

# Home Health Line

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## Improve face-to-face compliance with customized education for specialists

Tailor your face-to-face education to the needs of specialists to get better compliance results from those referral sources.

*HHL's* recent face-to-face encounter physician documentation survey showed that specialists are less likely than primary physicians and hospitalists to respond to education on the face-to-face encounter requirement. Similarly, 33% of 156 responding agencies indicated that specialists are least likely to provide compliant face-to-face encounter documentation.

*(continued on p. 8)*

### Productivity survey, part 1

## OASIS completion, travel times are biggest drags on clinician productivity

Ongoing challenges such as the OASIS-C learning curve and long travel times to patient homes continue to affect clinician productivity, but many agencies have found ways to improve.

The results of *HHL's* 2012 productivity survey show that average visit numbers are up, but still below expectations. For example, registered nurses are expected to complete an average of 5.71 visits per day before weights are considered and end up making only 5.30. However, that compares to an average of 4.51 visits last year (*see box, p. 5 for more data*).

## Use HH-CAHPS to grow referrals



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But maintaining consistently high productivity remains a challenge for many agencies, especially those with large, rural territories. Daily clinician productivity fluctuates from anywhere between 4 and 8 visits based on the amount of travel on a given day, says Tina Gibson, administrator at Medway Home Healthcare in San Angelo, Texas.

The team of nurses at Partners in Home Care currently makes an average of 3.4 visit per day, says Dianne Hansen, director of clinical operations at the Missoula, Mont. agency. The agency's main productivity challenges are getting new clinicians up to speed on OASIS competency and scheduling visits to outlying patient homes.

### Agency strategies show results

But changes to the agency's productivity monitoring and scheduling practices helped it improve from last year, when nursing productivity was below 3, she says (*see box, p. 4 for more details on how the agency improved its productivity*).

Other agencies have been able to increase OASIS accuracy, reducing the time clinicians are spending on corrections. "There's still a learning curve" on OASIS completion due to the extreme complexity of the form and the large number of factors clinicians must weigh during each assessment, says Rebecca McGrew, administrator of Woodland Village Home Health in Suring, Wis.

However, the agency's clinicians have improved considerably in the past year, she says. McGrew attributes that improvement to a comprehensive six-hour training for all clinicians on every M item, McGrew says. Clinicians also undergo a quarterly test to measure their competency.

### Reevaluate productivity standards

Although the factors impacting clinician productivity haven't changed much over the past year, finding the right balance for productivity expectations remains challenging. Revenue suffers if expectations are too low.

On the other hand, the quality of care will suffer if your expectations are too high, says Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich.

Registered nurses, for example, generally should make between 5.5 and 6 visits, but you need to be flexible in adjusting those expectations as appropriate, she says.

Consider the following factors to ensure productivity expectations are fair and fit your agency's needs:

- **Reflect patient acuity in visit expectations.**

Some patients will require more of a clinician's attention than others, Maxim notes. Make sure this is reflected in the visit weight. For example, a visit to a patient with an intravenous (IV) line can take some two hours out of a clinician's day, Gibson says. That's usually more than one unit would account for. For example, each visit unit used by Partners in Home Care equals 90 minutes of clinician time.

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- **Change expectations based on mileage.** Add one unit to the visit if the clinician will travel 50 miles or more to and from the patient's home. Add another unit if the total travel amounts to more than 100 miles, Maxim suggests. Also note that you shouldn't expect clinicians who travel those distances to perform more than about two visits per day.

- **Cap the number of total visits per day.** In an eight-hour day, clinicians shouldn't normally be able to make more than six visits, Maxim says. If clinicians are making more visits than that, it's likely the quality of care will suffer. – Tina Irgang ([tirgang@decisionhealth.com](mailto:tirgang@decisionhealth.com))

## Teach physicians proper CPO documentation to earn trust, referrals

Help your referring physicians capture more than \$100 per month per home health patient by educating them on correct documentation for care plan oversight (CPO). In turn, physicians may be more willing to send patients your way.

Denials for G0181 (home health care supervision) are increasing at family practices. In 2010, 23.6% of claims with that code were denied, up from 18.0% in 2009, according to an analysis of Medicare data by HHL's sister publication *Part B News*.

To bill care plan oversight for a home health patient, the physician must document that he or she spent at least 30 minutes in one month developing or revising care plans, reviewing lab tests and reports of the patient's status, communicating with other providers and making changes to treatment, according to CMS' HCPCS definition of the code.

Documenting 30 minutes of that work often causes problems, says Donna Beaulieu, director of revenue cycle management for Alton Healthcare, Stockbridge, Ga. Physicians don't track the time or don't perform the right services that qualify.

