

# Home Health Line

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### Audits and compliance

## Face-to-face developments prompt staffing changes, more physician education in 2015

Many agencies plan to shift roles internally and educate physicians in order to prepare for the changing face-to-face requirements and to prevent future denials.

Some agencies will send letters to physicians explaining the changes while others will visit offices and educate staff about the continued need to justify homebound status and the need for skilled care, according to 280 respondents to *HHL's* 2015 Trends Survey.

(see **Face to face**, p. 6)

### ICD-10 implementation

## Agencies brace for productivity declines, increased coding detail with ICD-10

The results are in: home health agencies nationwide believe the scheduled implementation of ICD-10 — more than payment cuts, Medicare audits or face-to-face changes — will have the biggest impact on home health operations and financials in 2015.

The implementation of ICD-10 on Oct. 1, 2015, will have the greatest regulatory impact for the home health industry, according to 32% of 274 respondents to a question within *HHL's* 2015 Trends Survey.

(see **ICD-10**, p. 8)

## Educate physicians about new face-to-face requirements



CMS is deleting the face-to-face narrative requirement yet still requires documentation supporting home care. It's up to your sales team to educate your referring physicians about these changes to avoid denials. Attend *HHL's* annual

**Power Home Health Referrals** conference to learn more. Get full details about this conference at: [www.powerreferrals.com](http://www.powerreferrals.com).

## OASIS-C1 implementation

### Prepare for new items, submission process when OASIS-C1 takes effect

Agencies will receive extensive, ongoing training this year for OASIS-C1/ICD-9, which took effect Jan. 1.

But a couple of hour-long in-service trainings covering the changes in the OASIS-C1/ICD-9 assessment form — including for new measures such as M1046 (Influenza vaccine received) and M1309 (Worsening in pressure ulcer status) — helped FIRST At Home clinicians become mostly prepared, believes Janet Kondziela, director of nursing for FIRST At Home in Atlantis, Fla.

The agency recently sent one of its case managers to an OASIS-C1 training seminar at the Home Care Association of Florida, and the agency uses materials gathered there to conduct scenario-based training.

The agency also has trained on changes to M2250 (Plan of care synopsis), including “d — depression intervention(s),” which now includes the phrase “and/or physician notified the patient screened positive for depression,” to allow agencies to receive credit when they attempt to notify the physician but don’t get through.

Knowledge of the changes is tested by having clinicians complete a discharge OASIS in OASIS-C1/ICD-9 and OASIS-C about once a week, she says.

Clinicians at Northern Rose Home Health, in Libertyville, Ill., also were well-prepared for OASIS-C1/ICD-9, Administrator Kate Semmerling says.

Clinicians there have discussed changes to the assessment form in every second or third weekly clinical team meeting.

Both agencies plan on reviewing ongoing mistakes or other issues that arise with OASIS-C1/ICD-9 following its implementation.

In addition to training to receiving ongoing training, agencies should remember to check with their vendors for any issues that arise with the new OASIS submission process, dubbed the Assessment Submission and Processing (ASAP) system. The process took effect Jan. 1. — *Nicholas Stern (nstern@decisionhealth.com)*

## Conditions of participation

### Agencies gear up for quality assurance requirements proposed in the CoPs

What it will take to satisfy the quality assurance performance improvement (QAPI) provisions of the proposed home health CoPs is becoming apparent to Medicare-certified agencies. Compared with CMS’ estimate of a relatively mild economic impact, the news isn’t good.

Just ask Kristin Glover, staff education director of Aspire Home Care in Marlow, Okla. After assessing

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### EDITORIAL

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**President:** Steve Greenberg  
1-301-287-2734  
[sgreenberg@decisionhealth.com](mailto:sgreenberg@decisionhealth.com)

**Vice President:**  
Corinne Kuypers-Denlinger  
1-301-287-2363  
[ckuypers-denlinger@decisionhealth.com](mailto:ckuypers-denlinger@decisionhealth.com)

**Senior Content Manager:**  
Marcie Heydt, 1-301-287-2299  
[mheydt@decisionhealth.com](mailto:mheydt@decisionhealth.com)

**Product Manager:**  
Maria Tsigas, 1-301-287-2305  
[mtsigas@decisionhealth.com](mailto:mtsigas@decisionhealth.com)

**Senior Editor:** Burt Schorr  
1-240-497-0392  
[burt.schorr@verizon.net](mailto:burt.schorr@verizon.net)

**Lead Editor:** Josh Poltilove  
1-301-287-2593  
[jpoltilove@decisionhealth.com](mailto:jpoltilove@decisionhealth.com)



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the quality assurance proposals, the 12-office agency concluded it will need five to eight more administrative and clerical staffers to compile the required patient data, at an annual cost of up to \$200,000.

That's far more than the average \$3,810 per year CMS estimates Medicare-certified agencies will have to spend on their QAPI programs (*HHL 10/20/14*). In addition to training clinicians, agencies will be expected to monitor reports such as diagnoses related to hospital admissions and readmissions, diagnoses by referral source and criteria for determining what places patients at high risk for readmission, consultants say.

