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## IN THIS ISSUE

**Special Issue**



*Regulatory compliance*

## Get doctors to detail homebound status on face-to-face forms to avoid denials

Now more than ever, agencies need to analyze doctors' narratives on face-to-face forms to avoid claim denials due to lack of enough detail to justify the patient's homebound status.

Face-to-face forms have been under greater scrutiny from intermediaries in the past several months, and lack of proper documentation of homebound status is one of the top reasons for claim denials.

Regardless of why the patient is homebound, the physician's narrative must be thoroughly detailed, says Arlene Maxim, founder and owner of A.D. Maxim Consulting, a home health and hospice consulting firm in Troy, Mich.

Circular logic, such as "They're homebound because they're homebound," with no explanation as to why, will result in a denial from an intermediary such as Medicare administrative contractor Palmetto GBA, Maxim says.

*(see **Homebound status**, p. 5)*

*ICD-10 transition*

## Agencies, individuals comment on CMS' OASIS-C1 draft

Agencies nationwide are concerned that item M1309 (Worsening in pressure ulcer status since start-of-care/resumption-of-care), which is similarly collected now in column two of M1308 (Current number of unhealed pressure ulcers), lacks an "Unstageable" response.

While M1309 does not include a selection in the responses for "Unstageable," it is possible for a stage 2 or 3 to progress to unstageable and thus, indicate a worsening ulcer status, says Mary Carr, associate director for regulatory affairs at the National Association for Home Care & Hospice (NAHC).

*(see **OASIS-C1 draft**, p. 6)*

*HIPAA compliance*

## Covered entities struggle to interpret and implement parts of the HIPAA mega rule

HIPAA's new standard for judging whether an incident involving mishandled patient health information (PHI) is serious enough to be reported to the patient or HHS is stricter than the one it replaces.

HHS decided that the risk of harm standard, which is defined as the "significant risk of financial, reputational or other harm to the individual," was too subjective and that it set the bar too high for what constitutes a reportable breach. Under that standard, "we were considered innocent until found guilty," explains Frank Ruelas, privacy, security and compliance officer at Gila River Health Care in Sacaton, Ariz.

The new standard stated in the HIPAA mega rule, which took effect on Sept. 23, allows to go unreported only incidents that show a "low probability of compromise of information," which means that "now it's up to us to prove that no serious breach has occurred," Ruelas adds.

But determining what constitutes a reportable breach under the new standard can be tricky because HHS' Office for Civil Rights (OCR) doesn't define what it means by "compromise," he warns. "I tell people to ask themselves, if someone has a secret and, as the result of something that has happened it's no longer a secret, you have to assume the information has been compromised."

Failure to notify the patient and HHS without conducting a risk assessment to determine whether unintended PHI disclosure has occurred could be costly, Philip Gordon of Littler Mendelson's Privacy and Data Protection Practices Division says. HHS must impose a penalty if it concludes that a covered entity's HIPAA violation resulted from "willful neglect," which it defines as "conscious, intentional failure or reckless indifference to the obligation to comply with the regulation that is the target of the complaint." If HHS decides that this category applies to an unreported breach, it could impose penalties ranging from $10,000 to $50,000 per violation.

If the violation isn't corrected within 30 days after HHS notifies the agency of the violation, the penalty would increase from a minimum of $50,000 to a maximum of $1.5 million per violation, Gordon adds.

### Four signs that it could be a breach

Covered entities and business associates who handle PHI on their behalf must develop a risk assessment plan for determining whether a breach occurred. The plan also should reflect state law requirements, the Health Resources and Services Administration says on its website. "I hope HHS/OCR will provide its own breach assessment tool but right now, no one knows what it'll look like," Ruelas says.

To conduct a risk assessment, covered entities should consider the following four factors, which will help to

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determine whether a breach meets the low probability of compromise of information standard, Ruela says.

