Home Health Line

Regulatory news, benchmarks and best practices
to build profitable home care agencies

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Clinical training

Agencies should take several steps to avoid diabetes claims denials

Medicare Administrative Contractor (MAC) Palmetto GBA has started issuing full denials on home health claims with a diagnosis of diabetes coded in either M1021 (Primary diagnosis) or M1023 (Other diagnoses) when there is no current HbA1c test result on file.

Home health experts believe this ultimately could expand to other MACs as well.

For agencies to avoid denials right now within Palmetto's territory, results from HbA1c tests within 120 days should be on

*(see **Diabetes**, p. 5)*

Visit utilization

Data show lower therapy usage: Prepare for greater quality, efficiency going forward

New CMS data emphasize the importance of making every therapy visit count by adopting more efficient treatment plans and documentation processes.

Doing so will be key to staying competitive as CMS implements value-based purchasing and bundled care initiatives, which reward providers for improving outcomes while offering cost-effective care and smart visit utilization, says Dr. Kenneth Miller, clinical educator at Catholic Home Care in Farmingdale, N.Y.

*(see **Therapy**, p. 6)*

M&A: Medicare home health

M&A experts: When it comes to sales, the state of home health is strong

Mergers and acquisitions experts are bullish on the state of Medicare home health sales now and for the next several years.

Potential buyers are comforted by the fact that with rebasing, there's a certainty about where the industry is heading — and buyers love certainty, says Dexter Braff, president of Pittsburgh-based mergers and acquisitions advisory firm the Braff Group.

The industry has rebounded from the financial crisis — when valuations and activity were depressed — by having a lot of activity and a number of large transactions in 2015, adds Jack Eskenazi, managing partner of Healthcare Advisory Partners in Los Angeles.

Among the biggest deals in 2015: HealthSouth acquired Encompass, which acquired CareSouth. Also, Amedisys bought Florida-based Infinity HomeCare in a $63 million deal and Almost Family bought Ohio-based Home Care by Black Stone in a $40 million deal.

Even though Braff says the sheer number of Medicare home health sales dropped from 65 in the first three quarters of 2014 to 32 in the first three quarters of 2015, the quality of deals remained high and indicates the market has remained strong, he says. Also, sales in the health care services industry as a whole are down about 25% from 2014 to 2015.

"In just six months, you got five or six good deals that have occurred," Braff says. "And those deals don't happen when people are afraid of the market."

Put yourself in the best position to sell

- **Look at referral sources.** Buyers want to purchase a business that can carry on operating without the current owner/operator and continue to sustain referrals and solid care management plans, says Scott Osborne, managing principal at home care mergers and acquisition practice Osborne HomeCare Group of St. Louis.

Reputation is crucial when it comes to selling in the Medicare home health and private duty industries. Agencies should make sure they fully track and quantify the value of referral sources, he says. Buyers realize that people typically refer to home care and home health agencies based on reputation and reliability, not just on relationship with the owner.

- **Look at office staff data.** Keep a record of the tenure and performance of your office employees, Osborne advises. While there is no hard and fast rule in terms of precise retention rates, buyers want to see excellent retention rates for this workforce, as it is key to the continued success of the agency through the purchase transition.

- **Look at knowledge and knowhow.** You'll also want to demonstrate you are on top of tracking other key performance indicators.

For Medicare home health and private duty agencies, this includes where you're obtaining employees, how

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many inquiries you receive, how many of these turn into home visits, how many of these turn into clients/patients and how long your clients/patients stay with you. And for private duty, you also should track how much clients spend over the course of service, Osborne says.

Also, ask through exit interviews why your agency is losing clients/patients, Osborne recommends. Is it through natural attrition, poor service or otherwise?

"Understand why you get them and why you lose them," he says. — *Josh Poltilove (jpoltilove@decisionhealth.com) and Nicholas Stern (nstern@decisionhealth.com)*

M&A: Private duty

Experts contend now is a great time to sell in the private duty industry

Highly favorable market conditions and a steady demand for home care acquisitions reported by industry experts mean it's a great time to sell your home care business.

That's due to a mix of factors, including the fact that many baby boomers, who prefer to age in place, still have to reach the age — 75 and older — when they'll require home care services, says Scott Osborne, managing principal at home care mergers and acquisition practice Osborne HomeCare Group of St. Louis. The better an agency's outlook, the more attractive it is to a potential buyer.