Glover believes QAPI will add to the uncompensated regulatory burdens Aspire Home Care's clinicians already bear, such as making certain every admission complies with the face-to-face requirement.

CMS has up to three years from the Oct. 9, 2014, publication date to make the proposed CoPs final. But more than half of agencies believe QAPI is the CoP that will affect them most, followed by revisions to the patient assessment requirement, according to 280 responses to *HHL's* 2015 Trends Survey.

By comparison, only 20% of respondents ranked "Revision of patient assessment requirements to reflect patients' physical, mental and psychosocial conditions" — the second biggest concern of survey respondents — as the CoP provision having the greatest impact on them.

The National Association for Home Care & Hospice (NAHC), in a draft comment on the proposed CoPs, suggests CMS has greatly underestimated what it will take for small and medium-sized agencies to create a comprehensive QAPI program.

In its discussion of the proposed provision, CMS maintains its proposals provide agencies "enough flexibility" to carry out the QAPI provisions. But given the complexity of the QAPI requirements and the likelihood that many agencies currently couldn't meet them, NAHC recommends that the quality assurance be phased in gradually.

On the other hand, Brookdale Senior Living Solutions, a 90-agency agency system headquartered in Brentwood, Tenn., only will need to "tweak" its existing quality assurance programs to meet the QAPI requirement, believes Maureen Last, the agency's director of quality assurance.

Even so, Brookdale intends to "drill down" further than it has until now on the effectiveness of infection

control by geographic area and by individual nurse. It also intends to step up its Ebola training to more than the single educational session a year it now provides clinicians, Last says.

But for smaller home health organizations, QAPI readiness is more uncertain. To Cody Sorenson, administrator of 200-patient Five Star Home Health in Los Angeles, for example, "it's always what I can pay for" given the squeeze on Medicare rates.

For five-nurse Hometown Homecare in Fayette, Mo., QAPI compliance will be up to "whoever has the time to spare," says Katie Boeger, the agency's chief operating officer. In December 2014, Hometown's focus was on training its staff how to use the new OASIS form, which took effect Jan. 1. — *Burt Schorr* ([burt.schorr@verizon.net](mailto:burt.schorr@verizon.net))

### *Mergers & acquisitions*

## **Home health expected to continue increased M&A activity in 2015**

The home health industry saw a significant uptick in merger and acquisition (M&A) activity in 2014. While the valuations of larger agencies remained high, the bifurcated market showing low valuations of mom-and-pop agencies is likely to continue into 2015.

The latter half of 2014 boasted two substantial acquisitions: Kindred Healthcare Inc.'s \$1.8 billion takeover of Gentiva Health Services and HealthSouth Corporation's \$750 million acquisition of Encompass Home Health and Hospice (*HHL 10/9/14*).

Under the Kindred definitive merger agreement, the company acquired all outstanding shares of Gentiva stock for \$19.50 per share in a combination of cash and stock, creating the largest home health and hospice company in the world at \$2.3 billion in revenues. HealthSouth, meanwhile, has positioned itself as a force to be reckoned with in the home health market with its acquisition of Encompass at a price more than two times the home health agency's revenue.

**Pittsburgh-based The Braff Group recorded 74 transactions in the first nine months of the year, which President Dexter Braff says is up from 67, the company noted in 2013.**

**"What's happening is that buyers are looking at the conditions in the marketplace and seeing them as being challenging but predictable," Braff says.**

Braff noted that the market is wide open to sellers of all sizes, when in the past few years the numbers have been limited to smaller providers.

“But now big deals are back in play,” Braff explains. “I wouldn’t be surprised if we wind up seeing a record number of transactions in home health and hospice.”

He expects to see acceleration in transactions completed by private-equity firms and non-traditional ancillary service providers trying to position themselves as the go-to company for coordinated care management.

Beth DaSilva, president of Fleetridge Pacific in San Diego, expects 2015 to be a great year for M&A based on the present climate.

“We are right now experiencing a perfect storm of health care consolidation, increased demand for companies and low cost of capital,” she says. “As valuations are pushed up, I see more sellers coming to the table.”

DaSilva expects compliance will continue to be one of the most important factors in driving value as well as successfully completing transactions. And having accurate accrual-based financial statements will also increase in importance in M&A, Braff says.

“The overwhelming majority of providers that we see have shortfalls in their financial reporting,” he says. “The more private equity gets involved, the greater the reliance on active financial reporting.”

### Bifurcated market trend to continue

The bifurcated market likely will continue its trend, with a valuation divide between large home health agencies and smaller independent agencies in the coming year.

“The larger well-run agencies are increasing in value, and this is evidenced by the multiples that the public companies are selling for,” says Don Cummins, president of Stoneridge Partners in Fort Myers, Fla. “One year ago, the public home care companies were selling on average for 58.5% of revenue. As of Dec. 1, 2014, they were selling for on average 76% of revenue. This increase translates to well-run private companies.”

The under \$5 million agencies have been dropping in value, and the combination of decreased reimbursement rates, increased government scrutiny, face-to-face requirements and additional medical reviews will leave many of these smaller agencies hard-pressed to survive in coming years, fears Thomas Boyd, Rohnert Park,

Calif.-based vice president of reimbursable services for Simone Healthcare Consultants.

