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# Home Health Line

Regulatory news, benchmarks and best practices

## In this Issue



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*Compliance*

## Speed up RAP submission process, but don't rush OASIS, coding finalization

Only 12% of the respondents to the *HHL* 2021 trends survey said they are submitting their RAPs by days three or four. If you're not one of these few agencies, then you might want to revisit your workflow to ensure you aren't risking payment penalties by delaying the timely submission or needlessly rushing other important tasks to meet the new requirement for RAP acceptance within the first five days.

Now that CMS no longer provides any payment with the RAP, several steps in the first days of care can now be handled after the RAP is submitted:

- **Complete the OASIS.** Even before 2021, some agencies would rush through an OASIS to get the RAP submitted. Now, it might still feel like an urgent task, but a finalized OASIS isn't required before submitting a RAP.
- **Determine the proper HIPPS code.** Any valid HIPPS code can be included with a RAP submission, as long as it matches the HIPPS code included on the final claim. "You can use a generic HIPPS code — you can pick any generic HIPPS code and use it for every patient," says Sharon Litwin, senior manager for coding and consulting at 5 Star Consultants/Healthcare Provider Solutions Inc.
- **Establish the plan of care.** Like the OASIS, the plan of care and final approval can wait until after the RAP is submitted.

Clinicians shouldn't wait to confirm visits in the system, says Melinda Gaboury, CEO of Healthcare Provider Solutions Inc. in Nashville, Tenn, speaking during an *HHL* webinar Jan. 5. "They have got to get the visit confirmed and in the system."

CMS now uses the RAPs solely to establish the beneficiary's primary home health agency, so that it can then reject claims submitted by other providers or suppliers that are subject to consolidated billing.

"Your patient admission process really hasn't changed from what it was before," Gaboury says. "The only thing you need to push on is to make sure the start-of-care information is confirmed in the system as soon as the visit happens."

Agencies are still required to submit a RAP at the beginning of each 30-day period of care, but there are only two items on the to-do list for RAP submittals (*MM11855*):

1. Receive and document the written or verbal order from the physician setting out the services required for the initial visit as required at 42 Code of Federal Regulations (CFR) Sections § 484.60(b) and § 409.43(d)
2. Conduct the initial visit within the 60-day certification period and admit the individual to home health care.

## Focus on important RAP tips

- **Keep stiff penalties in mind.** An agency that fails to meet the requirement within five calendar days (including weekends and holidays) will see a significant cut to its payment. For each day late, an agency would be subject to a 1/30th reduction in payment, beginning on the start-of-care date. That means a RAP certified just one day late would come with a 20% reduction in payment (*HHL 12/07/20*).
- **Submit RAPs by third day.** Agencies shouldn't expect approval by their MACs within 24 hours, Gaboury says. Therefore, to allow time for the MAC to approve the RAP in time, shoot to submit it by Day 3.
- **Resolve errors swiftly.** CMS has made it clear in calls with agency leaders that there is no grace period if a RAP is returned to the provider.
- **Use the extra time you're given.** With less urgency for the OASIS before the RAP, agencies should use a collaborative approach to building out an OASIS that incorporates input from various staff working with the patient in the first few days of care. "That's plenty of time to get that collaboration," Litwin says. "You don't have to do it on the first day."
- **Thinking LUPA? Just file the RAP.** A claim that ends in a low-utilization payment adjustment (LUPA) doesn't need a RAP, so some agencies may choose not to submit a RAP at all if they expect a LUPA.

But the consequences if the visits climb above the LUPA threshold make it important to file a RAP, Gaboury says.

"If it were my agency, I would be filing a RAP for every single 30-day period, regardless," she says.