Steady industry growth — about 10% from 2013 to 2014, according to Home Care Pulse's 2015 Private Duty Benchmarking Study — combined with low interest rates that make borrowing easier and a favorable view of the industry among banks is making home care businesses attractive to a variety of buyers, Osborne says.

But to get full market value for your agency, which can earn you as much as 10% more than a fair market value, make sure you leave yourself a one- to three-year planning window to make your business more attractive to buyers, he says.

Use that extra time to gather data that's fundamental to demonstrating your agency is an attractive buy, Osborne adds.

At the top of this list, ideally owners should include two years of monthly accrual statements that break out the cost for caregivers, including payroll and workers' compensation insurance, says Don Cummins, president of Florida-based Stoneridge Partners, a health care mergers and acquisitions firm.

Since 2010, the Osborne HomeCare Group has taken 60 home care firms to market in deals that value about $75 million, Osborne says.

Fifty-five of those firms were acquired, and of those, about 20% took one to three years to prepare for their sale, while the remainder went to market in about a month. Those who planned longer saw better outcomes, Osborne says. — *Nicholas Stern (nstern@decisionhealth.com)*

RAC reviews

CMS plan for RAC reviews of MA programs threatens agencies' bottom line

Medicare Advantage plans may soon come under the scrutiny of recovery audit contractors (RACs), and industry experts contend that ultimately could hurt home health agencies' bottom lines.

If the RAC program begins recouping money from the plans, the rates your agency receives ultimately may get even worse, says attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath and Lyman.

In a December 2015 request for information, CMS outlined how its recovery audit program would expand to include examining Medicare Advantage claims. Comments on the request for information about the Medicare Advantage RAC program are due by 10 a.m. EST Feb. 1. After that, CMS will determine the next steps for procurement of a RAC.

CMS is expected to task RACs with conducting risk-adjustment data validation reviews. Although such reviews of Medicare Advantage in the past have been sparse, they have led to millions in recoupments.

Medicare Advantage plans receive payments from the government based on risk-adjustment scores. The sicker and more in need of care its members are, the more money the insurer receives.

Indeed, risk validation is a "big fraud area for Medicare Advantage," contends Emily Evans, a partner and legislative/regulatory analyst for Nashville-based Obsidian Research Group. Obsidian is a research firm serving investment professionals and health care executives.

The risk-adjustment validation reviews will look at a sample of medical records to determine whether Medicare

Advantage plans are intentionally inflating risk scores in an attempt to receive higher payments, Evans says.

As part of its tasks, RACs also will perform condition-specific, risk-adjustment data validation audits. The program will focus on specific codes or conditions with high rates of payment errors. For example, CMS says, it may be decided that diabetes should be the subject of this targeted review.

"Errors and omissions in the diagnosis data submitted to CMS by Medicare Advantage organizations are the drivers of the 9.5% improper payment rate in Medicare Part C," CMS says in a draft statement of work.

CMS currently audits 30 Medicare Advantage contracts — about 5% of its total Medicare Advantage contracts — per year.

With the help of the RAC program, CMS says its goal is to have all Medicare Advantage contracts subject to a comprehensive or condition specific risk-adjustment data validation audit each payment year.

How long will it be until the RAC arrives?

The process of securing a RAC could take at least a year, given the steps required for a contract to be awarded and the potential legal challenges CMS may face after it awards a contract, Markette predicts.

CMS says the RAC program ensures the proper amount of taxpayer money is being paid. But providers including home health agencies have long argued that RACs are incentivized to identify overpayments even when overpayments don't exist. That's because the more money RACs recover, the more money RACs get paid, Evans says.

When the RAC program expands to include Medicare Advantage, as required by the Affordable Care Act, one or more recovery auditors will investigate whether Medicare Advantage plans are making inappropriate payments to providers.

Millions collected in first round of audits

Reviews based on 2007 payment data resulted in $13.7 million being recouped from sampled beneficiaries, according to a December 2015 CMS document.

Among the recoveries: More than $1 million from Independence Blue Cross, more than $1 million from Elderplan, Inc. and nearly $1 million from Aetna Health, Inc.

The document doesn't detail how much money those plans initially received from the government.

For the 2011 and 2012 payment reviews, 30 plan contracts for each year were selected.

With the 2011 reviews, "Medicare Advantage organizations have submitted their medical records and CMS is currently reviewing this medical record documentation," the CMS document states. "Unlike the 2007 audits, the payment error calculated for the sampled beneficiaries in these audits will be extrapolated to the contract population. For this reason, CMS expects much more significant recoveries from the 2011 audits."