- **The extent to which a violation of privacy was involved.** To determine this, ask yourself if the disclosed information can be linked to the patient's identity and whether that which was private before is a little less private now. For example, medical information that can be linked to a specific patient stored on a laptop that was stolen is a reportable breach. But if an agency sends a medical record to the wrong doctor — who, as a covered entity must protect that information — it is a breach but, under the low probability of compromise standard, would probably not be considered a reportable security breach.

- **Whether a person who was not authorized to handle PHI is involved in the security breach.**

- **Whether the medical information is actually acquired or viewed**. For example, if a laptop is misplaced, then recovered and you had taken precautions that allow you to verify whether someone has accessed it and can confirm that no one has, it's safe to assume the information has not been compromised.

- **Whether you took measures to mitigate the risk.** Implement, document and be prepared to report to HHS any steps you've taken to verify that PHI data was not inadvertently exposed to an unintended recipient. You should also document all steps you're taking to prevent any type of breach that has occurred from happening again.

### Ensure new HIPAA standard compliance

Take the following steps to ensure that you're informing the public about HIPAA and to ensure that you are handling PHI properly.

- **Complete the required Notice of Privacy Practice and make sure it's visible to the public.** In other words, put it on a wall, Ruelas advises; don't try to bury it in small print in a form or website.

- **Be ready to provide patients with all types of PHI to which they're entitled.** Originally, as introduced under HITECH Act, patients could request an electronic copy of PHI that was maintained in the covered entity's electronic health record (EHR). The new rule expanded patients' accessibility to health information to include that which is not stored in the EHR. This additional information includes lab packages, patient registration systems and X-rays. Unfortunately, the different systems in which the data are stored aren't connected so additional effort is necessary to collect the data for provision to the patient.

- **Send PHI through unencrypted email, if the patient demands it.** This requirement violates many agencies' security policies but HIPAA says you must send it, even if the information is unprotected, if the patient insists upon receiving it in this manner. But once the high security risk of doing so is explained to patients, many are willing to accept a different, more secure delivery method, Ruelas has found. — *Barbara Bryant* (*bbryant@decisionhealth.com*)

***Editor's Note*:** Several links to risk assessment tools are on the HRSA website at *http://1.usa.gov/1fiFqnD*.

*Cost-cutting strategies*

## Home health agencies save by leasing vehicles, using fleet management

Rather than reimbursing clinicians for miles driven, consider leasing cars, but avoiding the hassles that come with it, by hiring a company to manage your fleet.

By leasing cars through Enterprise since 2008, ADORAY Home Health and Hospice in Baldwin, Wis., has saved more than $10,000, says Mary Troftgruben, the agency's executive director. The agency is expected to save about $400 per vehicle this year.

ADORAY pays Enterprise about $350 a month for each of its seven vehicles, and those costs include insurance, gasoline and maintenance. When comparing those costs to the amount of money the agency would have paid those seven employees for mileage, the agency saves a total of $2,800 per year, Troftgruben says.

Despite any potential cost savings, ADORAY wouldn't lease vehicles without having an outside agency manage the fleet.

Managing vehicles is "a business in and of itself," Troftgruben says. "It's not a business ADORAY is interested in operating." She's pleased with her agency's relationship with the rental company.

Enterprise tracks ADORAY's employee mileage, giving "wonderful reports on usage," Troftgruben says. The company also keeps all the leased vehicles' service records, emails ADORAY employees when it's time for maintenance such as oil changes, obtains

titles and plates and handles selling the vehicles when the time comes, says Mike Niemuth, an Enterprise sales manager for Wisconsin.

### Do a cost analysis based on mileage

The amount an agency can save will vary based on several factors, including how much agencies have been reimbursing clinicians for mileage driven in their own cars. Seven of ADORAY's clinicians drive leased vehicles and it pays other clinicians 47 cents a mile for personal vehicle use on the job.

IRS' mileage reimbursement rate for 2013 is 56.5 cents per mile for business travel, and agencies that have been paying that rate will save more than ADORAY has if they lease vehicles instead, Troftgruben says.