For example, a physician might not be able to justify 30 minutes of oversight for a patient who doesn't need much change to his or her treatment, she says. But a doctor likely spends at least 30 minutes a month on care plan oversight of a brain-surgery patient who needs medication management, wound debridement and physical therapy.

## Office staff see productivity impact of face-to-face encounters

Agency productivity also has been impacted by the face-to-face encounter requirement, but that impact has been felt in the office rather than the field.

Only 8% of agencies responding to HHL's 2012 productivity survey indicated that field staff are involved in tracking the documentation.

At Medway Home Healthcare, for example, the only face-to-face task clinicians perform is making and tracking appointments for those patients who haven't had an encounter, says Tina Gibson, administrator of the agency in San Angelo, Texas. Even that is a rare occurrence, as most patients who come to the agency have had a physician encounter before the first visit, she says.

On the other hand, agencies report that the impact on those who do track documentation, mostly intake staff and billers, has gotten worse. More than half of agencies responding to the survey said the time spent by staff on tracking documentation has gone up in the past year (*for strategies to help you get compliant documentation more often and more quickly, see story p. 1*).

### Q: How much time per week do staff members at your agency spend tracking delivery of face-to-face encounter documentation? (Please estimate overall time spent by all staff members.)

Less than 1 hour	5%
1-2 hours	12%
<b>3-5 hours</b>	<b>38%</b>
6-10 hours	16%
11-15 hours	13%
More than 15 hours	16%

### Q: Has this amount of time gone up, down or stayed the same since this time last year?

<b>Up</b>	<b>59%</b>
Down	16%
Same	25%

Source: HHL's 2012 productivity survey

Also, physicians who did not order the patient's home health care or assume responsibility for the patient after a hospital stay would not get CPO payments. Neither would doctors who are not seeing the patient for the conditions that necessitated home health, she adds.

### 6 tips to help docs get paid

Use these tips to assist the physicians your agency works with in securing payment for CPO services:

- **Provide the physician with a form that includes spaces to fill in time spent and what the doctor did.** The tool prompts the physician to document the time and activity "so that we hit all the bases that are required to trigger payment as opposed to denial," says Peter Canney, general manager at the practice of Donna Canney M.D. Ph.D., Navasota, Texas (*see insert for an*

*example of a tracking tool*). Practices also can submit those forms if they need to appeal denials, he adds.

- **Notify the practice if the patient leaves home health, then comes back.** That restarts the CPO clock. For example, patients might stop home health services when they elect hospice but later be discharged from hospice when their condition improves. If they are readmitted to home health, the monthly CPO clock would start fresh.

Make sure to communicate with the physicians in those cases or you could risk losing referrals. Canney says his practice won't work with agencies that don't inform the practice when patients leave home health.

- **Recommend that the practice has an "iron-clad method" of filing the documentation of care plan oversight.** Because CPO is billed monthly,

## Case study: Monitoring, scheduling changes grow agency's productivity

Flexible productivity expectations and scheduling based on individual clinicians' needs have helped Partners in Home Care in Missoula, Mont. grow its productivity for nurses and therapists.

Visits per day for the agency's nurses are up to 3.4 from less than 3 a year ago. The same number for physical therapists has climbed to 4 from 3.75, says Dianne Hansen, the agency's director of clinical operations. One challenge for the agency: It serves a territory of more than 100 miles in rural Montana, meaning visit numbers will be low at the best of times due to long drives.

Here are the strategies that contributed to Partners in Home Care's success:

- **Individualize productivity expectations based on each clinician's actual work day.** Rather than creating uniform productivity standards for all clinicians, Partners in Home Care formulates individual goals based on travel distances between patient homes, the types of visit, the acuity of each patient and whether the clinician has case management duties in addition to visit duties, Hansen says.

For example, a clinician who travels more than 120 miles back and forth to a visit would have an additional unit added to that visit. This is especially important because some clinicians travel a lot, while others barely travel at all, she says.

- **Stay in close touch with far-flung clinicians to hold them accountable.** Partners in Home Care has hired a clerical scheduler whose task it is to contact each clinician at the beginning of the day, check in and convey the day's visit expectation. Accountability can be a challenge when clinicians travel such long distances, but the new scheduling system has helped, Hansen says.

- **Let clinicians know you're monitoring adherence to individualized visit plans.** Doing this also has helped Partners in Home Care increase staff accountability, Hansen says.

"Somebody who is not a case manager and has no travel, if their productivity was at 3, we would have a conversation," Hansen says.