How agencies should react to the RAC

- **Make sure you're properly coding claims submitted to Medicare Advantage** and that your documentation is thorough. If during a risk-adjustment validation review a RAC says a Medicare Advantage plan made one of your agency's patients appear sicker than he actually was, the insurer is likely to turn around and audit your claims, Markette says.

"Bad things tend to roll downhill, and you're the home health agency and at the bottom of the hill," he says.

- **Be wary of expanding into Medicare Advantage.** And take a hard look at what the plans pay and how much money you'll make for providing care, Markette says. Right now, many agencies already find Medicare Advantage rates to be low. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

HHCAHPS submission

CMS to make HHCAHPS data submission for agencies unavailable for two weeks

The HHCAHPS Data Submission Tool will be unavailable for about two weeks beginning Jan. 25 as the HHCAHPS Coordination Team transitions the tool to accept ICD-10 codes.

CMS is asking agencies to refrain from submitting data files until an announcement has been posted indicating the submission tool is available again.

Once the tool reopens, submit at least one data file containing ICD-10 codes prior to the April 21 deadline to ensure you can successfully submit with the new code format, CMS says.

Contact the HHCAHPS Survey Coordination Team if you have any questions about HHCAHPS registration or vendor authorization. Email the team at *hhcahps@rti.org* or call 866-354-0985.

Quality outcomes

Educational OASIS data submission reports will be available by end of January

CMS will make interim Quality Assessment Only (QAO) data available through CASPER reports that show agency performance against the QAO metric.

Recall that CMS finalized in the 2016 PPS final rule its pay-for-reporting performance requirement of submitting 70% of its quality assessments to CMS through ASAP on or after July 1, 2015, and before June 30, 2016, with appropriate start-of-care (SOC) dates or be subject to a 2% reduction to their market basket update for 2017.

CMS will ramp up its required percentage of submitted quality assessments to 80% for the reporting period from July 1, 2016, to June 30, 2017, and 90% for the July 1, 2017, to June 30, 2018, reporting period and thereafter, it says in the final rule.

CMS says in a Jan. 12 post that the interim QAO data is to be used for informational purposes only and will not be used to determine pay-for-reporting compliance. The first such report is scheduled to be released by the end of January and will be based on OASIS assessments completed from Oct. 1, 2014, to Sept. 30, 2015, CMS says.

The federal Medicare agency intends to release these informational reports quarterly going forward.
— *Nicholas Stern (nstern@decisionhealth.com)*

Related link: Find the brief on the QAO reports at *http://bit.ly/1U0PjYr*.

Diabetes

(continued from p. 1)

file, notes Lori Kao, medical review assistant for A.D. Maxim Consulting in Troy, Mich.

While there is no current edit in place for this specific piece of information, if documentation is requested in support of a home health service and the beneficiary has diabetes mellitus, Palmetto would expect to receive the hemoglobin A1c information as part of the documentation, a Palmetto spokesman tells DecisionHealth.

Kao has seen eight full denials of these types of claims from one Florida agency. She expects to see more.

"It is our experience that once we see a flat denial from Palmetto for an entire claim [over one] reason, we will end up seeing many more for that exact reason," she says.

The denials are the consequence of a Palmetto local coverage determination (LCD) that requires current HbA1c test results be noted in the charts of diabetes patients starting with services performed on or after Dec. 30, 2014.

The denials are for claims submitted with ICD-9 codes under Palmetto LCD L3541, Kao says. But don't expect them to stop: An identical LCD listing ICD-10 codes, L35132, took effect Oct. 1, 2015.

Experts warned that this could mean that claims could be downcoded for whatever points the diabetes codes earned or even denied in full — the latter of which is now coming to fruition.

LCD likely to spread to other MACs

For now, only agencies with Palmetto as their MAC are affected.

But MACs often pick up each other's LCD after a period of time, notes Brandi Whitemyer, product specialist for DecisionHealth in Gaithersburg, Md.

"So Palmetto implements an LCD, then after a bit, let's say a year or two, NGS will pick it up," she says. "Same thing with common claims edits for ADRs. They trickle down through the MACs over time."

Given patterns of practice with how MACs operate, Whitemyer expects the other MACs to pick up a similar or the same LCD regarding diabetes "at some point in the near/projected future."

Agencies should still code diabetes

Unfortunately, some coders appear to be responding to the denials by questioning whether it's wise to code diabetes on a claim at all unless it's the focus of care or receiving other active interventions.

That's a dangerous approach, though, because diabetes is an important comorbidity that always must be coded when it is present, according to official coding guidelines.