- **Get ready for more change.** Beginning in 2022, CMS plans to replace RAPs with a notice of admission. The requirements will be similar to the 2021 RAPs. But it will only be required at the start of care, Gaboury says. The notice of admission is expected to include the required physician order and initial visit and will result in a penalty if it's not accepted in five days. — *Greg Hambrick (ghambrick@decisionhealth.com)*

***Related link:*** See CMS guidance on RAPs at *https://www.cms.gov/files/document/MM11855.pdf*.

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## Average days for RAP submittal

The majority of agencies are taking well over the required five days to submit their RAPs and get them accepted, putting them at risk for financial penalties, which started Jan. 1. See below for a breakdown of the number of days it takes agencies to submit their RAPs according to the *HHL* 2021 trends survey. (*See related story, p. 1.*)

| Days from SOC | % of agencies |
|---|---|
| 3 to 4 days | 12% |
| 5 to 6 days | 13% |
| 7 to 8 days | 17% |
| 9 to 10 days | 18% |
| 11 to 12 days | 13% |
| 13 to 14 days | 4% |
| 15 days or more | 22% |

*Patient outcomes and telehealth*

# Teletherapy targets higher functional impairment in COVID-19 patients

The percent of COVID-19 patients with high functional impairment was 49% versus 44% of all patients who had high functional status between April and December 2020, according to Strategic Healthcare Programs' (SHP) national database. (*See benchmark, p. 8.*)

But the good news is that agencies have found creative ways to supplement in-person visits with telehealth to help patients stay safe at home.

Agencies have quickly adopted telehealth as a tool for delivering therapy treatments, says Lee Horner, CEO of Synzi in St. Petersburg, Fla. This allows agencies to deliver needed therapy care while alleviating patient, family caregiver and staff concerns about the risk of infection and transmission, he says.

"Since the start of the pandemic, patients (and their family caregivers) have been hesitant to let nurses into their homes for in-person visits," Horner says. Plus, skilled nursing facilities and long-term care facilities have been restricting visits from external staff such as therapists.

The use of virtual care and teletherapy enables agencies to conserve their available personal protective equipment (PPE), Horner says.

Agencies can use telehealth, pulse oximeters and blood pressure cuffs specifically for COVID-19 patients to allow them to take their own vital signs and monitor them in between visits, says Megan Valenzano, PT, DPT, GCS, director of regulatory affairs and documentation review at Fox Rehabilitation in Cherry Hill, N.J.

Telehealth ensures patients don't lose their momentum in the recovery process amid the pandemic and allows clinicians to work with patients to improve their movement and manage their pain more efficiently via HIPAA-compliant video and messaging, Horner says.

### COVID-19 creates functional impairment

Much of the functional impairment seen with COVID-19 patients can be attributed to pulmonary damage and cardiovascular issues. Patients are debilitated from injuries to these systems, and they often struggle to get back to normal function, Valenzano says.

Clinicians are treating sicker patients in the home. "I had a client come home on 6 to 8 liters of oxygen," says Philip Goldsmith, PT, MSPT, EMT, DScPT, COS-C, owner/physical therapist of Goldsmith Professional Ventures LLC in Hanover, Pa., which contracts with home health agencies to provide therapy services.

COVID-19 patients encounter many functional impairments due to post intensive care debility and an array of respiratory symptoms, Goldsmith says. This includes poor endurance and deconditioning.

Treatments for these patients include work on cardio-pulmonary function, energy conservation techniques and breathing from the diaphragm, says Dr. Monique J. Caruth, DPT, CEO of Fyzio4u Rehab Staffing Group in Washington, D.C.

### Tips for effective teletherapy

- **Use telehealth as a communication tool.** Agencies are also using virtual care platforms to quickly push messaging, reminders and vaccination tips about the coronavirus to their patients, Horner says. "Whether these are weekly or one-time /ad hoc messages, agencies appreciate being able to easily broadcast valuable education and timely updates about COVID-19 to their census," he says. Such messages also can be used to remind patients to "get up and get moving" on a regular basis and fulfill their role in executing their own home exercise plan, Horner says.
- **Assess employees and health of patients.** Telehealth also allows agencies to assess employees and patients at key points. Patients can be sent assessments to their smartphones or tablets to collect information about their conditions between visits. As-

sessments can be pushed to the patients before or after each virtual visit to gauge how the patient is feeling as well as the patient's exercise activities. These assessments enable the therapists to check on the patient's progress and modify the exercises going forward, Horner says. And agencies can send employees assessments to see if they are "fit to work" and free of COVID-19 symptoms.

- **Guide patients through visits.** During the virtual visits, therapists guide their patients through the exercises needed to improve outcomes (e.g., more strength and movement with less pain) and reinforce how to correctly do each exercise, Horner says.