Boyd expects valuations of small agencies to continue to decrease but that valuations of large agencies will hold up. “I think we’re going to be seeing more interest [in home health] from skilled nursing facility chains, hospital chains and health groups.”

Mark Davis, president of Healthcare Transactions Group, Inc., in Baltimore, agrees that the industry’s trend of consolidation will continue.

“Capital is very inexpensive at the moment and it’s providing the fuel for the acquisitions,” he says. “But I think that prices are moderating a bit. Since the industry has gone through a lot of consolidation already, I don’t see a dramatic increase in prices.”

But Davis notes that he expects large home health companies with a substantial presence in diverse markets to continue to command a premium.

While no crystal ball exists to predict which companies will make moves in 2015, hedge fund North Tide Capital — which has a financial stake in Amedisys and Almost Family — suggested that a merger of the two large players would make sense and would result in a home health and hospice company with revenues of \$1.7 billion. — *Angela Childers* ([angela.childers@gmail.com](mailto:angela.childers@gmail.com))

### Technology trends

## Telehealth, mobile devices among keys to meeting industry challenges

Many agencies plan on taking advantage of the latest and greatest in technology trends, such as mobile telehealth, to meet growing challenges faced by the industry.

From advances in telehealth and point-of-care hardware and software, to mobile, GPS-enabled electronic visit verification (EVV) and cheaper smartphones, agencies have a plethora of options from which to choose.

They plan on doing so in 2015, according to the 280 respondents to *HHL’s* 2015 Trends Survey.

And agencies will require some help as they face shifts and productivity declines associated with the 2015 PPS final rule and the implementation of ICD-10 and OASIS-C1.

The health care industry has generally not kept pace with the consumer sector’s dependence on mobile devices and productivity apps, but such tools are becoming a necessity to manage medical records and allow clinicians to

become more efficient with documentation, for instance, says Andrew Olowu, chief technology officer of Dallas-based Axxess, a home health technology company.

Specifically, in 2015 agencies will be using GPS for electronic notes, activity reporting and EVV — a service that captures clinicians' arrival and departure times, says Michael McAlpin, vice president of business development for Kinnser ADL in Austin, Texas, which produces home care software solutions and support.

For the most part, agencies are likely to implement these technologies in a bring your own device (BYOD) format, allowing the employee to use personal smartphones or tablets to access controlled and encrypted data, McAlpin says.

The benefits of this type of mobile use are lower cost, real-time information and continuity of care.

For example, mobile users from any socioeconomic background can purchase a smartphone for \$30 to \$300, including a variety of models well under \$100, McAlpin says.

In 2010, fewer than 10% of the caregivers in ADLWare's (now Kinnser ADL) test pilot had smartphones, he says. By mid-2014, that number exceeded 70% and is growing.

EVV tools are also becoming more common as states like Florida, South Carolina, Tennessee and Texas mandate their use, according to Axxess.

These tools can be used via a landline telephone or with GPS-enabled systems, but GPS should be the preferred solution for agencies to a consumer decline in usage of landline telephony in favor of mobile phones, Olowu says.

### **Try cheaper, mobile telehealth solutions**

Telehealth has been around for decades, but more and more agencies will adopt the technology by overcoming traditional barriers such as cost and interoperability among devices and data collection software, says Roegen Roashan, analyst of medical devices and health care IT with IHS Technology of El Segundo, Calif.

More than 47% of 278 respondents to a technology question within *HHL's* trends survey said their agency either is using telehealth or plans to in 2015.

A new trend on the horizon is using consumer grade smartphones or tablets to transmit vital sign information, for instance, from peripheral devices like blood pressure monitors among providers, Roashan says.

Qualcomm Life, for instance, has developed its 2net Hub — a piece of hardware the size of a deck of cards that transmits home medical device measurements from a wide variety of devices into the patient record in an electronic medical record, says Dr. James Mault, vice president and chief medical officer of Qualcomm Life.

The system can cost about \$50 per month per patient, about half of the historic rate of about \$100 per patient per month for traditional telemonitors and peripherals, Mault says.

CareCentrix, one of the nation's largest home health agencies, is adopting 2net and associated technologies, he says.

The patient can simply plug this device into the wall and it will start working, freeing up time agencies would typically spend installing traditional telehealth monitors, Mault says.

The company also has its 2net Mobile software module that enables multiple clinicians with smart phones or tablets to collect clinical data like blood pressure readings into a unified stream and transmit the data in a system designed to meet HIPAA security requirements, he says.

Multiple clinicians on a care team can share the health data.

Nursing case managers can also monitor 1,000 or more patients at one time and see which patients are having trouble and needs attention and which are doing well.

### **Make sure BYOD is secure**

BYOD may enhance productivity and be a cost-effective solution to taking advantage of many new technologies in the industry, Olowu says.

But agencies need to ensure the use of personal devices in home health are HIPAA compliant and ensure patient information and communications are secure.

