

# Home Health Line

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

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### Comply with new CoPs

## Use this last-minute checklist to comply with the revised Home Health CoPs

Agencies should carefully review the checklist below to determine whether they're complying with the revised Home Health Conditions of Participation (CoPs), which took effect Jan. 13.

Agencies in noncompliance could be cited during surveys.

[ ] **Review the final CoPs and the interpretive guidelines.**

Sections of the CoPs to review include: patient rights, QAPI, infection control, organizational structure and professional services.

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

### Comply with new CoPs

## Use caution with physician-ordered resumption of care beyond 48-hour window

A significant OASIS-related change outlined in the revised Home Health Conditions of Participation (CoPs) allows for a physician-ordered resumption of care (ROC) date beyond 48 hours for patients coming from an inpatient facility.

Allowance of a physician-ordered ROC date outside the 48-hour window is designed to allow "physicians to specify a resumption of care date that is tailored to the particular needs and preferences of each patient," the revised CoPs state.

(see **ROC**, p. 7)

## Sign up for a new webinar to help your agency with patient rights



Get expert guidance on how to prepare for the patient rights requirement by attending a webinar hosted by industry expert J'hon Griffin from 1 p.m. to 2:30 p.m. EST Jan. 30. Sign up at <https://store.decisionhealth.com/ensure-compliance-and-mitigate-risk-with-new-patient-rights-cop>.

## Coding

## Implement a back-up plan for coders' time off or prepare for cash flow losses

Not having a back-up coder on staff or an on-call contract with an outsourcing company to fill in when your coders are out of the office could cost your agency a hefty sum — perhaps six figures or more.

Coders report completing, on average, 15 records per day if they're doing coding only or coding and partial OASIS review, according to DecisionHealth's 2017 Home Health Coders' Productivity Survey of 266 respondents.

That means that when an agency's sole coder who has no backup is on vacation for five business days, 75 records will sit undone.

Yet these interruptions are rather common: 43% of survey respondents reported that their agencies do not have a back-up coder or make use of coding services.

If the average record is worth about \$2,500 in reimbursement, at least half of which is paid up front in the form of the Request for Anticipated Payment (RAP), the resulting cash-flow hiccup can be "thousands of dollars," says J'non Griffin, principal of Home Health Solutions in Carbon Hill, Ala.

Beyond cash flow interruptions, holding OASIS assessments until a vacationing or sick coder returns can cause further issues, such as delaying the reconciliation of the face-to-face document with the record, says Arlene Maxim, a home health expert based in Troy, Mich.

If discrepancies requiring another evaluation by the physician are found and aren't properly cleared up in a timely manner, it could prevent the OASIS from being submitted within the required 30 days. A pattern of late OASIS transmissions can trigger a survey, Maxim says.

### How agencies are handling time off

Of those survey respondents who don't report having a back-up plan in place, 36% say they have another fully certified coder on staff who spends most of the time coding.

For another 10% of respondents, the back-up coder has another job within the agency but has some coding skills and fills in when needed.

When Maurice Frear takes time off, another employee who is coding certified but has another job within the agency fills in for him, says Frear, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va.

That back-up coder is a nurse manager who stays on top of coding updates and reads a coding publication, Frear says.

Additionally, Frear and his backup plan for his absences. He gives her charts to code a month or two before he's out, to enable her to "get back in the swing of things," he says.

His agency's corporate office also has an ongoing contract with an outsourcing company to manage what the back-up coder is unable to do. With this plan in place, Frear doesn't usually face a big backlog when he returns.

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Frear codes an average of 20 to 22 records per day. His colleague who codes in his absence can get through between 10 and 12 records a day, he says.

### Missed time costs more than you think

Missing one week of coding will take your agency more than a workweek to make up if you don't have a backup.

About 65% of respondents report that it takes them 31 to 60 minutes to code the average chart, according to survey results. (See *benchmark*, p. 4.) So if the average coder's five-day absence leaves 75 charts undone in a week, it will take that coder an entire workweek plus another two days to make up the missed work.

### Qualifications, accuracy matters in plans

Don't forget to factor in the qualifications of those who will fill in for a full-time coder, or it could end up costing you down the road.

Needing cash on hand to make payroll and other business expenses can create a feeling of pressure to get charts out the door, sometimes leading agencies to have whoever can complete the charts do it — even if that person isn't a qualified coder, Griffin says.

This can lead to coding errors and perhaps audits down the road, she warns.