- **Give new clinicians time to get up to speed.** Partners in Home Care has decided not to monitor productivity at all for the first three months of a new clinician's tenure at the agency. It's one of the factors that have kept the agency's turnover around 20%, even as an unusual number of nurses retired or moved recently.

The agency's turnover rate compares to a 19% national average, according to the 2011-2012 Homecare Salary and Benefits Report published by the Hospital & Healthcare Compensation Service in Oakland, N.J. (*HHL 2/27/12*). – Tina Irgang ([tirgang@decisionhealth.com](mailto:tirgang@decisionhealth.com))



practices have to keep track of the documentation during that time. Misplacing the documentation would mean the practice can't bill for that service. Canney's practice uses a specific folder to keep CPO documentation until it's complete, then puts the documentation into the patient's chart, he says.

- **Instruct the doctor to exclude phone calls to the patient's family when counting time toward the 30-minute requirement.** Those calls, even if the physician talks about care a relative will have to provide the patient, do not count toward the 30 minutes, Canney notes.

But phone calls to other providers involved in the patient's care to discuss or make changes to the care plan do contribute to the time requirement, according to CMS' definition of G0181.

- **Inform the physician that he or she must see the patient within six months of the first CPO activity.** The encounter must be for an evaluation and management service, according to the Medicare Benefit Policy Manual.

- **Direct the doctor to use G0182 for care plan oversight of hospice.** If a patient elects hospice and the practice provides CPO services for at least 30 minutes a month, the practice should bill the hospice code, G0182. – *Karen Long (klong@decisionhealth.com)*

## CMS issues results of voluntary hospice quality reporting period

The results of the voluntary hospice quality reporting period are in and provide an overview of the patient-care measures hospices across the country are tracking.

CMS nurse consultant Robin Dowell shared key results of the voluntary period, which covered Oct. 1 through Dec. 31, 2011, at a May 23 open-door forum (*for more open-door forum announcements, see p. 6*).

The announcement was paired with the release of a more comprehensive summary report compiled by CMS contractor RTI International in Research Triangle Park, N.C., which coordinated the voluntary reporting effort.

The voluntary period asked hospices to report whether they have a quality assessment and performance improvement (QAPI) program in place that includes at least three indicators related to patient care. Hospices also were required to list the patient care indicators they use, the report notes.

The report found the following:

- 911 hospices participated in the voluntary reporting period.

## BENCHMARK of the Week

### Clinician productivity: Expected vs. actual visits per day

The data below show that most disciplines underperform when compared to their productivity expectations. However, they also show that clinicians have generally improved on productivity over the past year.

According to agency representatives, the biggest obstacles to greater clinician productivity this year were the ongoing OASIS-C learning curve and the difficulty of planning efficient routes to outlying patient homes (*see related story, p. 1*).

The data below are based on answers from 137 agency representatives who completed *HHL's* 2012 productivity survey and 212 who completed the 2011 productivity survey. Visits are not weighted.

Discipline	Productivity expectation per eight-hour day	Actual visits performed per eight-hour day, May 2012	Actual visits performed per eight-hour day, May 2011
RN	5.71	5.30	4.51
PT	5.87	5.62	5.38
OT	5.84	5.57	5.13
ST	5.70	4.25	4.42
LPN/LVN	6.76	7.03	5.81

Source: *HHL's* 2012 and 2011 productivity surveys

- 95.7% of hospices have a QAPI program with three or more patient-care measures.

- Pain assessment or management was the most common topic for patient-care indicators, followed by communication with patients and family.

- A plurality of the indicators (34.3%) was measured based on information in electronic medical records, followed by patient or family surveys, paper records and incident logs.

Data collection for mandatory hospice quality reporting is set to begin Oct. 1 (*HHL 2/20/12*).

### CMS shares hospice cap, F2F updates

Other hospice information shared by CMS during the call included:

- **CMS has instructed the Medicare administrative contractors (MACs) to resume hospice cap calculations.** Cap calculations had been suspended while several lawsuits involving hospice cap demands were litigated (*HHL 5/9/11*). Hospices can elect one of two calculation methodologies and the MACs have begun issuing information on how to inform your MAC of your selection (*see for example <http://tinyurl.com/7v638wv>*). CMS also will issue a transmittal explaining the selection process in the coming days, said Katie Lucas, a senior hospice payment policy analyst with the federal Medicare agency. Check CMS' transmittal page at <http://tinyurl.com/7vokl78> for updates.

- **Hospices are still accountable when incorrect patient information causes them to miss required face-to-face encounters.** Several hospices had contacted CMS with the concern that patient information in the common working file (CWF) often is not up to date, making it hard to determine whether a patient is in the third or later benefit period, Lucas said. Only those patients are required to have face-to-face encounters.