  For instance, a COVID-19 positive patient who is in isolation at home could still work through a modified exercise program via telehealth if the patient had the appropriate equipment to monitor their vitals, Valenzano says. Some of these interventions can include standing from a chair and walking up stairs at home. Note: This may be difficult depending on the technology, but the patient could do step-ups on the first step only, Valenzano suggests.

  Clinicians can observe patients navigating narrow spaces, performing side steps and tandem walking and standing on one leg while holding onto a counter while the clinician watches for a steady pelvis and evaluates breathing. Pay attention to how difficult you make the strength and balance challenge if you don't have a clinician or caregiver in the home to prevent falls or overexertion, Valenzano warns.
- **Track patients' vital signs.** Telehealth allows patients to share their vital signs from a smartphone or tablet with Bluetooth-enabled devices. Staff can monitor weight, temperature, blood pressure, blood oxygen levels, heart rate and glucose, Horner says. "The Synzi dashboard highlights real-time patient data and triggers alerts when a patient's data is out of a normal range so the agency's clinicians can quickly intervene. Plus, referral partners can also continue tracking health data for a patient who has been released to one's home or a nursing facility," Horner says.
- **Fill staffing shortage in a pinch.** The flexibility in providing care virtually also helps agencies stay in contact with patients when a therapist is unexpectedly unavailable for an upcoming virtual visit, Horner notes. Other available therapists can use their telehealth platform to provide short-term coverage via video. It could lead to fewer visits that need to be rescheduled and patients will be able to access the therapy support they need on a more consistent basis, he says. — *Megan Pielmeier (mpielmeier@decisionhealth.com)* ■

*Hospital partnerships*

## Hospital at Home offers agencies a chance to build partnerships

Acute Hospital Care at Home could serve as an opportunity for home health agencies to partner with hospitals.

A new program from CMS, "Acute Hospital Care at Home" has been designed for patients who meet acute inpatient or overnight observation admission criteria for hospital-level care, according to a CMS announcement November 25.

This program opens the door for a whole new set of patients to receive home care and integrates home health services with the benefits the hospital has to offer, says Bill Dombi, president of the National Association for Home Care & Hospice (NAHC) in Washington, D.C.

An agency that offers skilled services can provide a number of the home-based services that hospital care at home needs to function, says Bruce Leff, MD, professor of medicine and director of the Center for Transformative Geriatric Research, a division of Geriatric Medicine at the Johns Hopkins University School of Medicine.

The hospital bills for Hospital Care at Home services, and the payment runs through the hospital, Leff says. Agencies would have to work with hospitals to determine how the reimbursement gets divided among the partners.

### Strengthen care to build partnerships

In some cases it will be up to the home health agencies and hospitals to determine how they will integrate their services and work together.

Agencies would have to examine the role they can play in this program and whether they have the resources to do it. "Hospital-at-home means 24/7 attention to some degree," Dombi says.

This is an attempt from CMS to offer patients acute hospital level care in the home as a substitute for people going into the hospital, says Leff.

For systems that are looking to develop Hospital Care at Home programs, hospitals are not always the best providers of care in the home, Leff says. Home health agencies are better positioned to adjust their culture and service delivery model to provide hospital care at home safely, Leff says.

"It's not typical skilled home health care. It's a whole new game," Leff says.

The patient that gets care through this program would have been admitted to the hospital (had hospital care at home not been available), but would not be so sick that the ICU is needed, Leff says.

Common diagnoses that these patients might have include pneumonia, CHF, COPD, hypovolemia, complicated UTI and many others, Leff explains.

Agencies must be able to provide top-tier care for these patients. They can't just offer services the same way they always have, Leff says. "It truly is a new service line.

### It's a win-win for all partners

The Medical University of South Carolina (MUSC) Health and BAYADA Home Health Care are involved in a joint-venture partnership that delivers short-term care to adults recovering at home after an illness, injury or surgery or to manage a chronic condition.

The MUSC Health at Home by BAYADA in Mount Pleasant, S.C., was started in 2016 and is equally owned by MUSC and BAYADA. The home health portion is managed by BAYADA and accountable to a board made up of half of its members from MUSC and half from BAYADA, says Nicole Hansen, MAG, BS-SLP, BSN, RN, marketing manager at MUSC Health at Home by BAYADA.