Additionally, a chart completed by an untrained coder that contains major inaccuracies, such as coding surgical wounds as open (trauma) wounds, might require that the claim be re-opened, recoded and resubmitted. All of this can lead to significant hiccups with billing, says Brandi Whitemyer, an independent home health and hospice consultant based in Canton, Ohio.

### Outsourcing can be used as needed

About 11% of survey respondents report using a coding service, outsourcing company or have a contract with a certified, professional home health coder to fill in when needed.

Of those who report using outsourcing companies for at least some coding, the largest percentage report using these services for 25% or less of their coding needs.

"There are a number of outsource coding companies that are 'easy in easy out,'" meaning that they don't require long-term contracts and can do work on short notice, Maxim says.

Lisa Selman-Holman runs one such outsourcing company, CoDR — Coding Done Right, in Denton, Texas. Agencies can devise standing contracts to use her company's services only as needed, Selman-Holman says.

The cost of hiring an outsourcing company can vary between \$40 to \$100 per chart, Whitemyer says.

Compared with potentially nearly six figures of held-up cash flow each week a coder is out of the office with no backup, using stop-gap outsourcing services may constitute a relative bargain. — *Megan Batty (mbatty@decisionhealth.com)*

### Mergers & Acquisitions

## Humana's agreement to buy Kindred further 'validates the value of home health'

The recent announcement that health insurance giant Humana Inc. is involved in purchasing the home health and hospice side of Kindred Healthcare Inc. is notable for its size and scope — and because an insurer wants to dive deeply into the home health market.

The Dec. 19 transaction further validates the value of home health, notes Mark Kulik, managing director at Pittsburgh-based mergers and acquisitions advisory firm The Braff Group. It further points toward combined, managed care not disconnected by payer method but merged to meet patient need, he adds.

The deal is indicative of one of the most important trends in the health care industry — moving from fee-for-service to value-based purchasing, adds Jack Eskenazi, Jr., managing partner of Soquel, Calif.-based mergers & acquisitions advisory firm Healthcare Advisory Partners.

"In pursuit of efficiency, we've seen a convergence of facility-based and community-based care over the last several years and introducing an insurance payer with population health management expertise should increase the potential for even greater efficiency," he adds.

Mergers and acquisitions experts contend the future will hold more consolidation for the still-fragmented home health industry.

### Humana's stake in deal is significant

Kindred agreed to be sold for about \$4.1 billion. Humana will acquire 40% of Kindred's home care division for about \$800 million, with two private equity firms to own the rest, a news release from Humana states (*HHL 1/1/18*).

Over time, Humana will have a right to buy the remaining ownership interest in Kindred at Home.

Kindred is the nation's largest home health provider and second-largest hospice provider.

Kindred will be split into two entities: one home health and hospice, the other specialty hospital and rehabilitation.

Louisville, Ky.-based Humana has 51,600 employees and is primarily a health insurance company.

Currently, about 40,000 caregivers serve approximately 130,000 patients daily in Kindred at Home. Annual revenues are about \$2.5 billion.

Note that not all of Kindred’s stakeholders support the deal. A Dec. 27 release from Brigade Capital Management, a global investment management firm, states that the company would vote against the transaction under its current terms.

“Brigade believes that from the perspective of maximizing shareholder value, the proposed acquisition severely undervalues the company and ensures that the buyers — rather than existing shareholders — will reap the benefits of value enhancement the business is expected to generate from a number of initiatives and other factors,” the release states.

Brigade Capital has a 5.8% stake in Kindred, according to Reuters.

Brigade might be trying to get other stakeholders involved in order to increase Kindred’s valuation, Kulik says.

“It only affects the deal if more shareholders feel the same and join in,” adds Rich Tinsley, CEO and president of Louisville, Ky.-based Stoneridge Partners, a merger and acquisition advisory firm that focuses on selling home care, hospice and behavioral health agencies.

**Humana aims to provide better care**

Humana already provides its Humana at Home program to its members.

The program offers benefits such as a personal care manager who helps coordinate care, particularly after discharge.

This service is currently offered at no additional costs to those enrolled in Humana’s Medicare Advantage plan.

Acquiring Kindred helps put Humana more in control of the care side, expanding this type of program, says William Fleming, president of Health Care Services at Humana.

“This expands our ability from care coordination and management to also include robust care delivery capability,” he says. “Fast-forward to what the future holds. It’s the ability to deliver care in the home and advance technology and telehealth to speed up and make care more efficient.”

With this deal, Fleming says, Humana aims to achieve better telehealth care with better technology, and to gather analytics and use predictive monitoring to align with value-based purchasing goals and improve quality and outcomes.

