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Home Health Line

Regulatory news, benchmarks and best practices

In this Issue

1 **M&A activity**
Play to your strengths if you want to sell in the thriving M&A market

3 **Benchmark**
Home health, hospice and home care transactions by quarter

4 **OASIS-E**
Develop a process for tracking data for a successful CDI program

5 **Compliance**
RCD checklist to avoid the top 5 reasons for non-affirmations

6 **Documentation**
Prove medical necessity when billing GIP care days to avoid hospice denials

8 **Benchmark**
Top reasons for hospice payment denial for GIP claims

*M&A activity*

# Play to your strengths if you want to sell in the thriving M&A market

Proposed cuts to Medicare payments next year, with more cuts possible in the near future, may impact the M&A market down the road. But, for now, demand for home health agencies remains high.

The market continues to thrive, says Jack Eskenazi Jr., managing partner of Healthcare Advisory Partners, based in Soquel, Calif. "Agency owners I speak with are being bombarded with sales calls, so they know it's a sellers' market," he says.

CMS' plan for a 4.2% cut in payments for 2023 could impact sales in the future, says Cory Mertz, managing partner with Mertz Taggart of Fort Myers, Fla.

"It will impact deals and deal volume as some would-be sellers will be in a wait-and-see mode," Mertz says. "For deals in the works, it can certainly create a valuation gap between the buyer and seller that will need to be worked through. Anytime there is uncertainty in the marketplace, valuation gaps occur."

## Take yourself out of the equation

When considering whether your agency is ready to sell, try taking yourself out of the equation.

When looking at agencies to buy, it's not just hands-on leadership that catches the eye of buyers, but hands-off leadership, as well, says Mike Moran, co-founder of M&A Healthcare Advisors of Calabasas, Calif.

## OASIS-E tips and guidance to minimize productivity declines

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When owners or CEOs don't have an active, day-to-day role in the agency, it's a great sign that the agency is a well-conducted and efficient business, Moran says.

"If you as the owner can remove yourself for a couple months and know that everything is going to run and operate to status quo, that's a prime acquisition target," Moran stresses.

This all comes back to hiring and retaining quality staff members. Staff are the bread and butter in the M&A market.

## Market has proven resilient

The home health mergers and acquisitions market has received a lot of attention lately as anti-trust violations and the blocking of major hospital mergers made headlines this summer.

This isn't necessarily something home health agencies should be concerned about.

"The current state of the M&A market continues to be very active," Eskenazi says. "Veterans of the industry have seen this scenario before as we always seem to be lurching from feast to famine and back to feast again."

In recent years, agencies worried that PDGM and COVID-19 would decimate the industry, but instead the market thrived.

Over the past couple of years the M&A market for home health has been thriving.

"Most of the activity we're seeing right now is well-run agencies taking advantage of favorable market conditions to sell for premium valuations," Eskenazi says.

The market is seeing far fewer agencies distressed by these factors to the point that they are forced to sell for a discount, he continues.

## Buyers grow more selective

While the market is still very active, the low-hanging fruit is gone and buyers have gotten pickier, warns Tom Fennell, vice president of Healthcare Advisory Partners.

Consequently, it's harder to find good deals and this translates to higher valuations for agencies, Fennell says.

The primary factor driving the market continues to be demographics, Eskenazi says.

There is always tension between the growing demand for services from beneficiaries and growing demand for efficiency from payers, he continues.

"Rate cuts, rising inflation and the potential for recession are all valid headwinds that providers need to navigate, but they don't change the fundamentals driving growth and consolidation," Eskenazi says.

## Your staff is your biggest asset

Agencies across the county have struggled with adequate staffing throughout the past few years, so staffing is one of the primary issues that buyers look at.

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Acquisitions have become a way to bring on more staff, to bring on great leadership teams, to bring people to these larger organizations to help grow and provide excellent care, Moran explains.

Because of this, agencies aren't just looking at patient populations when looking to merge or acquire. They are looking at the staff.

The Great Resignation shuffled the labor market, but workers weren't attracted to in-home care because the pay is too low, Fennell adds.

Rate cuts and inflation now make it even harder to pay employees more, but an overall economic downturn could mean more people looking for work.

Buyers want to see that agencies have a solid workforce and are able to not only recruit, but retain the staff that they have.