Typically, agencies using Enterprise for fleet management save 20% to 30% when compared to those reimbursing at the IRS rate, Niemuth claims, although he declines to provide details.

Recognizing rising IRS reimbursement rates and a changing health care industry, Enterprise started focusing on fleet management for home health agencies and hospices in 2008, Niemuth says. At least eight home health agencies or hospices in Wisconsin alone use Enterprise for fleet management.

"A lot of agencies have saved a whole bunch of money" through using fleet management instead of paying the IRS rate to reimburse for mileage," says Pat Laff of Laff Associates in Hilton Head Island, S.C.

There are other benefits, too: letting employees drive company cars is good for recruitment and retention, and since the leased cars are newer vehicles, they rarely incur issues resulting in lost employee productivity, Niemuth says.

Still, some agencies find cost savings on gas without taking on a fleet. They lower mileage reimbursement rates or pay employees per visit as opposed to paying per mile, Laff says.

Agencies that should consider leasing and fleet management as an option include those whose field staff travel more than 10 or 12 miles on average per visit, Laff says.

### Determining who gets the cars

All of ADORAY's 30 clinicians in the field were encouraged to apply to drive one of the agency's seven leased vehicles.

They were given two options: drive for business purposes only or drive for business and personal use. Four of the agency's seven cars are currently being used for business and personal trips.

Either way, clinicians receiving leased cars are no longer reimbursed from the agency for miles driven but they benefit from not having to pay for gas and for reducing the wear and tear on their own cars. They also don't pay for the leased vehicles' insurance, maintenance, accidents, wear and tear, tires or gasoline. They're responsible only for covering the cost of speeding or parking tickets.

Clinicians who use the cars solely for business purposes do not pay ADORAY any fees. But the agency charges those who drive the cars for business *and* personal use $250 to $300 a month, Troftgruben says. That cost could rise or drop quarterly depending on the number of personal miles driven.

Employees who take on the leased cars for personal use love it, Troftgruben says. "But I tell the staff that if they already have car payments, this is not a good program for them."

Employees who drive the leased vehicles could save a significant amount of money. People leasing on their own might spend hundreds a month on a car lease, $80 more for insurance, $250 to $300 for fuel and $25 to $150 in maintenance costs, Niemuth says.

The money agencies charge to employees for driving leased cars for personal use generally helps offsets depreciation, he adds.

Before you lease, be sure to:

- **Set a minimum number of driving miles.**

Ask for volunteers and gauge interest. ADORAY first considers the number of business miles the applicant drives per year; the agency wants to make sure it is profitable to lease the car. (ADORAY would have had to spend $470 per employee, paying them 47 cents a mile to drive 1,000 miles in a month. Instead, the agency only pays Enterprise $350 a month per car, a savings of $120.)

At ADORAY, clinicians under consideration must drive a minimum of 9,000 business miles a year although the agency prefers that clinicians drive at least 10,000 and at least half do. When the agency started leasing vehicles, one part-time employee was only driving 6,000 to 7,000 miles a year. That turned out to be a losing proposition for the agency, which gave

her "adequate notice" that it would reclaim the vehicle and she needed another vehicle for personal use, Troftgruben says.

- **Set clear rules about who will get the cars and why.** The agency takes into account the employee's tenure at the agency. Clinicians are also given greater consideration if they want the cars for personal and business use, Troftgruben says. Although it's not clear why, the agency reports that it pays out less for business mileage on leased cars when clinicians use cars for business and personal use as opposed to just business use.

Agencies that clearly specify which types of employees get leased cars will protect themselves from potential Equal Employment Opportunity Commission complaints, says attorney Robert Markette with Hall, Render, Killian, Heath & Lyman in Indianapolis. For example, making it clear that you only give cars to nurses will protect you if a non-nurse files a complaint.

- **Set a minimum usage period.** ADORAY tells employees that they should commit to driving the vehicles for at least a year. It's a hassle to switch drivers any sooner because it requires an insurance transfer, but the agency is willing do so if another clinician is willing to take on the vehicle, Troftgruben says. At the very least, the agency asks for clinicians to provide one or two months' notice if they no longer can or want to drive the leased car.