Payments come from a variety of sources including Medicare, managed care, commercial insurances, Medicaid and chartable assistance for the uninsured, she says.

Some of the skilled home health services provided include infusion care, trach care, post-op transplant, wound care, physical therapy, occupational therapy, speech therapy, social work and case management, care from aides and help with dietary capabilities, Hansen says.

One of the benefits of partnering with MUSC is that it allows the home health clinicians to receive specific training for continued care in the home after hospital discharge. It also increases the EMR transparency such as medical history, clinical appointments, lab results and medication management, leading to better continuity of care, Hansen notes. This partnership also allowed the home health agency to gain the support with quality outcomes and cost savings by working with the MUSC Health Alliance ACO and patients involved in Bundled Payments for Care Improvement (BPCI) programs, Hansen says.

"We now service six, soon to be seven counties," Hansen says. As the hospital footprint grows, the home health growth will follow.

A telehealth assistance program allows the agency to be the clinical eyes and ears for the clinicians in real time, serve as the patient advocate and reinforce education in the home, Hansen explains.

Telehealth is increasingly important with "stay at home" COVID-19 and flu season precautions and it's also critical for homebound and bed bound patients to have continued success in their treatment plans, Hansen notes.

MUSC and the community have also benefited from the lowest rehospitalization rate in the service area, increased CMS star rating with a largely increased census, the SHP Best Premier Performer award based on patient satisfaction and cost savings for all involved, Hansen says. — *Megan Pielmeier* (*mpielmeier@decisionhealth.com*) ■

***Related link:*** For a recent Q&A on Acute Hospital Care at Home, visit: *https://www.cms.gov/files/document/covid-acute-hospital-care-home-faqs.pdf*.

***Wage-and-hour issues***

## DOL finalizes contractor rule, but more change may be on the way

*By Tammy Binford*

The announcement of a new final rule addressing when workers can legally be classified as independent contractors emphasizes the U.S. Department of Labor's (DOL) intent to bring clarity to the issue, but with a change in administration January 20, the future of the rule is up in the air.

The final rule, announced January 6, is slated to take effect on March 8. It doesn't make major changes to the current standard for determining when workers can be classified as independent contractors instead of employees, but it is

seen as making it easier to justify an independent contractor classification. The use of independent contractors can be attractive since businesses don't pay employment taxes on contractors or provide them with benefits.

## Future of rule uncertain

Burton J. Fishman, an attorney with FortneyScott in Washington, D.C., says the incoming Biden administration would be able to freeze the rule before its effective date. Another option for change would be to use the Congressional Review Act (CRA), which allows Congress to review new regulations and rescind them.

Since the CRA would prohibit the new administration from reregulating in that area in the same or similar manner, Fishman says the Biden administration is unlikely to try to rescind it under that law.

He expects a Biden administration rule to reflect the ABC rule, which makes it much harder to justify an independent contractor classification.

As the newly finalized rule stands now, it includes two "core factors" examining the nature and degree of the worker's control over the work and the worker's opportunity for profit or loss. The more control workers have, the more likely they are to be legally classified as contractors under the new rule.

The rule also includes three other factors: the amount of skill required for the work, the degree of permanence of the working relationship between the worker and the potential employer, and whether the work is part of an integrated unit of production.

## Risks of contractor classification

Jodi R. Bohr, an attorney with Tiffany & Bosco, P.A. in Phoenix, Ariz., says the new rule "only slightly" restates the factors currently outlined in the DOL's Fact Sheet 13, Employment Relationship Under the Fair Labor Standards Act (FLSA).

"The revised factors have not been adopted by the courts, and they are not intended to change the economic realities test currently used," Bohr says. "Instead, the factors are meant to provide additional clarity to employers and emphasize certain factors within the test."

Even though the rule seems to look favorably on an independent contractor classification, Bohr says employers seeking to use contractors should do so carefully.

"With the change to the Biden administration, the DOL's interpretation will be strictly construed in favor of a classification of employee instead of independent contractor," Bohr says, adding that companies should ask themselves this question: "Is this individual properly classified under the current factors?" If the answer is "no," a correction should be made swiftly, and the company should work with counsel to determine potential liability for the previous improper classification.

In her experience defending clients under DOL scrutiny over the last year, Bohr says DOL investigators have mentioned that the result would likely have been more severe under the Biden administration and to keep an eye out for more of these investigations in 2021.