The hospices had asked CMS to hold harmless providers who acted in good faith, but based on outdated CWF information. However, the statutory language in health care reform which addresses hospice face-to-face encounters does not give CMS that authority, Lucas said. – *Tina Irgang ([tirgang@decisionhealth.com](mailto:tirgang@decisionhealth.com))*

**Editor's note:** The hospice quality reporting summary is available at <http://tinyurl.com/cxgzr3a>.

## Major associations to CMS: We endorse Oct. 1, 2014 start of ICD-10

Delaying ICD-10 implementation until 2014 would provide badly needed relief to providers.

That's the message from a trio of major associations in comments on the HHS proposal to postpone use of the new codes for a year (*HHL 4/9/12*).

The National Association for Home Care & Hospice (NAHC) endorses the delay because it will allow agencies "the time necessary to conduct education of their clinical and billing personnel and carry out operational and computer system changes," says Mary St. Pierre, VP for regulatory affairs, in one of nearly 150 comments HHS received on its proposal during the 30-day comment period which ended May 17.

Home health providers, many of them small businesses, already are struggling with a number of new regulatory requirements. Those include face-to-face encounter documentation, therapy reassessment responsibilities, revalidation and provider enrollment, chain and ownership system (PECOS) enrollment by referring physicians, St. Pierre notes.

### Physician, hospital groups weigh in

The American Medical Association (AMA), for its part, would welcome an even longer delay, until Oct. 1, 2015, given "the tremendous administrative and financial burdens," writes James Madara, the AMA's CEO.

The necessary education, software, coder training and testing with payers will cost medical practices between \$83,290 and more than \$2.7 million, Madara predicts.

The American Hospital Association (AHA), which speaks for hospital-based agencies as well as hospitals, reports that 70% of member hospitals responding to its ICD-10 survey endorsed a delay and a majority of those thought it should be no longer than the 12 months HHS has proposed.

"A longer delay would escalate the costs of maintaining the current level of readiness considerably, as training and system upgrades are subjected to repeated refinements," says Rick Pollack, AHA's executive VP. – *Burt Schorr ([bschorr@decisionhealth.com](mailto:bschorr@decisionhealth.com))*

## NAHC affiliate offers agencies a format for more accurate cost reports

The home health industry now has a uniform cost-reporting format that could prove Medicare isn't overpaying agencies and save you money on professional help with cost reports.

The Excel spreadsheet was developed by the National Association for Home Care & Hospice (NAHC) financial managers' association. It's designed to create an accurate financial statement agencies can use in preparing a Medicare cost report.

While Medicare payments currently aren't tied directly to cost reporting, CMS plans to use cost report data when it begins its rebasing of home health rates in 2014. This means that any inaccurate information on cost reports could lead to future Medicare rates that won't cover agency costs (*HHL 8/15/11*).

But agencies also can realize more immediate financial advantages from using the spreadsheet. It lists out each operating expense agencies must consider and whether it should be tallied as a direct or indirect cost.

As a result, agencies will be able to put costs in the correct audit silos right from the start, says consultant Tom Boyd of Boyd & Nicholas, Rohnert Park, Calif. When that's done, a CPA will need to spend less time preparing the annual cost report and thus is likely to charge less, Boyd notes.

By contrast, some agencies track the costs for all six home health disciplines as a single figure, requiring extra hours for their CPAs to untangle them as best they can.

### Common errors you can avoid

The new format also can help your agency prevent these common cost report inaccuracies:

- **Misclassified medical social worker services.**

This is now the single most common error in home health cost reports, says consultant Pat Laff of Laff Associates, Hilton Head Island, S.C. The salary, tax and expense costs of social workers should be treated as indirect visit costs in a majority of cases, but aren't. As a result, the cost per visit for social workers can be overstated in some cases and understated in others, says Laff, who played a leading role in developing the new format.

- **Overstated nurse visit costs.** Many agencies erroneously lump the costs of nurse managers who work in an agency's office with those of field nurses, Laff says.

Work on the format – called “the uniform chart of accounts” – actually began in 1992 as a joint project of the Illinois and Indiana home health associations. But the result remained unpublished after funds ran out, NAHC notes in a May 18 announcement. Now NAHC's affiliate, the Home Care and Hospice Financial Managers Association (HHFMA) has completed the job.