## Homebound status

*(continued from p. 1)*

Other documentation that could trigger denials include: frequent absences from the home for nonmedical reasons, the beneficiary is working a regular job or the beneficiary is regularly walking out of the home, Maxim says.

Reviewers and administrative law judges place little weight on the following reasons doctors provide for homebound status, Maxim says: Unable to safely leave home unassisted; medical restrictions; severe shortness of breath, shortness of breath upon exertion; confusion, unable to get out of home alone; dependent upon adaptive devices; and requires assistance to ambulate. To avoid denials, these items must be explained in detail, Maxim says. For example, doctors should explain what happens when patients do leave home alone.

If a doctor says on the face-to-face form that a patient is homebound due to Parkinson's disease, that alone won't explain why the patient is homebound. Further explanation, such as noting that the patient was in the latter stages of Parkinson's, would be needed.

### Examples of good, bad narratives

Nearly half of the denials Palmetto issues are for face-to-face encounter requirements not met, according to an analysis of the home health claims it processed from April 2013 to June 2013 (*HHL 9/23/13*).

Use these examples provided by Maxim as a guide to narratives that are acceptable and those that are not:

- **Acceptable example:** Patient paralyzed from a recent stroke and is unable to ambulate safely, requires wheelchair for home mobility and is unable to drive. Transfer and self care ADLs require assistance from another person and patient is limited by low back pain rated 9/10. Patient also experiences dyspnea with minimal exertion. Further, when out of the home without supervision the patient's safety is an issue due to diagnosis of dementia. The totality of these findings support a considerable and taxing effort to leave home by way of mobility, pain, mobility and altered mental status.

- **Denied example:** I certify my clinical findings support that this patient is homebound per CMS guidelines due to: Patient unable to leave home unattended and continues to require assistance with ADLs.

Maxim believes this was denied due the circular logic, lack of specificity to the patient and lack of detail.

- **Acceptable example:** The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD medical regimen.

This narrative, Maxim says, is detailed and offers specific information for a specific patient, listing safety issues relative to the patient's inability to leave home.

- **Denied example:** I certify my clinical findings support that this patient is homebound per CMS guidelines due to: s/p left hip fracture surgery.

There is circular, nonspecific logic in the narrative and could relate to any patient who had hip surgery, Maxim says.

- **Acceptable example:** Based on my clinical findings this patient is homebound due to extreme dyspnea limiting her ambulation. This patient is currently walker dependent related to muscle weakness. PT is needed to restore the ability to walk without support.

This example has specificity, the homebound reason is related to the dyspnea and the patient is currently unsafe, Maxim says.

- **Denied example:** My clinical findings support the need for home health services as follows: skilled nursing, home health aide, physical therapy. I certify my clinical findings support that this patient is homebound per CMS guidelines due to: poor ambulation, risk for falls.

### Improve your face-to-face chances

- **Educate the office manager or medical supervisor at the doctor's office about proper wording.** The office manager or medical supervisor would be the one responsible for gathering the needed documentation and getting the doctor to sign the face-to-face form, Maxim says.

- **Give physicians' offices a list of questions doctors can use to probe for homebound status during face-to-face visits.** Questions would include such details as how far can a patient walk before feeling shortness of breath, says Mary Carr, associate director for regulatory affairs for the National Association for Home Care & Hospice.

- **Adapt the face-to-face forms you provide doctor's offices.** Remove unnecessary information, such as asking for the referral date or patient's birth date, since those details aren't needed by intermediaries and will eat into the doctors' time. Asking for unnecessary details will cause the physicians to spend less time writing detailed narratives, Maxim says.

- **Include on the face-to-face form two distinct areas in which doctors will fill out narratives**: One for homebound status, the other to detail a need for skilled services. And provide plenty of space for doctors to fill out each of those narratives. The extra space will help doctors understand they need to provide detailed content, Maxim says. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

## OASIS-C1 draft

*(continued from p. 1)*

In M1308, two or more pressure ulcers at Stage III and IV can be worth up to five additional case-mix points and earn nonroutine supply payment points.