Beyond the staffing, there are a few other constants that buyers continue to look for in agencies, Eskenazi explains:

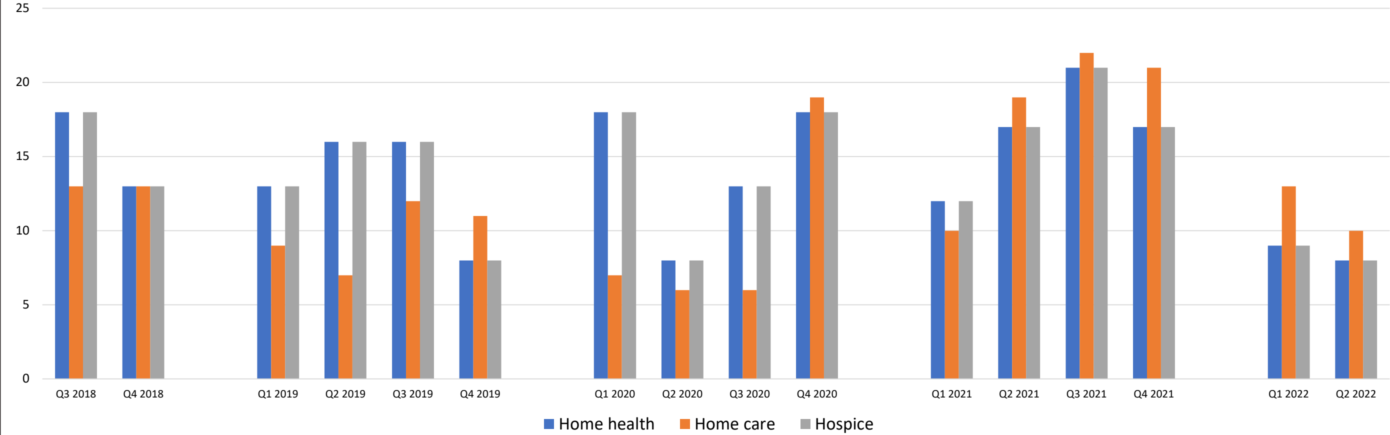
- **Leadership.** Buyers care about employee continuity and an owner-operator who wants to leave at closing will impair the valuation. If a seller wants a premium, make sure to have a stable management team in place that the buyer can rely on post-closing.
- **Profit margins.** Buyers are looking for agencies with high profit margins. "When going to market, the slimmer the margin that you have, the less your company is worth," Moran says.

  As profitability is something that directly impacts the worth of your agency, it's important that agencies factor in the resumption of CMS' 2% sequester payments, as that will directly affect an agency's margin.
- **Financial statements.** Buyers need reliable information upon which to make decisions, so it's preferable to use accrual-basis accounting and to break out administrative expenses from direct expenses to calculate gross profit margin.
- **Compliance**. Buyers want clean agencies with little or no liabilities, so make sure to be compliant with all federal and state laws and program regulations and to clear any ADRs or other compliance audits before going to market.

## Benchmark of the Week

### Home health, hospice and home care transactions by quarter

This graph shows the general trends in transactions made in the certified home health and hospice industries, as well as non-medical home care agencies, from 2018 through the second quarter of 2022. Data were compiled by health care mergers and acquisitions firm Mertz Taggart based on the transactions they were aware of. It may exclude smaller transactions that didn't receive widespread attention and franchise activity. *(See story, p. 1.)*




*Note:* Total industry transactions does not necessarily equal the sum of the sub-industries, as many transactions include more than one sub-industry.
*Source:* Mertz Taggert Home Health, Hospice and Home Care M&A Report Q2 2022

- **Strategy.** Buyers make acquisitions to execute on strategy, so sellers should be mindful of popular strategic themes.

  One dominant theme right now is private equity investors rolling up pure-play assets, so sellers who want to appeal to that set of buyers will want to focus on growing one core business rather than a diversified payer mix.

- **Contracts.** Sometimes a premium valuation is informed by the seller having an important contract. In these cases, it's imperative for the contract to remain valid and to prepare a transferability strategy such as utilizing a stock purchase.

- **Operations.** Selling the company can take several months, so it's important to maintain good operations throughout the process and make sure the divesture doesn't become a distraction. If operations falter during the process, buyers will have a reason to lean toward a discount valuation. If operations remain strong throughout the process, sellers can make a stronger case for a premium valuation. — *Sarah Schock* (sschock@decisionhealth.com) ■

*OASIS-E*

## Develop a process for tracking data for a successful CDI program

Having an effective clinical documentation improvement (CDI) program may be key as home health faces an increase in third-party scrutiny related to additional documentation requests (ADRs) and the Review Choice Demonstration (RCD).

CDI programs manage the tracking of diagnoses, data, documentation and the impact on agency practice and outcomes including payment, explains Brandi Whitemyer, RN, CDIP, COS-C, HCS-D, an Ohio-based independent home health & hospice consultant.

