this date or if the information listed is incorrect please contact the Bureau of Home Care and Rehab Standards at 573-751-6336.

- **County -** (listed on page 1) – No action required. The county will pre-populate based on the agency selected from the drop down menu.

- **Number of Branch Offices -** Enter the total number of branch locations of the agency as of December 31 of this report year.

- **CMS Certification Number (CCN) –** No action required. The CCN (previously the Medicare provider number) will pre-populate based on the agency selected from the drop down menu.

- **NPI # -** Enter your National Provider Identifier number. Health care providers such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and home care companies who transmit health information electronically are required to obtain NPIs. For further information visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

- **Agency Types**
  - **Facility Based –** Any home health agency that is owned or affiliated with a hospital, nursing facility or rehabilitation facility.
  - **Freestanding -** Any home health agency that is **not** owned or affiliated with a hospital, nursing facility or rehabilitation facility.
  - **Government Based –** Any home health agency that is County, City-County, City, or District owned or affiliated.

- **Unduplicated Intermittent Patients -** (reported on page 1, Item 1) - The number of individuals receiving **intermittent** service from an agency during the report year **counted only once, regardless of the number of services, frequency of admission, or payor source.**

- **12/31/2015 Census:** Insert the end of year census as reported on the prior year annual survey. This number should be close to the number reported in line 2 – Census 1/1/2016. This is for informational purposes only to assist with data comparison.

- **Admissions (General Definition) -** [reported on page 1, Item 3(a)] - The total number of admissions during the report year regardless of the number of individuals involved. For example, the same individual admitted more than once during the reporting period would be counted each time admitted. Multiple admissions of same patient would be included in 3a total.

- **Intermittent Visits -** Direct face-to-face contact with a client for the purpose of delivering service measured in visits regardless of length of time of the visits or payment source. Include all visits made during the report year, including visits for patients already on service at the beginning of the report year. Intermittent data is required information. Agencies must complete **all** sections of the Annual Report form.

- **Medicare PPS Patients -**Report all requested information for patients covered by regular Medicare, billed to the Medicare Fiscal Intermediary

- **Medicare Managed Care** -Report all requested information for Medicare patients covered by an approved Medicare Health Maintenance Organization (HMO) plan

ITEM-BY-ITEM INSTRUCTIONS

ITEM 1 UNDUPLICATED INTERMITTENT PATIENTS: Patients admitted during the calendar year. Enter the unduplicated intermittent patients admitted (this is equal to the number of individuals receiving **intermittent** service from an agency during the report year **counted only once**, regardless of the number of admissions, frequency of admission, number of services, or payor source to the agency from the period January 1 - December 31 of the report year.) The total of this line **will not** correspond with any other totals reported on this Annual Report. **The number of unduplicated intermittent patients must be equal or less than the intermittent admissions in Item 3a.**

12/31/2015 CENSUS: Insert the end of year census as reported on the prior year annual survey. This number should be close to the number reported in line 2 – Census 1/1/2016. This is for informational purposes only to assist with data comparison.

ITEM 2 INTERMITTENT CENSUS ON JANUARY 1: Enter the number of patients receiving **intermittent** services at the beginning of the business day on January 1 of the report year.

ITEM 3 INTERMITTENT ADMISSION AND DISCHARGE SUMMARY

(a) Admissions: Enter the number of **intermittent** admissions - those admitted **after** the beginning of the business day on January 1 of the report year. (See definition above for “Admissions.”) The number of intermittent admissions must be equal or greater than the unduplicated intermittent patients in Item 1.

(b) Discharges: Enter the number of times intermittent services to patients were terminated in the report year.

ITEM 4 INTERMITTENT CENSUS ON DECEMBER 31: This number will automatically be calculated. The number is derived from the following: # 2 + 3a – 3b = 4

ITEM 5 NUMBER OF MEDICARE PPS EPISODES ENDED DURING THE YEAR:
A Medicare PPS Episode is 60 days or less. Each 60-day certification period is considered an episode.

Coverage for Medicare PPS beneficiaries is covered in “episodes” of care not to exceed 60 days in duration. Enter the number of episodes ended during the reporting year, including both episodes ended due to completion of a 60 day period (patients eligible for recertification and start of a new episode during the same admission) and episodes ended due to patient discharge. Episodes in process at the beginning of the year are included, but episodes started during the year and in process at the end of the year are not included.

ITEM 6 DISPOSITION UPON DISCHARGE: Refers to the level of care to which the client was discharged upon termination of services. Self/Family Care includes independent resources such as family and neighbors. Do not include patients who are discharged (or transferred) from one source of payment and immediately receive services under another payment source; only those discharged **from the agency** should be counted here. The total (g) will equal the total of Item 3, line (b).

ITEM 7 VISITS BY DISCIPLINE & PRINCIPAL PAYOR SOURCE: Include the number of intermittent visits made for each discipline and principal payor source listed. Include all visits, made during the report year, including visits for patients already on service at the beginning of the report year.

ITEM 8 PATIENTS BY PRIMARY DIAGNOSIS (ICD-10-CM) AT TIME OF ADMISSION: List the number of patients according to the primary diagnosis at the time of admission. Only include admissions made after January 1 and through December 31 for the report year. The total (w) will equal the total Item 3, line (a); Item 9, line (h); and Item 10 total admissions.

ITEM 9 PATIENTS BY AGE: List the number of patients according to age at the time of admission to the agency. Only include admissions made after January 1 and through December 31 of the report year. The age categories listed correspond with the age guidelines for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and other funding sources. The total (h) will equal the total of Item 3, line (a); Item 8, line (t) and Item 10 total admissions.

ITEM 10 NUMBER OF ADMISSIONS BY COUNTY: List the intermittent admissions made within each county. In the admissions columns, only include admissions made after January 1 and through December 31 of the report year. The totals at the bottom of the page will correspond as follows: intermittent total number of admissions will equal the total of Item 3, line (a); Item 8, line (t) and Item 9, line (h).

- **VALIDATE AGENCY** – Click “yes” to verify agency name, provider number and address listed on page 1 is correct.

CHECK YOUR 2016 ANNUAL REPORT TOTALS!

Avoid errors in your data reporting. Use this page as a cross-reference to be sure your section totals are correct.

NOTE: Do not include data for patients residing outside of Missouri. **Only report information for services rendered to patients in Missouri.**

Y	Total of This Item:	Should Equal the following Items:	Other Hints
	1	No other sections	The number of unduplicated intermittent patients must be equal or less than the intermittent admissions in Item 3a.
	2	No other sections	Vertically: check calculations for columns. Add Item 2 plus Item 3(a) minus Item 3(b). Should equal Item 4
	3(a)	8(t); 9(h) & 10 total admissions	
	3(b)	6(g)	
	4	No other sections	
	5	No other sections	
	6(g)	3(b)	
	7(h)	No other sections	Item 7 should add correctly both vertically and horizontally.
	8(t)	3(a) total; 9(h) & 10 total admissions	
	9(h)	3(a) total; 8(t) & 10 total admissions	
	10 admissions	3(a) total; 8(t) & 9(h)	