The HHFMA chart of accounts work group also developed similar formats for hospice, private duty, pharmacy and infusion therapy as guides for financial analysis of

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each specific product line, NAHC's announcement states.  
– Burt Schorr ([bschorr@decisionhealth.com](mailto:bschorr@decisionhealth.com))

**Editor's note:** For the uniform charts of accounts for all provider groups, see <http://www.hhfm.org/Accounts.htm>.

## Breaking News: RAC Connolly posts another home health issue

Recovery audit contractor (RAC) Connolly has announced it will audit home health episodes where the request for anticipated payment (RAP) has no associated final claim in the system.

That could happen, for example, when the physician doesn't submit face-to-face encounter documentation, meaning the agency can't bill the final claim for that episode, notes Bob Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis.

The review will target claims filed on or after Oct. 1, 2007, according to the auditor's website. The audits will affect agencies in southern and southwestern states (*for more details, see <http://tinyurl.com/23u2koe>*).

It's still unclear whether the review will probe for overpayments or underpayments, and what action the RAC would take when it identifies a RAP with a missing final claim. CMS and Connolly did not respond to requests for comment by press time.

Connolly already has one active home health audit, which checks for underpayments related to unnecessary partial episode payment (PEP) adjustments (*HHL 2/27/12*).

For more details on this new audit, see the next issue of *HHL*. – Tina Irgang ([tirgang@decisionhealth.com](mailto:tirgang@decisionhealth.com))

## Improve face-to-face compliance

(continued from p. 1)

Agencies report a range of face-to-face problems with specialists. Care Connection of Cincinnati dealt with an orthopedic surgeon who created his own face-to-face form. The form includes all the required elements, but the physician's narrative section is low on detail needed to justify the necessity of home health services, says Bob James, VP of clinical operations for the agency.

Another problem is that specialists often practice far from agencies' locations, making follow-up more challenging. For example, most of Hsc Home Care's referring specialists practice in Little Rock, about 50 miles

from the agency's rural location in Malvern, Ark., says Sherry Wylie, the agency's director.

### Provide specific examples to educate

Some specialists don't refer nearly as many patients as other physicians, so they may not understand the need for face-to-face encounters, says Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C.

Use these tips to ensure your face-to-face encounter education fits the needs of specialists:

- **Provide examples of compliant face-to-face answers that relate to the specialty,** Adams says. For example, a cardiologist could benefit from the following sample: "The patient needs to be monitored closely by a clinician because he has had an irregular heart rate and increased symptoms of heart failure, and the patient is homebound due to restrictive activity as a result of the heart condition." If all of your examples are general, it's going to be difficult for the specialist to understand and relate it to his or her individual experience, Adams says.

When educating orthopedic surgeons, provide them with an example similar to this: "The patient needs physical therapy to improve ambulation and strength, and is homebound due to restrictions from recent orthopedic surgery," Adams says.

- **Assign an agency expert to the referring specialist.** If anyone in your agency has extensive knowledge about the specialty, make him or her the go-to person to educate the physician on what to include on the face-to-face form, Adams says.

- **Build a phone relationship with someone in the specialist's office,** such as an office coordinator or billing manager, suggests Adams. It's often easier than getting the specialist on the phone. You can mail out educational materials to that specific person as well.  
– Danielle Cralle ([dcralle@decisionhealth.com](mailto:dcralle@decisionhealth.com))

## Discharge note

- **CMS has issued new accrediting standards for HME suppliers** that provide negative wound pressure therapy (NWPT) equipment to Medicare beneficiaries. The new standards include requirements to show that the supplier has provided beneficiaries with 24/7 contact information, has consulted with the physician on new or changed orders, and more. For a detailed description of the new standards, see <http://tinyurl.com/cw6muwj>.



## Tool: Track care plan oversight (CPO) minutes

Give this tool to your referring physicians to help them track time spent on care plan oversight (CPO). Physicians must document time they spend performing the tasks below to bill for this service successfully. As a result of successful CPO billing, physicians may be more willing to send referrals your way. The tool was created by Judith Sweet, a community liaison nurse with At Home Care in Oneonta, N.Y.

### Physician Care Plan Oversight Billing for Medicare Home Health

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Month: \_\_\_\_\_

*CARE PLAN OVERSIGHT/G0181	DATE	MIN	DATE	MIN	DATE	MIN
Activities to coordinate services						
Documentation						
Medical decision-making						
Review (charts, treatment plans, lab or other test results)						
Telephone calls with other health care professionals						
Team conferences						
Discussions with pharmacist (telephone or face-to-face) re: pharmaceutical therapies						

### Total of monthly minutes:

\*CPO: Time spent must equal at least **30 minutes** in a calendar month to bill Medicare.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(NOTE: Activities listed as countable toward the 30 minutes a month of physician supervision time required for CPO payments are based on information published by CMS.)

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