“We have a strong belief in integrating care and promoting population health management,” Fleming says.

Fleming points to its Making Progress, Seeing Results value-based care report, which details the company’s 2016 results for Humana Medicare Advantage (MA) members affiliated with providers in Humana value-based reimbursement model agreements.

The report studied 1.65 million Medicare Advantage members compared with 191,000 members who were under standard Medicare Advantage settings, which didn’t add incentives to providers for meeting quality or cost targets.

The report states that Humana Medicare Advantage members in this program experienced 6% fewer hospital patient readmissions and 7% fewer trips to the emergency department.

Preventive screening for breast and colorectal cancer also were higher.

**BENCHMARK of the Week**

**How long does it take to complete a chart on average?**

Having coders out of the office with no backup can mean that work quickly builds up. About 65% of respondents to DecisionHealth’s 2017 Home Health Coders’ Productivity Survey say it takes 31 to 60 minutes to complete a chart. (See story, p. 2.)

| Time to complete a chart | Percentage of respondents |
|--------------------------|---------------------------|
| 31 to 60 minutes         | 65.3%                     |
| 30 minutes or less       | 27.6%                     |
| 61 to 120 minutes        | 7.2%                      |

**Source:** DecisionHealth’s 2017 Home Health Coders’ Productivity Survey

## Insurers have made deals before

While the Kindred deal is significant, it's not unheard of, industry experts note.

In 2012, Humana bought SeniorBridge, a national chronic-care provider best known for providing in-home care management and caregiving services for seniors.

Other insurers also have purchased health care providers in recent months.

In December 2017, it was announced that insurer UnitedHealth Group would buy DaVita Inc.'s physician group for \$4.9 billion.

As for the Kindred deal, it's "very interesting for Humana to jump back in in such a big way," Tinsley says.

"Obviously, not only can they make money on the home care side, a needed service, but they can save money of the total cost of a patient by helping to keep them healthy at home."

## Points of potential conflict for hospice

There are complications for a large-scale managed care company providing clinical care.

Humana will now provide hospice, which is lower-cost, and so Tinsley says that perceived or real, there might be a point of contention of when patients are encouraged to enroll in hospice.

"Some in the industry are guessing that they might sell this portion," Tinsley says. "It'll be interesting to see how that plays out." — *Tami Swartz (tswartz@hcpro.com)*

**Related link:** View Humana's report at <https://humana/2Ccnwvk>.

## Operations

### Buckle up: IRS drives mileage rates up one cent for 2018

The IRS has announced that standard mileage rates for the use of a car in 2018 rose to 54.5 cents per mile of business travel.

That's a one-cent increase from 2017.

The standard mileage rate is based on an annual study of variable and fixed costs of operating a car, according to a Dec. 14 post on the IRS website.

"Taxpayers always have the option of calculating the actual costs of using their vehicle rather than using the standard mileage rates," the IRS notes.

About 47% of agencies reimburse at the IRS rate, according to the 136 respondents in *HHL's* 2013

Productivity Survey. More than 44% of agencies pay below the IRS rate; fewer than 1% pay above the IRS rate and 8% don't reimburse for mileage. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

**Related link:** View the IRS post at <http://bit.ly/2BaNaau>.

## Survey readiness

### CHAP announces CMS has approved 2018 standards that comply with revised CoPs

CMS has approved the 2018 standards set forth by the home health accrediting body Community Health Accreditation Partner (CHAP).

CHAP's 2018 Standards of Excellence for Home Health Providers incorporates the revised Home Health Conditions of Participation (CoPs).

All initial and renewing Medicare-certified home health providers with site visits on or after Jan. 13 are evaluated against these standards.

The standards also apply to Medicaid providers seeking initial or renewed accreditation in states that require compliance with CMS' home health CoPs. — *Tami Swartz (tswartz@hcpro.com)*

## Checklist

(continued from p. 1)

The final interpretive guidelines had not been released as of press time. But they're expected to be released soon, industry experts say. Draft guidelines were released in October.

On Jan. 4, the National Association for Home Care & Hospice (NAHC) announced that it had received a message from a CMS official that indicates:

- Until final guidelines are released, surveyors will use draft guidelines.
- Final guidelines will be similar to the draft.
- The final CoPs control survey determinations as opposed to interpretive guidelines.
- The regulations and guidelines offer flexibility on compliance, with CMS removing "guidance that may have been overly prescriptive."