Bohr says she has recently seen the DOL "come down hard on employers who it felt improperly classified employees as independent contractors." In a January 2021 article for Arizona Employment Law Letter, she noted "contradictory actions" coming out of the DOL.

In the DOL's efforts to investigate wage-and hour-practices, Bohr's article says the agency seemed to focus on companies using independent contractors as part of their workforce, "all the while seemingly revising regulations to make it easier for businesses to classify workers as independent contractors."

## State laws also apply

In addition to complying with any new federal rule, businesses need to keep state laws in mind. For example, California law uses the ABC test to determine if workers can be properly classified as independent contractors instead of employees.

Cathleen S. Yonahara, an attorney with Freeland Cooper & Foreman LLP in San Francisco, says in spite of the new rule, businesses in California "should tread carefully."

"The ABC test is remarkably different from the federal rule," Yonahara says. She explains that under the ABC test, a person will be considered an employee instead of an independent contractor unless the hiring entity demonstrates that all the following conditions are satisfied. The worker must:

(A) Be free from the company's control and direction in connection with the performance of the work;

(B) Perform work that is outside the usual course of the hiring entity's business; and

(C) Be customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed.

Yonahara says the B prong of the ABC rule is the most problematic factor and has forced California employers to reclassify numerous workers as employees. ■

***About the author:*** Tammy Binford writes and edits news alerts and newsletter articles on labor and employment law topics for web and print publications produced by DH's sister company BLR.

***Related link:*** View the rule https://tinyurl.com/y4p6x6qy.

*PDGM: Intake processes*

## Develop documentation processes & tools to educate intake staff

Nearly half, 48%, of the respondents to a December 2020 trends survey report "changing the behavior of intake staff to capture the info they need to collect" as one of the biggest barriers to PDGM success in 2020.

A few common mistakes made during the intake process are missing physician PECOS ID or the most recent provider history and physical and not having enough specificity to identify the provider's reason for referral.

It's common to see physician documentation that is symptom-based rather than disease specific, and there's often a lack of specific information such as laterality or site of the condition, explains Melissa Weigand, quality resource utilization manager at St. Luke's Home Health in Bethlehem, Pa.

This can be avoided by having a checklist or script to remind intake staff to ask for specificity, says Pauline Christensen, coding manager for home health and hospice with Hartford HealthCare in Hartford, Conn.

**Tip:** When creating goals for intake staff to process a certain volume of claims within a certain time period, managers need to be careful to set realistic expectations that allow staff to balance quality with speed, she adds.

Because intake staff members don't always have coding, quality assurance or clinical experience, they might mistake any document with a clinical term on it as an encounter note when it really is a face sheet or medication list, for example, says Ohio-based independent home health and hospice consultant Brandi Whitemyer.

Whitemyer says staff sometimes fail to identify a missing, current encounter note that relates to the admission.

For example, staff might receive a one-year-old encounter note that does not apply to the admission, and they fail to raise a flag that the correct encounter note is missing, Whitemyer adds.

"Agencies should provide intake staff with a searchable list of PDGM-acceptable diagnoses to avoid accepting documentation without a PDGM diagnosis as this tends to cause the most significant delays," Whitemyer says.

Christensen said her agency provided intake with a one-page intake tip sheet describing PDGM, the most common questionable encounter codes, diagnoses including the word "unspecified" or ending with number "9" and injuries or conditions that could be limited to one side of the body requiring specificity.

Additionally, Whitemyer recommends agencies also provide intake with examples of appropriate and inappropriate documentation to demonstrate how to identify proper encounter documents.

### Strategies for improvement

Christensen says her agency did three things to help improve its intake process:

- **Create an email address** specifically for intake staff, sales staff and providers to reach out to coding specialists for assistance. This email address was included on all tools that were distributed to all of these team members.
- **Identify a physician champion** who works with specific providers and referral sources who often fail to provide additional information or signatures on orders. Hartford HealthCare's champion "meets with coding and sales teams regularly and assists with peer-to-peer provider intervention as needed," Christensen says.
- **Appoint a clinical documentation specialist (CDS)** in the intake space to initiate physician queries immediately when questionable encounter diagnosis codes are identified by the provider as the reason for referral. "This has been working well with getting queries out to providers in less than 24 hours from referral date and collaborating with the coding/OASIS review team," Christensen says.