BYOD is a cost-effective measure for agencies as agencies don't have to issue a second device or provide maintenance and technical support to clinicians, he says.

For the clinician, the learning curve for the device is reduced as she is already familiar with it.

Data must not be stored on a personal device and should have multi-platform integration to relay information back to health care software, he says. Partnering with a software vendor that offers apps on

agnostic (can be run on a variety of devices) devices and multi-platform integration is crucial.

But agencies with custom solutions or client/server systems (in-office server systems) will find greater frustration from users due to a lack of access and pressure from management because of the heavy cost of controlling the related devices, McAlpin says.

Therefore, those agencies that take advantage of software as a service (SaaS) or cloud-delivered systems might quickly be able to capture market share based on the low cost to entry, device-independent access and controlled and encrypted security.

### Stay competitive with social media

Agencies that use social media and work on their social media presence on sites like Facebook and Spotify will likely see an increase in search engine optimization scores, site traffic and ultimately online referral leads, McAlpin says.

With proper guidelines in place, staff members can participate by reposting or commenting on the agency's social media posts to broaden the agency's network and increase brand awareness, Olowu says.

Social media should also be a part of an agency's recruiting strategy. Agency staff can post job openings, search for potential candidates and interact with job seekers in the home health industry.

It can also be used to follow referral sources and as marketing and sales tools, McAlpin says. — *Nicholas Stern (nsterne@decisionhealth.com)*

## Face to face

*(continued from p. 1)*

One West Virginia agency even plans to provide laminated sample documentation to its referring physicians to illustrate the required information.

The 2015 PPS final rule eliminated the face-to-face narrative requirement for episodes beginning Jan. 1, 2015. But CMS made clear it expects to see documentation verifying why a patient is eligible for home health services (*HHL 11/10/14*).

The documentation, which would justify homebound status and the need for skilled care, would be added to medical records.

As a result of changing face-to-face requirements, one Vermont agency says its intake and quality assurance responsibilities will increase. A Texas agency says the

changes may require a clinical employee — instead of clerical one — to oversee face-to-face documentation. And one Montana agency says nursing and rehabilitation employees will have an increased burden to create a summary for the physician that helps support eligibility.

Agencies are continuing to learn more information about what documentation CMS will consider acceptable. The federal Medicare agency held an open-door forum Dec. 16 that discussed face-to-face documentation. It provided examples of discharge summaries and progress notes that would support the need to provide home health services (*HHL 12/22/14*).

### Will face-to-face denials continue?

The industry remains divided about whether revamped face-to-face documentation requirements will affect the volume of denials from CMS auditors in 2015, the survey shows. There's also no consensus about whether it will be easier or harder to get documentation from physicians.

Nearly 35% of survey respondents say there will be fewer denials in 2015, 32% say there will be more denials and 34% say there will be about the same number.

Meanwhile, about 43% of respondents say it will be easier to get the required information from physicians, 27% say it will be harder and about 30% say the level of difficulty will remain the same.

Attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman, in Indianapolis, believes getting documentation may be easier. But the real issue is whether the documentation meets auditors' standards, he says.

Overall, Markette doesn't feel the volume of denials this year will change much from 2014.

"They were previously knocking out claims for deficient narrative," he says. The 2015 PPS final rule appears to give them the same leeway to deny claims based upon "deficient physician documentation."

But agencies can help bolster documentation.

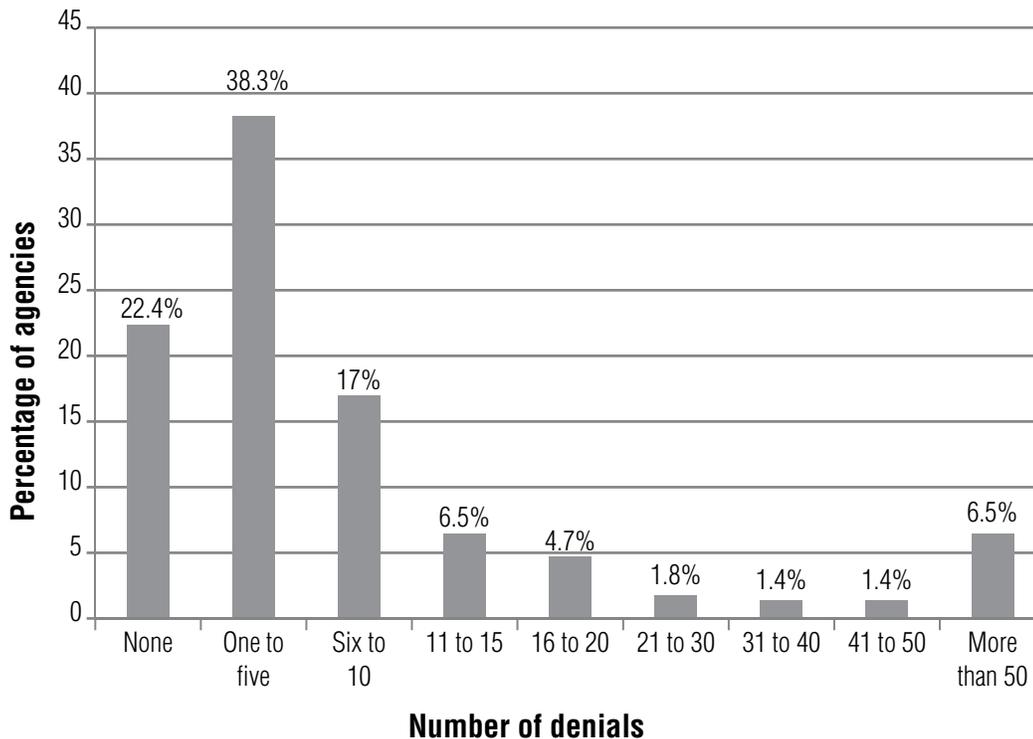
The rule lets agencies provide certifying physicians additional homebound/skilled need explanation to sign and incorporate into the medical record, reminds Laura Montalvo, chief clinical officer for SelectData of Anaheim, Calif.