NAHC offered the following recommendations for agencies: "Survey management should focus on the regulations over any guidance issued in draft by CMS. If

[an agency] is cited for a deficiency but believes that its conduct complied with the applicable regulation, NAHC advises that the [agency] bring the CMS Regional Office into the matter and to convey the incident to NAHC as well. It is anticipated that CMS and surveyors will approach the early stages of the new CoP surveys with an openness rather than a ‘cookbook’ approach to compliance where there is only [one] path to compliance.”

### **[ ] Review your bill of rights.**

Compile information you don’t have such as names, addresses and phone numbers for the area agency on aging, center for independent living, protection for advocacy agency, aging and disability resource center and quality improvement organizations in your region (*HHL 7/17/17*).

Make sure there’s space on your bill of rights for the patient and/or legal representative to sign. Identify a printing company if you need one. And determine whether most of your patients will be able to understand the bill of rights in terms of language and readability.

### **[ ] Revamp your transfer/discharge policy.**

Add specific language explaining the seven reasons outlined in the revised CoPs for why your agency would be allowed to transfer or discharge patients. Under the revised CoPs, agencies must provide a copy of this policy to each patient.

View the reasons why an agency can transfer/discharge a patient at <http://bit.ly/2EPU1Y7>.

### **[ ] Revamp your referral form, train staff.**

Add triggers to identify whether the patient has a legal or patient-assigned representative, whether the patient speaks a language other than English and whether the patient has any impairments that would require your agency to, for example, provide patient rights in Braille or with a larger font.

Note that agencies should document the representative’s name, phone number and address. The agency also must collect legal documentation to support that person’s designation.

### **[ ] Revise your notice of patient rights.**

Include the following elements when updating your notice: The patient will be free from abuse; the patient has the right to refuse treatments; the patient will be included in expected outcomes of care, identification of patient goals and anticipated risk and benefits; the patient will receive all services outlined in the plan of care; a confidential clinical record will be maintained; and patients who speak English as a second language can receive language assistance for free.

The notice also should list specific, federally funded and state-funded agencies that could serve as additional resources.

View more details about those elements at <http://bit.ly/2CYqPxF>.

### **[ ] Identify other forms to update.**

Ensure consent forms cover items such as discipline frequencies and any charges the patient may incur. And figure out a place in your agency’s admit pack where you’ll provide the administrator’s contact information for complaints and the clinical manager’s number for clinical issues.

### **[ ] Examine your care planning and coordination.**

Ensure you have an effective way to communicate with team members about patient goals and interventions. Note that team members include physicians, agency staff including home health aides, patients and patient-appointed representatives.

Remember you must provide written information to patients after the comprehensive assessment is completed (within five days of the initial visit). This information includes visit schedules and medications. This information must be listed in a language easily understood by the patient, patient representative and caregiver.

### **[ ] Pay close attention to infection control.**

Review agency policies and procedures around infection control and update them.

Draft interpretive guidelines for the revised CoPs list six elements to infection control: hand hygiene; environmental cleaning and disinfection; injection and medication safety; appropriate use of personal protective equipment; minimizing potential exposures; and reprocessing of reusable medical equipment between each patient and when soiled.

Also provide education to patients, caregivers and staff about infection control best practices.

### **[ ] Ensure you properly handle patients who require assistance with English.**

Select a translation service if you haven’t done so already. Such a service will help your agency better communicate patients’ rights and other information in the event your clinicians don’t speak the same language as your patients (*HHL 10/3/16*).

Also review your compliance with Section 1557 of the Affordable Care Act — including whether you have

identified the most common languages in your community (*HHL 9/26/16*).

**[ ] Educate your governing body.**

Explain the results of your gap analysis and what you must do to comply with the CoPs.

Ensure your governing body is involved with QAPI initiatives, data and quality outcomes on an ongoing basis — and not just after QAPI meetings.

The governing body’s involvement will need to be documented in board minutes, including any board resolutions related to QAPI.

**[ ] Educate and train staff.**

Teach clinicians about the revised forms your agency will have and about the process changes your agency must make. Focus significant education on the patient rights changes, including designation of appointed representatives.

Train clinicians to identify patients who have language barriers that make it difficult to communicate patient rights.

Educate aides to recognize changes in skin integrity and train them to recognize signs of neglect, physical and/or emotional abuse.

**[ ] Review and revise job descriptions you use.**

Pay close attention to changes in the CoPs for administrators and clinical managers. — *Josh Poltilove (jpoltilove@decisionhealth.com) with contributions from consultants Diane Link of BlackTree Healthcare Consulting in Conshohocken, Pa., and J’non Griffin of Home Health Solutions LLC in Carbon Hill, Ala.*

**ROC**

*(continued from p. 1)*

But in these situations, agencies should clearly document the reason why the physician-ordered date occurred outside that 48-hour window, says Diane Link, director of clinical services with Conshohocken, Pa.-based BlackTree Healthcare Consulting.