### Signatures are important

Another potential issue that agencies should be aware of is the need to have acceptable signatures based upon CMS signature guidelines.

"Review Choice Demonstration (RCD) state agencies have become very familiar with these guidelines as they cannot submit documents for pre-claim review and have them affirmed until appropriate signatures are obtained," Whitemyer says. However, the same guidelines apply to all providers. Failure to capture a signature on the encounter note from an appropriate provider, whether hand or electronically signed, can result in an ADR or denial of a claim upon medical review.

## Educate referral sources, too

Make sure referral sources have information about common non-acceptable diagnoses in PDGM, including weakness, abnormal gait, falls and dizziness, as well as examples of specificity, Whitemyer says. "Signature requirements should be reinforced with referral sources, as well."

St. Luke's Home Health in Bethlehem, Pa., continues to offer individualized education to referral sources when they provide a referral that does not qualify for PDGM billing, says Melissa Weigand, quality resource utilization manager at St. Luke's.

Ensuring that our referral sources understand that we need valid face-to-face documentation, the most recent encounter notes and complete and accurate information is vital to this process, says Elizabeth Robinson, clinical and quality review nurse with Advantage Home Health Services Inc. in North Canton, Ohio.

Robinson says her agency's sources have access to checklists and "cheat sheets" to ensure they are submitting what we need to provide great care.

## Lessons learned from PDGM thus far:

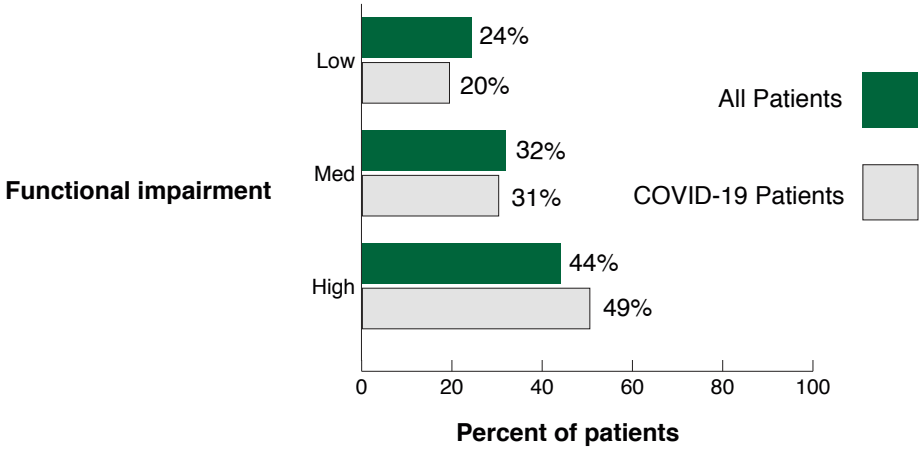
- **Don't accept a referral without a PDGM-acceptable diagnosis.** Using searchable lists for PDGM diagnoses seems to have helped many agencies. Other agencies have had their intake and coding staffs collaborate to review the encounter note provided at referral prior to the acceptance of the patient referral to assure that a PDGM-acceptable diagnosis is present for primary grouping, Whitemyer says. "If not, the coder indicates this to intake and the referral is deferred back to the referral source without acceptance, indicating a need for an acceptable diagnosis — and appropriate query if one can be made from the info given."
- **Take a close look at referral sources.** "One lesson learned is that agencies may need to begin declining referrals from providers who are not responsive to requests for additional information, even after meeting peer-to-peer with a physician champion," Christensen says. — *Megan Herr (mherr@decisionhealth.com)* ■

***Related link:*** For a summary of the information needed at intake to ensure correct PDGM payments, visit: https://bit.ly/3bsSEBu.

## Benchmark of the Week

# More COVID-19 patients with a 'high' functional impairment level

This table shows the percentage of all patients with low, medium and high functional impairment levels, along with the percentage breakdown for COVID-19 patients. Note that a larger percentage of COVID-19 patients reported high functional impairment when compared to all patients.




***Source:*** SHP National Database: April – Dec 2020 (Run as of Jan. 8, 2021)