While such programs should start with review of documentation in the home health record, the core of CDI is statistical analysis of data extracted from the documentation.

All staff within the agency needs to have some level of understanding of what they should be charting related to regulations, rules, Medicare expectations and Local Coverage Determinations, says Sherri Parson, HCS-D, post-acute education senior manager with McBee Associates of Wayne, Pa.

"Not having that support in the documentation can often leave the agency with lost revenue, compliance issues or further scrutiny," Parson says.

In addition, agency staff responsible for intake, coding and quality assurance needs to be aware of what documentation is needed within the physician or provider documentation to meet regulatory requirements and support the home health clinical records from the admission forward, Whitemyer says.

### Begin with documentation

When starting an analysis of CDI data, agencies should follow the hierarchy of documentation, Parson says:

- **Start with technical components.** When reviewing documentation, begin with key items that include certification, orders, physician provided documentation and face-to-face encounters.
- **Review requirements for care.** After that, take a look at homebound documentation, intermittent skilled nursing or therapy and documentation supporting medical necessity.
- **Conclude with OASIS documentation.** Finally, agencies should focus on OASIS, coding and the record documentation supporting code assignment and assessment coding.

Prioritize your analysis, Parson recommends. "Once you have identified and made consistent improvements in an area, move to the next area of improvement."

CDI can be part of your QAPI program, but whenever approaching agency improvement, you have to focus your efforts on an area or two, she says. You can't improve everything all at once.

### Practice CDI with realistic scenarios

The core part of a true CDI program is following up on the review of documentation, including provider documentation such as face-to-face encounters, orders and queries; home health agency documentation; and other documentation within the home health record, with a focused analysis of how this documentation impacts agency operations in a targeted manner.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CDI data should be analyzed and reviewed in a predetermined manner to obtain detailed statistics related to agency compliance, payment, referral management and other key areas. These statistics can then be rolled into the agency's QAPI program to determine goals for improvement.

There are many different ways to target your CDI analyses including focusing on physicians with higher query and referral rates.

A proper CDI analysis, as laid out by Whitemyer, could look something like this:

Physician X has increased referrals to the agency by 25% in the past quarter. CDI program analysis has revealed:

- Physician X requires query on 30% of the 126 cases referred in the past quarter.

  Note: Since the total number of referrals went up for this physician by 25%, the total percentage of queries must be compared to prior quarter analyses from the same physician to see if the query requirement went up or down with the referral increase.

  Of the queries sent, Physician X responded to 90%.
- Of this 90% response to queries, only 80% provided additional information.
- Of the 90% of queries responded to, the physician responded to 100% of queries related to billable vs. non billable PDGM diagnoses, with only 50% of those being positive responses that resulted in ability to bill (50% remained non billable).
- The average Home Health Resource Group (HHRG) amounts per 30-day period for Physician X was $2,265 for the prior quarter. This represents a decrease from an average of $2,655 in the quarter prior, despite the increase in referrals.

### What would this analysis tell you?

Despite more referrals from this physician, payments have actually decreased.

And this physician has a poor response rate (50%) for queries related directly to billable diagnoses (need for PDGM diagnosis). This also reduces payment overall as these cases are not billable at all due to negative response.

Next steps can include:

- **Review specific cases.** See if this relates to specific types of referrals or diagnoses.
- **Educate the physician.** Specifically target training on PDGM and primary diagnosis, as well as required documentation to support these diagnoses.
- **Consider not targeting this physician for additional referrals.** This would come after further analysis or post education analysis, since the provider does not easily respond to the most important queries and payment decreased despite more referrals (and queries have exceeded the number of referrals increased). — *Sarah Schock* (*ssschock@decisionhealth.com*) ■

*Compliance*

## RCD checklist to avoid the top 5 reasons for non-affirmations

Below are the top five non-affirmation issues in Review Choice Demo (RCD) as seen by Brandi Whitemyer, RN, CDIP, COS-C, HCS-D, Ohio-based home health and hospice consultant, who advises agencies going through RCD audits. Use this list to assess your agency's audit risk.

1. The most common issue is simply the **primary diagnosis not matching the encounter note focus**. It is critical that the diagnosis coded as primary on the home health plan of care not just be any diagnosis mentioned or confirmed in a provider/physician encounter note, but rather the presenting issue for the encounter (the problem diagnosis) and it must be reported as unstable and changes in the patient's medications, treatments, etc. ordered as a result of the problems resulting from the unstable diagnosis. A diagnosis that is simply chronic and progressing will not substantiate payment.
2. **Primary diagnosis assigned based on non-eligible form or encounter note**. In order for affirmation to be provided under pre-claim review (PCR), the primary diagnosis must substantiate a need for home health, justify homebound condition and indicate a need for the services to be provided by home health.