Carr was among 10 respondents who provided comments to CMS on the federal Medicare agency's OASIS-C1 draft. The comment period closed to the public on Aug. 20.

While CMS has yet to announce when the draft will be finalized, commenters like Rhonda Crawford, regional educational consultant of Foundation Management Services in Denton, Texas, speculate it could be by mid-summer next year.

OASIS-C1 will be implemented concurrently with ICD-10 on Oct. 1, 2014. The draft contains 110 items, compared with 114 items on the current version of OASIS-C. The reduction is mainly due to the elimination of several items at the start of care (SOC), resumption of care (ROC) and discharge time points.

CMS' removal of column two from M1308 (Current number of unhealed pressure ulcers at each stage) deserves praise but the federal agency should further clarify the intent of the proposed item M1309 by defining "worsening" and whether it intends to include only observable ulcers when evaluating worsening, says Crawford.

"I am concerned that clinicians correctly identify which ulcers present at discharge should be included for determination of worsening from SOC/ROC," says Crawford.

While CMS has not indicated that M1309 will have direct effect on payment or outcomes, the item has the potential to negatively impact pay-for-performance enhancements to the home health payment methodology and outcome scores if it were included among Potentially Avoidable Events, she further clarifies.

### Frustration with optional diagnoses item

Commenters also expressed frustration that M1024 (Payment diagnoses) in OASIS-C would be replaced with M1025 (Optional diagnoses) in OASIS-C1 rather than being eliminated.

The new item is redefined as a slot for additional optional diagnoses and will be used for risk adjustment for resolved conditions only, not for payment.

"Since the original purpose of M1024 was to capture case mix points only in specific situations, and the new M1025 item is not going to serve that purpose, I would like to see it eliminated entirely," says Crawford.

However, if M1025 is retained, a listing of the specific resolved conditions that might be appropriate, i.e., the ICD-10 equivalent for those diagnoses that have been found to be significant factors toward risk adjustment of quality measures, would be appreciated, she suggests.

Further, CMS, through the Home Health Prospective Payment System 2014 proposed rule, stated it would eventually retire the payment diagnostic field once there was a complete transition to ICD-10, comments Paul Rockar, Jr., president of the American Physical Therapy Association (APTA).

The proposed item, M1025, is obsolete and has no impact on Medicare home health payment and should be removed, he adds.

"The inclusion of this measure will only cause confusion and administrative burden for home health agencies, as they will be required to train their staff on how to document this measure," Rockar explains.

### More guidance needed on falls risk item

The new response options that CMS provides to M1910 (Falls risk assessment) in the OASIS-C1 draft are also potentially problematic, says Carr at NAHC.

These responses include no, low, minimal or more than a minimal risk for falls, but not all standardized, validated falls risk assessment tools indicate risk on a scale of low or minimal risk, she says.

Indeed, the MAHC-10 and other commonly used falls risk assessments such as the Timed Up and Go don't use the term "minimal risk."

CMS should provide instructions on how to complete responses to the item when a falls risk assessment tool is used that only indicates a patient is or is not at risk for falls, says Carr.

The draft measure also does not seem to address how often the patient should be assessed for falls, says Rockar of the APTA. Aside from assessing the patient at the SOC/ROC, it may also be appropriate to assess the patient's risk for falling at other intervals during the episode of care, such as following the addition of stairs or new furniture.

In some cases, it may not be medically necessary to assess a patient for falls risk, he says. For example, a patient who has had a double amputation or has cervical spinal conditions may not need such an assessment because not assessing for falls risk in such cases does not diminish the quality of care.

CMS should therefore revise the measure to include an option that allows home health clinicians to indicate there was no clinical need to assess for falls risk, says Rockar.

