OASIS Alert

Compliance: BATTEN DOWN THE HATCHES FOR MORE OIG PROBES

Here's what you can do to protect your agency under heightened federal scrutiny.

Home health agencies have enjoyed the relative peace of a honeymoon period as they adjusted to the prospective payment system changes - but the honeymoon is over.

Starting with M0175 errors last year (see Eli's OASIS Alert, Vol. 4, No. 3. p. 28), the **HHS Office of Inspector General** is looking once again at home health. And this time the feds will use agencies' own data in the enforcement effort.

Heads up: The OIG's recently released 2005 Work Plan focuses attention on access to home health care. The OIG's concern is that the fall in the average number of visits per episode may indicate agencies' reluctance to "accept patients who need extensive services," the agency says.

"A decrease in visits per episode often means agencies are getting smarter with how they manage cases, rather than meaning they're not taking hard cases," says **Carrie Knittel**, Washington-based **Assured Home Health and Hospice's** director of clinical services.

Many agencies simply don't have the staff available to provide care for certain types of patients or for patients with very intensive needs, which is something the OIG probably hasn't considered, argues Burtonsville, MD-based health care attorney **Elizabeth Hogue**. An agency's ability to care for a certain kind of patient can vary from day to day depending on many factors, she says.

Even if agencies choose not to accept patients with very intensive needs because of financial pressures, that is not fraud or abuse, Hogue tells **Eli**. It is a reasonable response to the design and incentives of PPS, she suggests.

Experts warn: The OIG also plans to look at quality of care under PPS by using rate of rehospitalization and use of emergent care as indicators. This plan doesn't make sense to many in home care.

"I absolutely do not believe that these outcomes are reflective of [a provider's] quality of care," says consultant **Pam Warmack** with Ruston, LA-based **Clinic Connections**. Re-hospitalizations and emergent care reflect the case mix of the patient population and the practices of the medical community where the patient lives, she adds.

Other experts agree, citing cases of physicians who insist a patient meet them at the ER "just to check" whenever there's a concern, or who readmit patients because there are too many empty beds in the hospital.

Relevant factors an agency has very little control over include family availability and competence, patient age and lack of education, multiple comorbidities and limited access to medication or proper diet, providers argue.

High acuity patients and those hospice-eligible, but not in hospice care, also increase rates of hospitalization and emergent care, Knittel reports.

What to do: In the face of these challenges, agencies must concentrate harder than ever on the factors they can control, Warmack says. For example, you should:

1. Educate patients. Provide handouts to patients and families about symptoms that indicate they should call the home health nurse who can visit and perhaps prevent the patient from returning to the hospital.

2. Educate physicians. Teach physicians about the outcomes and enlist their help to prevent some unnecessary hospitalizations.

3. Increase communication. Nurses and therapists staying in closer touch with physicians may head off problems before they reach a crisis point.

4. Structure care. Use disease management programs and care maps to maximize rehabilitation potential and minimize complications.

   Agencies also will need to decline admissions that are inappropriate for home care or where inadequate discharge planning has made successful home care unlikely, Hogue advises.

   Look to therapy: Another OIG target for 2005 is the extra $2,000 in reimbursement agencies receive for a high therapy episode - one in which the patient requires 10 or more therapy visits. The OIG will study whether therapy visits comply with Medicare regs, as well as the duration of visits, the Work Plan indicates.

   Agencies are extremely vulnerable in this area, Hogue worries, because the data HHAs collect and transmit to the government is the same data the feds will use to come after the agency. If PPS data shows a big spike in therapy visits or visits of very short duration, it's likely to appear HHAs are trying to game the system - and that means a crackdown. Or CMS could argue an agency was underutilizing therapy in pre-PPS days, Hogue says.

   The key to surviving therapy scrutiny is coordinated team effort in providing quality care and excellent documentation, experts say.

   Another challenge: One more issue the OIG plans to investigate in 2005 is physician care plan oversight. A jump in CPO reimbursement from $15 million in 2000 to $41 million in 2001 has made the feds suspicious about the physician payments for 30 minutes or more of qualified management activities regarding home health patients.

   This focus follows an earlier study of CPO in Puerto Rico, where none of the claims met the requirements, the OIG claimed. But many CPO denials result from discrepencies between diagnosis codes on the physician's forms and those on the home health records, experts say.

   The OIG also plans to determine whether the current outlier system is equitable and whether outliers cluster in certain home health resource groups (HHRGs) or geographic locations, according to the work plan. The Centers for Medicare & Medicaid Services has already said it will change outlier policy starting in January.

   Editor's Note: The OIG's work plan for Medicare is at www.oig.hhs.gov/publications/docs/workplan/2005/2005WPCMS.pdf.