   In addition to this, the face-to-face encounter note must meet the requirements set forth by Medicare administrative contractor Palmetto GBA. A face-to-face "form" is not eligible for

consideration as a face-to-face verification as requirements in 2015 were updated to eliminate the form requirement and require that provider encounter notes substantiate the face-to-face requirement. In addition, all CMS signature requirements must be met. If the encounter note from which the primary diagnosis is coded does not meet signature requirements, the billing period will not be affirmed.

3. **Changes in focus of care without updated encounter notes/updated face-to-face documentation.** The primary diagnosis must reflect the focus of care for the home health episode. However, the primary diagnosis must match the encounter note problem diagnosis in order for affirmation to be provided by the PCR reviewer (See No.1 above). It's a common problem that clinicians assess a patient and find that the focus of care will be something other than that for which the patient was referred or the patient will be recertified for a new or changed problem other than that which is the problem diagnosis in the face-to-face encounter note.

   This will result in non-affirmation unless a new encounter note is provided to replace the initial face-to-face encounter if this occurs at the start of care or as an update if it occurs at the recertification. The PCR reviewer will require both the initial face to face and the update to be submitted if this occurs for a recertification.

   For example, patient is admitted following a fall with right hip fracture for physical therapy. PT sees patient for 56 days and goes to discharge, finding that the patient has a wound to the sacrum. The RN goes out and sees the patient and receives orders to recertify for a stage 3 wound of the sacrum. This will be the focus of care but a new face-to-face encounter note will need to be obtained in order to code this wound as primary and receive affirmation under RCD.

   A face to face attestation statement on the POC for a recert in a case such as this would look like this, for example: "Face to Face- Encounter Date: 7/17/20 for SOC updated encounter 11/9/20 — I certify that I, or a nurse practitioner or physician's assistant working with me, or a physician who cared for the patient in an acute or post-acute facility, had a face-to-face encounter with this patient and documentation of that encounter has been incorporated into my patient record."

4. **Aftercare.** When coding aftercare as a primary diagnosis and submitting for RCD pre-claim review, the face-to-face encounter note must be a post-op note or the billing periods will be returned as non-affirmed. Coders must be cautious in deciding when aftercare is the most appropriate diagnosis to code as primary.

   For example, when coding a PleurX catheter, Z48.813 must be coded per Coding Clinic, but this does not need to be primary. Because PleurX insertion is a procedure, there will not be a post op note, so it is not advised to code this primary in such a case, but rather first code the condition requiring the PleurX as this is most likely to be reflected as the focus or problem diagnosis in the face-to-face encounter note.

5. **Coding and the POC**. While the diagnosis MUST match the focus diagnosis on the face-to-face encounter note, the goals and interventions on the POC must also follow this. This is also true for secondary diagnosis. A non-affirmation will be issued for "content of the plan of care is not sufficient" if the goals and interventions do not closely match BOTH the diagnoses as assigned and sequenced AND the patient condition as reflected in the provider/physician encounter note.

*Documentation*

# Prove medical necessity when billing GIP care days to avoid hospice denials

The most common reason for denial of Hospice General Inpatient Care (GIP) under a recent review was "Hospice General Inpatient Reduction — Services not reasonable and necessary."

Palmetto GBA recently released the top five reasons for denials after performing provider-specific pre-payment probe review on hospice GIP claims.

The review included 2,504 claims from 216 providers processed between Sept. 1, 2021, and March 31, 2022. (*See benchmark, p. 8*.)


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Of those reviewed, 570 were either denied or partially denied resulting in a claim denial rate of 23%, Palmetto shares.

"Services not reasonable and necessary" accounted for 29% or 165 of the denied claims.

This GIP reduction is specific to services not found to be reasonable and necessary for the hospice days on the claim billed as general inpatient care, notes Ohio-based independent home health and hospice consultant Brandi Whitemyer, RN, CDIP, COS-C, HCS-D.

As there continues to be increased hospice utilization, there is understandably a marked increase in the use of GIP days, adds Nanette Minton, HCS-D, senior clinical coding manager with MAC Legacy in Denton, Texas. "Increased utilization equates to increased scrutiny as the audits flow to where the money is distributed."

"This is the top denial reason in this category due to increased oversight on utilization of the GIP level of care," she adds.

Supporting these services can be confusing as there are many gray areas in the interpretation of what qualifies a patient for GIP.