Diabetes is a serious disease that will have an impact on whatever health issue your agency focuses on, says Trish Twombly, senior director at DecisionHealth in Gaithersburg, Md.

It should be monitored even if considered stable.

So should you decide to simply leave a patient's diabetes diagnosis off the claim because there isn't a

current HbA1c test on file, you risk being cited on a survey for not addressing all of the patient's needs on the home health plan of care, Whitemyer says.

Agencies should provide adequate monitoring of diabetes by keeping tabs on the patient's HbA1c levels, she says. Agencies should consider investing in an HbA1c autocheck machine to ensure test results can be obtained. The machines can be expensive but are worth it to avoid denials of this nature, she says.

While a physician's order is required to run the test, the use of an agency's own machine is sufficient to provide the results and monitoring for the HbA1c value, Whitemyer says. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Therapy

(continued from p. 1)

All of the top 10 most common home health resource groups (HHRG) had lower levels (0-13 visits) of therapy, according to 2013 data on home health utilization, payments and submitted charges by provider, state and HHRG released by CMS in December 2015. (*See related benchmark, p. 7.*)

Industry experts believe a combination of changing dynamics, including intense auditor scrutiny on therapy use, likely were contributing factors that led to lower therapy utilization in 2013.

Another takeaway from the HHRG data is that agencies appear to have focused more on treating chronically ill patients, says Diana Kornetti, chief operations officer of Kornetti & Krafft Health Care Solutions.

Many of the top 10 HHRGs in 2013 by number of visits included those in which patients had high clinical and/or functional severity.

In cases where patients have COPD, dementia and/or chronic kidney disease, for instance, they typically don't require intensive bursts of therapy, Kornetti says.

Track time documenting vs. treating

To make fewer therapy visits count for more, agencies need to track at least on a monthly basis in their electronic health records (EHR) systems or data vendors the duration of therapy visits and how much time was spent treating the patient vs. documenting the visit, Miller says.

Quality or clinical managers can use clinicians' performance based on the agency's visit duration and documentation goals as a means to motivate staff to improve performance, he says.

A likely ideal visit would include 45 to 50 minutes of treatment and 10 to 15 minutes of documentation to ensure patients' deficits or impairments, planned interventions including patient goals and the outcomes of those interventions are accurately captured in clinical documentation, he says.

For example, the therapist will need to document objective range of motion data, limitations and interventions to improve the range of motion for a patient who's had a knee surgery and whose goal for treatment is returning to work or a favored hobby, Miller says.

Objective measurements could include that knee flexion is 40 degrees and knee extension is -10 degrees, while the goal of therapy is to get knee flexion to 90 degrees and knee extension to full or 0 degrees so the patient can get rise from his chair, ambulate normally and return to independent activities of daily living (ADL) function with normal gait function, he says.

More tips to improve efficiency, quality

- **Make sure your EHR follows clinicians' workflow as closely as possible.** For instance, your EHR should prompt clinicians to document results they gather about, for example, a patient's history, a review of systems and a physical examination, in the order they gather the information, Miller advises. This will save clinicians time.

Also, arrange "hard" and "soft" stops within the EHR so it doesn't needlessly slow workflow, Miller says. A hard stop forces the clinician to answer the question before moving on with documenting other parts of the assessment, while a soft stop prompts the clinician to answer or document but can be bypassed or returned to later as needed.

The system should require the clinician, for example, to conduct a 30-day functional assessment before moving on with the assessment, Miller says. Documenting on patient history and a review of systems could be designated as soft stops.

- **Have clinical managers evaluate at every recertification the potential need for therapy.** The clinical managers should check functional OASIS item

BENCHMARK of the Week

Top HHRGs by episode number

The following data for the top five HHRGs by highest number of episodes in 2013 was released by CMS in December 2015. (*See story, p. 1.*) The trove of data is dubbed the Home Health Agency Utilization and Payment Public Use File (Home Health Agency PUF). For data on total payment, visit *http://bit.ly/1U0h03t*. Find the larger data set here: *http://bit.ly/1Q8KI7i*.