### Greater specificity requested for M2102

The new item M2102 (Types and sources of assistance), revised from M2100 (Types of assistance needed and sources/availability), would provide more meaningful information if the choice of responses included: "No assistance needed; yes, they have adequate help or; no, they don't have adequate help," says Carr.

Clinicians responding to M2102 are instructed that if a patient needs assistance with any aspect of a category of assistance to consider the aspect that represents the most need and the availability and ability of the caregiver to meet that need, says Carr. But without specifying the task that requires the greatest assistance, the item doesn't provide useful information.

"Anyone reviewing this item will only know that the patient may or may not need some kind of help in one of those areas," says Carr.

Also, it is difficult to determine whether an available caregiver needs training or is likely to provide assistance if that person is not present when the data are collected, she says. The information collected, then, would not always be reliable.

But the Illinois Homecare & Hospice Council (IHHC) believes adding the sentence that excludes home health agency staff from the types and sources of assistance referenced in M2102 is helpful, says Cheryl Meyer, president of IHHC. — *Nicholas Stern (nstern@decisionhealth.com)*

# Face-to-face requirement causing 70% of Palmetto's claims denials

Roughly 70% of the denials Medicare administrative contractor Palmetto GBA issues are for face-to-face encounter requirements not met, new data show. That's a 20% increase from the Medicare administrative contactor's (MAC) analysis of home health claims denials released a few months ago.

Among the thousands of denials issued by Palmetto between July 2013 and September 2013, roughly 70% were issued due to denial code 5FF2F, described as face-to-face encounter requirements not met, according to data posted Oct. 28 on Palmetto's website.

On Medicare billing type 32x during that timeframe, 3,061 claims were denied due to face-to-face: 69.3% of all Palmetto's denials. On billing type 33x during that timeframe, 1,168 claims were denied due to face-to-face: 71.7% of all Palmetto's denials.

Until recently, under a home health plan of care, agencies had two bill types when they submitted claims — 32x and 33x. Code 32x was pulled from Part B; Code 33x was pulled from Part A (*HHL 9/23/13*). Code 33x was eliminated in October; it was deemed redundant because the portion of the program that paid for the services was determined at the system level.

**Billing Code 32x**

| Denial Code | Denial Description | % of Claims Denied |
|---|---|---|
| 5FF2F | Face-to-face encounter requirements not met | 69.3 |
| 56900 | Auto deny – requested records not submitted | 14.2 |
| 5A041 | Information provided does not support the medical necessity for this service | 4.1 |
| 5F041 | Information provided does not support the medical necessity for this service | 3.9 |
| 5FNOA | Unable to determine medical necessity of HIPPS code billed as appropriate OASIS not submitted | 2.0 |
| 5F012 | Physician's plan of care and/or certification present – signed but not dated | 1.5 |
| 5F023 | No plan of care or certification | 1.5 |
| 5CHG1 | Medical Review HIPPS code change/documentation contradicts M Item(s) | 1.4 |
| 5F011 | Physician's plan of care and/or certification present – no signature | 1.3 |
| 5CHG3 | Medical Review HIPPS code change due to partial denial of therapy | 0.9 |

**Billing Code 33x**

| Denial Code | Denial Description | % of Claims Denied |
|---|---|---|
| 5FF2F | Face-to-face encounter requirements not met | 71.7 |
| 56900 | Auto deny – requested records not submitted | 14.4 |
| 5FNOA | Unable to determine medical necessity of HIPPS code billed as appropriate OASIS not submitted | 2.9 |
| 5A041 | Information provided does not support the medical necessity for this service | 2.1 |
| 5CHG3 | Medical Review HIPPS code change due to partial denial of therapy | 2.1 |
| 5CHG1 | Medical Review HIPPS code change/documentation contradicts M Item(s) | 1.7 |
| 5F012 | Physician's plan of care and/or certification present – signed but not dated | 1.6 |
| 5F023 | No plan of care or certification | 1.3 |
| 5F041 | Information provided does not support the medical necessity for this service | 1.2 |
| 5T071 | Services billed were more than ordered | 1.0 |

*Source: Palmetto GBA*

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