Montalvo remains optimistic that the volume of denials will plummet.

**BENCHMARK** of the Week

**Number of face-to-face denials in 2014**

Nearly 61% of agencies received five or fewer denials in 2014 based on the face-to-face encounter requirement, according to the 280 respondents to HHL's 2015 Trends Survey (See *face-to-face story*, p. 1). But 6.5% of agencies received more than 50 denials last year.



Source: HHL's 2015 Trends Survey

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PAS 2014

“Under the old rules, agencies did not have the ability to develop or communicate the homebound/skilled need language to the physician,” she says. And none of the inpatient/other physician documentation was considered by Medicare administrative contractors (MACs) or recovery audit contractors (RACs) in denial decisions — and now that will change, she says.

### Doctors tell all about face-to-face rules

*HHL* went to the source, doctors’ offices and health care consultants, to find out the best way that agencies can educate physicians about the changing requirements. Here’s what they said:

- **Provide visuals.** Don’t rely on chats with doctors’ offices, suggests Peter Canney, manager of a physician practice in Navasota, Texas. Agencies could supply doctors with a flow chart comparing what the process

will be like before and after requirement changes. Agencies also could provide offices with a written bullet point description of the new requirements, Canney adds.

Supplying doctors with a checklist of what should be submitted will ensure they supply information “correctly the first time, every time.”

- **Education from auditors would help.** It would be valuable to show the video that MAC Palmetto GBA posted on YouTube in November about face-to-face encounters, Canney says. View the video at <http://bit.ly/1t3sGmQ>.

Information from CMS’ recent open-door forum, including examples of acceptable documentation, can be viewed at: <http://go.cms.gov/1yEGB8u>.

- **Keep the process as simple as possible.** Limit the number of times you contact doctors’ offices seeking face-to-face documentation, Canney advises.

- **Mail doctors education.** A detailed — yet brief — letter agencies send offices could explain how the documentation process should work, suggests David Zetter, founder and lead consultant with Zetter HealthCare in Mechanicsburg, Pa. The information could outline what Palmetto showed in its video and detail answers to frequently asked questions about face-to-face documentation.

An agency might have more luck getting someone at a doctor’s office to read the letter if it is addressed to, for instance, the doctor’s personal nurse, Zetter adds.  
— *Josh Poltilove* ([jpoltilove@decisionhealth.com](mailto:jpoltilove@decisionhealth.com))

## Agencies expect to see increased activity from RACs

Nearly two-thirds of the 280 respondents to *HHL*’s 2015 Trends Survey expect an uptick in additional documentation requests (ADRs) and denials in 2015.

Many respondents believe recovery audit contractors (RACs) will be part of the increase.

CMS previously announced that RACs will soon include Region 5, a national RAC for home health, hospice and durable medical equipment claim reviews.

RACs were temporarily suspended in 2014 but already have resumed certain audits. Once they are fully operational, agencies will see increased audit activity, believes Attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman, in Indianapolis.

“Once there is a specifically identified RAC that targets home health, all agencies will become very vulnerable,” says Arlene Maxim, consultant and owner of A.D. Maxim Consulting in Troy, Mich.

In addition to expecting auditor scrutiny on face-to-face documentation, industry experts also say a high number of therapy visits and a high number of visits triggering outliers will be targets for audits.

CMS is concerned about diabetics as outliers: “There is a focus on utilization of daily or more frequently than daily visits for insulin administration when there are other alternatives,” says Diane Link, president of home health and hospice consulting company Link Healthcare Advantage in Littlestown, Pa.

Therapy visits, meanwhile, have been on the HHS Office of Inspector General’s radar for years as having the potential for fraud and abuse, Link says. She also has seen a trend toward denial of therapy visits due to lack of supporting documentation for skilled therapy need.

## ICD-10

(continued from p. 1)

Other changes agencies ranked as having the top impact include payment cuts (31%), face-to-face changes (13%) and proposed conditions of participation (8%).