HHRG	HHRG description	Total number of episodes	Unique beneficiaries served	Average Medicare payment amount
1CGK	Early Episode, 0-13 therapies, Clinical Severity Level 3, Functional Severity Level 2, Service Severity Level 1	490,124	430,045	$2,442
1BGK	Early Episode, 0-13 therapies, Clinical Severity Level 2, Functional Severity Level 2, Service Severity Level 1	328,128	305,101	$2,188
3BGK	Late Episode, 0-13 therapies, Clinical Severity Level 2, Functional Severity Level 2, Service Severity Level 1	326,933	176,063	$2,101
3CGK	Late Episode, 0-13 therapies, Clinical Severity Level 3, Functional Severity Level 2, Service Severity Level 1	288,978	152,448	$2,717
3CHK	Late Episode, 0-13 therapies, Clinical Severity Level 3, Functional Severity Level 3, Service Severity Level 1	254,721	114,943	$2,888

data from the patient's most recent assessment to see if the patient got worse and is need of a therapy evaluation order from a doctor and a potential to improve or maintain a patient's functional ability, Miller says. The topic should be brought up in team case conferences that include a quality manager and the assessing clinician.

- **Make sure quality managers track changes in clinical utilization.** This should be done on a quarterly, monthly or more frequent basis depending on how fast outcomes data changes, Miller says. CHF patients with sudden worsening of symptoms or readmissions may require more front-loaded visits and weekly monitoring by a supervisor, for instance, he says.

Quality managers need to continually monitor data in CASPER reports, publicly reported data and internal dashboards maintained by an outcomes data vendor

to see if changes in clinician frequency had a positive or negative impact on the agency's quality scores, he says.

- **Develop individualized care plans and demonstrate in documentation the skilled need of the therapist.** Include details about what disease, patient acuity, comorbidities and contextual factors like caregiver support require the unique skilled care through a specific number of visits, she says. For instance, a patient with CHF who has a network of caregivers who aid him in daily activities likely will require fewer visits than a patient with CHF who is also blind and has no caregiver support, Kornetti says. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *Find the 2013 CMS data at http://bit.ly/1Q8KI7i. Visit the Home Health Section of the American Physical Therapy Association (APTA) for examples of standardized care and professional guidance at http://www.homehealthsection.org.*

Documentation compliance

CMS data serve as a reminder for clinicians to reinforce outlier documentation

Document the exact reasons why a patient requires an outlier payment from CMS for frequent, routine care such as insulin shots or wound dressing changes. This will prevent your agency from losing thousands in payment denials.

States with agencies that had an unusually high percentage of outlier payments was among the topics highlighted by CMS in its release of 2013 data on home health utilization, payments and submitted charges by provider, state and home health resource group (HHRG). *(See related article, p. 1.)*

Many agencies in Utah, New York and Florida had high levels of outlier payments in 2013 as a percentage of total payments, including many agencies that had the maximum percentage allowed by law — 10%.

CMS caps outlier payments at 10% of episode payments. Agencies can sometimes mistakenly assume the percentage is based on the total percentage of patients, says Brandi Whitemyer, AHIMA-approved ICD-10 trainer, product specialist with DecisionHealth.

That means outlier payments for a single patient — say one who requires three insulin shots every day — can attract the attention of surveyors who will want to see why so much care was provided by your agency, Whitemyer says.

Tips to protect outlier payments

- **Document thoroughly at every visit.** Documentation at every visit must be thorough to justify a need for skilled care, Whitemyer says. For instance, a clinician should note if a diabetic patient is mentally disabled and doesn't have access to caregivers who can give insulin shots three times a day because the patient lives in a remote area and needs a home health nurse to do so.

  Include details in the documentation such a patient's mental status, a diagnosis of Down's syndrome or an IQ assessment, she says. Also, describe what the patient can and can't understand regarding insulin administration.

  Likewise, clinicians need to document at each visit that a patient has poor vision due to glaucoma or macular degeneration and tried but can't read the fine lines on an insulin syringe to accurately draw up a required dose, Whitemyer says.

- **Ask doctors for different orders when needed.** This can help reduce the number of visits to a patient that lead to outlier payments for, say, someone who needs regular, frequent wound dressing changes, Whitemyer says.

  For example, a doctor may order wet-to-dry dressings to treat a wound that may need to be changed up to several times a day, Whitemyer says. But clinicians may find that using a more expensive dressing, which only needs to be changed three times a week, ultimately will cost the agency less overall, as nursing costs are significantly reduced with fewer visits, she says.

- **Discuss outliers at every case conference.** This can help your agency keep a close watch on patients receiving outlier payments and reduce visits to these patients where appropriate, Whitemyer says.

  At each meeting, clinical and quality managers should discuss the patient's status and whether the patient remains eligible for home health and ongoing care continues to be justified, she says. If not, the patient should be discharged. — *Nicholas Stern (nstern@decisionhealth.com)*

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