Draft interpretive guidelines for the revised CoPs — in effect as of Jan. 13 — imply a need for high-quality documentation around the reason for the later ROC date, Link notes.

The final guidelines had not been released as of press time.

At §484.55(a)(1), draft interpretive guidelines specify that a physician-ordered start of care (SOC) date can’t be requested simply because the agency is unable to complete an initial assessment within the allotted 48 hours.

The draft interpretive guidelines state that “it is not acceptable to request a different start of care date from the physician to ensure compliance with the regulation or to accommodate the convenience of the agency.”

Although that language discusses SOC, it is a strong indication that surveyors will consider the reasons why a physician-ordered date was used for SOC or ROC, Link contends.

The shift “was a very important and welcome change in the CoPs,” says Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C.

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PAS 2018

The new approach will help agencies improve on the timely-initiation-of-care process measure, Adams contends.

“Lots of times patients choose to delay and then the agency is caught over the barrel, so to speak,” Adams says.

The change may help agencies from being penalized on the measure when the ROC needs to be pushed beyond 48 hours because of circumstances outside the agency’s control, such as when a patient declines a visit within that time period, Adams says.

### Experts agree: Go with what’s in CoPs

While existing guidance may cause some confusion around how agencies should respond to M0102 (Date of Physician-ordered Start of Care (Resumption of Care)), experts agree it’s sound practice to follow what the CoPs lay out.

If clinicians have a physician-ordered date, that is what should be entered on M0102 at ROC, Link says.

Agencies may be hesitant because a revised state operations manual had not been released as of press time; the existing manual still required a visit within 48 hours of ROC following hospitalization.

Previous Q&As instructed clinicians to respond to M0102 with “N/A” when the physician-ordered ROC date was beyond two calendar days after facility discharge.

This reference was removed from the 2018 OASIS-C2 Guidance Manual, but OASIS Q&As on the subject have not been updated.

Even so, “it would be sensible to adjust what we’re doing based on the CoPs,” says Anita Werner, senior compliance consultant with Fazzi Associates in Northampton, Mass.

### 3 tips to comply with the change

- **Train clinicians on how to document why care didn’t resume within 48 hours.** Clear supporting documentation will be crucial in demonstrating that the reason for the order was not based on staffing needs. A valid reason could be because the patient was not discharged timely from the hospital or the patient asked the agency not to come, Link says.

“But if you don’t have a communication note that the patient said so, then it will look like you’re doing it based on staffing needs,” Link says.

Include in your documentation the circumstances that led to a delay in ROC, what you did to try to meet

the patient’s care need, details on communication with the physician and the physician’s decision on what to do, Adams says.

Agencies should also evaluate priority level and include that in documentation. For instance, someone who needs therapy for general declining ability would be a lower priority than a newly discharged knee replacement patient. If family is in the home and there is not an urgent need, this can further support the case for delaying ROC.

- **Examine agency referral processes.** Ensure the process for assessing referrals includes checking staffing levels, Link says.

You must have the staff to open a case and initiate care timely without requesting a change in SOC or ROC from the physician, Link says.

- **Be sure to get an order.** If your agency is initiating a request for a change in ROC date, a simple conversation with physician office staff is not enough, Werner cautions.

Sometimes agencies will make the call without first receiving an order, she says. Be sure to follow the appropriate steps and first check with the physician.

“If you don’t have that confirmation back, then it doesn’t count,” Werner says.

To help support your case when communicating with the physician, include details on efforts made to get the patient care, Adams says.

Instead of simply saying the patient declined the visit, let the physician know what staff said to try to convey the importance of the visit. For example, explain that you said, “If we don’t come out now, it could negatively impact your health outcomes.” — *Kirsten Dize* ([kdize@decisionhealth.com](mailto:kdize@decisionhealth.com))

**Related link:** Read the draft interpretive guidelines at <http://bit.ly/2Aih4HV>.

## New webinar helps agencies prepare for the QAPI requirement



Don’t wait until July to learn how to comply with the performance improvement project (PIP) portion of QAPI. During a webinar 1 to 2 p.m. EST Feb. 20, industry expert J’non Griffin will teach agencies how to craft, monitor and implement a PIP. Sign up at

<https://store.decisionhealth.com/qapi-performance-improvement-project>.

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