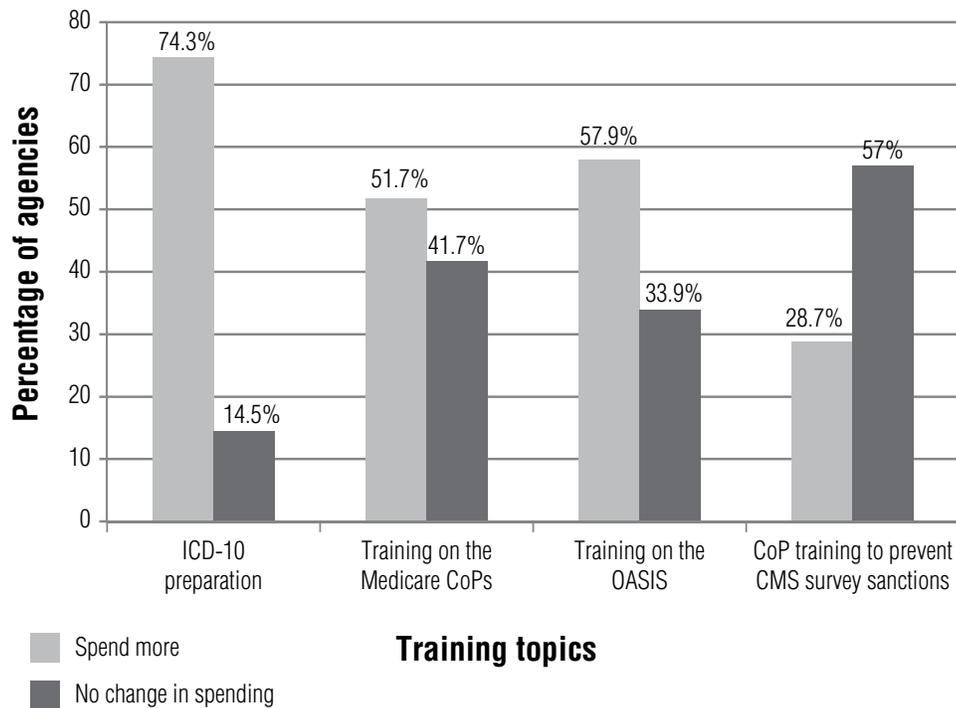
Part of the reason agencies are concerned about ICD-10 is that estimates circulating in the health care industry suggest ICD-10 could cause providers a decrease in productivity of 30% to 50%.

ICD-10’s impact is also particularly significant when you consider that about 56% of trends survey respondents believe they will see revenue decline in 2015.

In anticipation of the transition to the new code set and greater documentation specificity required, 74% of agencies surveyed said they plan to spend more on ICD-10 training this year. (See *benchmark*, p. 9, for more on where agencies are investing in training.)

**BENCHMARK** of the Week**How agencies plan to invest their training dollars in 2015**

About 74% of agencies plan to spend more money on ICD-10 preparation in 2015 than they did in 2014, according to the 280 respondents to HHL's 2015 Trends Survey. About 52% of agencies plan to spend more on training on the Medicare conditions of participation (CoPs). (See *ICD-10 story*, p. 1.)



Source: HHL's 2015 Trends Survey

Remember, even if ICD-10 is not implemented this year, training in terms of asking physicians for more documentation and having clinicians record more detailed documentation is a good policy to increase coding and payment accuracy, advises Joan Usher, president and CEO of JLU Health Record Systems, Pembroke, Mass., and an AHIMA-approved ICD-10-CM trainer.

Many agencies postponed ICD-10 training until late 2014 or early 2015 in the wake of Congress' delay of ICD-10 last year, Usher says.

Recent statements from some Congressmen suggest they are interested in holding fast to the current deadline.

House Energy and Commerce Committee Chairman Fred Upton (R-Mich.) and House Rules Committee Chairman Pete Sessions (R-Texas) issued a statement Dec. 10 that the Energy and Commerce Committee has

been working with CMS to ensure the implementation date will be followed.

In the meantime, the National Physicians' Council for Healthcare Policy, the Medical Society of the State of New York, the Texas Medical Association and other medical groups are requesting another delay until 2017, according to a report by [Healthcare-informatics.com](http://Healthcare-informatics.com).

Agencies still cautious and waiting to see what Congress will do in 2015 will really start to believe ICD-10 is coming if legislators pass the "doc fix" at about the end of March with no mention of an ICD-10 delay, says Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas.

"At that point ... 50% of us will function in full panic mode for the remainder of the year," she says. Remember: Congress snuck the latest ICD-10 delay into the "doc fix" bill in 2014.

## Agencies prepare for ICD-10 transition

Agencies need to start immediately preparing for the switch to ICD-10 by planning out what needs to be done.

By early spring, agencies should complete a gap analysis, check vendor readiness and purchase ICD-10 coding resources, Usher says.

Agencies should begin dual coding, assess productivity and educate intake, coding and performance improvement staff by late spring or early summer.

By July through September, agencies should continue dual coding, increase coding productivity and establish competency for ICD-10.

The increased level of specificity regarding, for instance, the more specific site location of pressure ulcers in the coding set will allow for more accurate coding and payment than currently available in ICD-9.

Home health agency FIRST At Home, in Atlantis, Fla., has been training coders and clinicians for ICD-10 for more than a year.

Janet Kondziela, its director of nursing, earned her HCS-D certification this summer in preparation for ICD-10. The agency's coders and clinicians also have been meeting for the past year at quarterly quality assurance meetings to review the need for more detailed documentation on areas such as precise pressure ulcer location and cardiac issues for treating patients coming out of open-heart surgery.

Part of this training involves reminding clinicians, particularly at intake, that they'll need to consistently ask for and make certain they receive doctors' notes coming from referrals, Kondziela says.

Her agency's electronic medical records (EMR) vendor, Kinnsler, also has a feature that allows her to type in a basic description of the code she's searching for and returning a list of possible codes in ICD-10. That feature has been helpful in her agency's coding training as the agency uses common coding scenarios from the types of patients it typically sees.

Kondziela's agency isn't alone in gearing up and getting ready for ICD-10 to take place.

Northern Rose Home Health, in Libertyville, Ill., sent its primary coder to an ICD-10 training seminar and purchased an ICD-10 training book. The agency reviewed the book, chapter by chapter, at least every

other week during hour-long in-service training sessions with coders and clinicians.

The agency has mostly used scenarios and practice questions to quiz staff, Administrator Kate Semmerling says.

Going forward, Semmerling plans to keep herself and others at the agency on their toes by dual coding every fifth or sixth chart in ICD-9 and ICD-10.

After each visit, clinicians complete documentation and consult with a nursing supervisor to ensure coding is as accurate as possible, she says.

## Prepare for productivity hit in ICD-10

To deal with productivity declines expected from ICD-10, many agencies will turn to outsourcing coding, Rambusch says.

Indeed, according to a fall 2014 *HHL* productivity survey, close to one third of 248 respondents were worried about reduced coder productivity. About 14.5% of respondents said they either planned to outsource coding for the first several weeks or months after ICD-10 implementation or would do so for the long term.

At FIRST At Home, productivity will definitely be impacted, though the agency plans on keeping coding in-house and will rely on continued training and experience to get back up to speed in the months following implementation, Kondziela says.

Kondziela has many codes in ICD-9 memorized. But she expects that with ICD-10, she'll likely drop productivity by about 50% — at least at first. The higher level of detail for the coding of fractures and cardiac conditions will be among the challenges that will likely slow her agency down, she says.

"But in home care, you really get used to change," she says. "It happens all the time. You just roll with it."

Much more of a concern from her perspective is the readiness of smaller physicians' offices, particularly primary care doctors who Kondziela believes may be having a tough time preparing for the code set switch.

Further, she worries CMS will not be ready for the shift to ICD-10 and may cause unnecessary denials or delays in payment.

According to the productivity survey, claims delays and denials was respondents' top category of concern related to ICD-10's implementation. — *Nicholas Stern* ([nstern@decisionhealth.com](mailto:nstern@decisionhealth.com))

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## Tool: 2015 regulatory calendar

### January

**January, February or March** — During at least one of these three months, hospices should test the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey.

**Jan. 1** — Medicare payments to home health agencies will be reduced by 0.30%, or \$60 million, according to the 2015 PPS final rule.

**Jan. 1** — OASIS-C1/ICD-9 goes into effect.

**Jan. 1** — Nearly 200 codes from commonly assigned pulmonary, psych 1, psych 2 and blindness/low vision diagnosis categories and two OASIS items will lose their case-mix value.

**Jan. 1** — Physician narratives no longer will be required for face-to-face documentation for home health agencies.

**Jan. 1** — Home health therapists will need to reassess patients at least every 30 calendar days.

**Jan. 1** — Home care agencies must comply with national minimum wage and overtime requirements, though the Labor Department enforcement won't begin for six months.

**Jan. 1** — Claims will be rejected automatically if the dates of service listed on the claims overlap with dates when patients are in inpatient hospitals, skilled nursing facilities (SNFs) or swing beds for which swing bed claims have been filed.

**Jan. 15** — Deadline for submitting third quarter 2014 data for the Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) survey.

**Jan. 26-30** — The first-ever ICD-10 end-to-end testing week will occur.

### March

**March 2-6** — ICD-10 acknowledgment testing week.

**March 18-19** — ICD-9-CM Coordination and Maintenance Committee meeting.

### April

**April 1** — Hospices must begin submitting information to vendors on a monthly basis for the CAHPS Hospice Survey.

**April 1** — By now, agencies should have started testing ICD-10 codes and systems with their coding, billing and clinical staff.

**April 16** — Deadline for submitting fourth quarter 2014 data for the HH-CAHPS survey.

**April 27-May 1** — A sample group of providers will participate in ICD-10 end-to-end testing.

### May

**May 1** — Deadline for hospices to authorize an approved CAHPS Hospice Survey vendor to submit data on their behalf for the 2015 administration of the CAHPS Hospice Survey.

### June

**June 1-5** — ICD-10 acknowledgment testing week.

### July

**July** — Proposed 2016 PPS rule expected.

**July 1** — The Labor Department's enforcement of the Companionship Exemption is slated to begin.

**July 16** — Deadline for submitting first quarter 2015 data for the HH-CAHPS survey.

**July 20-24** — A sample group of providers will participate in ICD-10 end-to-end testing.

### August

**August** — Hospice final rule expected to be released.

### September

**September** — ICD-10-CM Coordination and Maintenance Committee meeting.

### October

**Oct. 1** — Claims with ICD-10 codes should be submitted for payment beginning today.

**Oct. 1** — The wage index for hospice takes effect.

**Oct. 15** — Deadline for submitting second quarter 2015 data for the HH-CAHPS survey.

### November

**November** — Final 2016 PPS rule is expected.

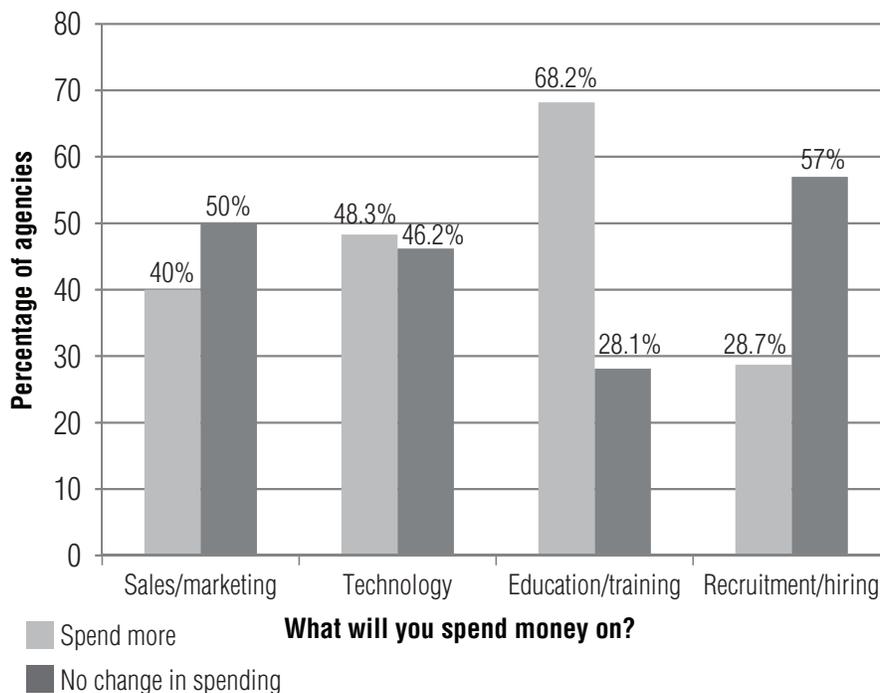
**November** — Home health case-mix grouper posted on CMS website.

## Home health leaders who contributed to HHL's trends

- ▶ **Katie Boeger**, chief operating officer of Hometown Homecare, Fayette, Mo.
- ▶ **Thomas Boyd**, vice president of reimbursable services for Simone Healthcare Consultants, Rohnert Park, Calif.
- ▶ **Dexter Braff**, president of The Braff Group, Pittsburgh.
- ▶ **Peter Canney**, manager of a physician practice, Navasota, Texas.
- ▶ **Don Cummins**, president of Stoneridge Partners, Fort Myers, Fla.
- ▶ **Beth DaSilva**, president of Fleetridge Pacific, San Diego.
- ▶ **Mark Davis**, president of Healthcare Transactions Group, Inc., Baltimore.
- ▶ **Kristin Glover**, staff education director of Aspire Home Care, Marlow, Okla.
- ▶ **Janet Kondziela**, director of nursing for FIRST At Home, Atlantis, Fla.
- ▶ **Maureen Last**, director of quality assurance for Brookdale Senior Living Solutions, Brentwood, Tenn.
- ▶ **Diane Link**, president of Link Healthcare Advantage, Littlestown, Pa.
- ▶ **Robert Markette**, attorney for Hall, Render, Killian, Heath & Lyman, Indianapolis.
- ▶ **Arlene Maxim**, consultant and owner of A.D. Maxim Consulting, Troy, Mich.
- ▶ **Laura Montalvo**, chief clinical officer for SelectData, Anaheim, Calif.
- ▶ **Lisa Phillips**, editor of Levin Associates' *Health Care M&A News*, Norwalk, Conn.
- ▶ **Ann Rambusch**, president of Rambusch3 Consulting, Georgetown, Texas.
- ▶ **Kate Semmerling**, administrator of Northern Rose Home Health, Libertyville, Ill.
- ▶ **Cody Sorenson**, administrator of Five Star Health, Los Angeles.
- ▶ **Joan Usher**, president and CEO of JLU Health Record Systems, Pembroke, Mass.
- ▶ **David Zetter**, founder and lead consultant with Zetter HealthCare, Mechanicsburg, Pa.

## Education and training tops list of investments in 2015

More than 68% of agencies will spend more money on education and training in 2015 than they did in 2014, according to the 280 respondents to HHL's 2015 Trends Survey. Only 29% of agencies will spend more on recruitment and hiring.



Source: HHL's 2015 Trends Survey