CMS has specific requirements for hospice that must be met for GIP level of service, which is a higher payment per day, Whitemyer explains.

Patients under hospice care must require acute pain management, medication adjustment, observation or other stabilizing care or skilled care that cannot be provided in the home setting on a short-term basis.

### What causes this denial?

This denial indicates that the hospice services billed for general inpatient care days were not covered.

"A claim could be denied if the documentation did not support medical necessity for this level of care," Minton says. When this happens the GIP care days are reduced to routine care days which leads to a significant change in reimbursement that has a negative financial impact for that certification period.

Therefore, having solid documentation is important.

Palmetto shared that in order to avoid this denial, documentation should include the following:

- Name of the contract facility in which the patient is receiving general inpatient care
- Explanation for admission to the inpatient facility
- Hospice interdisciplinary notes during the general inpatient stay and the physician's discharge summary
- Documentation of the patient's condition during the inpatient stay
- Hospitalization must be on a short-term basis and must be related to complications attributable to the terminal diagnosis such as pain control or symptom management which cannot be provided in other settings
- Need for pain control or symptom management that is not feasible in other settings
- Skilled care required when home support has broken down and it is no longer feasible to furnish needed care in the home setting
- Patient's need for medication adjustment, observation or other stabilizing treatments, which cannot be furnished in home

"Agencies need to ensure that they are only admitting patients that truly qualify for the GIP level of care," Minton says.

Hospices often fail to document the patient's condition any differently during the GIP days than during standard routine care days, other than noting that the patient is under GIP care. They may also fail to conduct interdisciplinary communication and team meetings regarding care, update the patient's hospice plan of care or further document changes in the patient's condition and how GIP is addressing this.


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## Other reasons for denials

The second most common denial, for invalid notices of election (NOEs) that don't not meet statutory/regulatory requirements, accounted for 26%, or 150 of the denials.

"Denials for this reason usually relate to missing information or information mismatched or invalid," Whitemyer says. "This could be anything from a patient date of birth to physician PECOS or NPI mismatch."

There are many elements to this statement and they must all be met to be in compliance including:

- What hospice will provide care
- An acknowledgment of full understanding of hospice care — palliative versus curative
- An acknowledgment that there is an understanding that certain Medicare services are waived by election
- The effective date of the election which cannot be retroactive
- Designation of attending physician if any with enough detail to identify the physician
- Acknowledgment that the designated attending physician was their choice
- Information on cost-sharing for hospice, the right to receive an election statement addendum as appropriate, information on the Beneficiary and Family Centered Care Quality Improvement Organization and the right to immediate advocacy
- The signature of the person electing hospice

Another denial reason that stands out to experts is "physicians' narrative statements not present or not valid," which accounted for 13% of the denials.

"One thing that I have seen trip up many hospice personnel is the fact that the physician must be the one who writes the brief narrative. It cannot contain checkboxes or standard language," Minton says. "There is also statutory language about where the narrative/signatures must fall if the narrative is an addendum to the certification."

Hospices must stay up to date with regulatory requirements and standards in order to be successful including the interpretation by experts of said statutory requirements, she adds.

Another issue that often comes up with this is with all the different EMRs out there, reviewers just don't know where to find the certification statement.

"Agencies need to make very clear where these required elements are when they provide records to CMS for review," Whitemyer says. — *Megan Herr* (*mherr@decisionhealth.com*) ■

**Editor's note:** For more details on Palmetto's top reasons for hospice denials, see https://tinyurl.com/mrx6f9as.

## Benchmark of the Week

### Top reasons for hospice payment denial for GIP claims

Palmetto GBA released the top five reasons for denials after performing provider-specific pre-payment probe review on Hospice: GIP — General Inpatient Care claims. The review included 2,504 claims from 216 providers processed between Sept. 1, 2021, and March 31, 2022. Of those reviewed, 570 were either denied or partially denied resulting in a claim denial rate of 23%, Palmetto shares. The most common reason for denial, "Hospice General Inpatient Reduction — Services not Reasonable and Necessary" accounted for 29% or 165 of the denied claims. *(See story, p. 6.)*

| Denial Description | Denial Code | Number of Occurrences | Percent of Total Denials |
|---|---|---|---|
| Hospice GIP Reduction - Services Not Reasonable and Necessary | 5CF91 | 165 | 29% |
| NOE Invalid; Does Not Meet Statutory/Regulatory Requirements | 5CNER/5FNER | 150 | 26% |
| Physicians Narrative Statement Not Present or Not Valid | 5CFH9/5FFH9 | 73 | 13% |
| No Plan of Care Submitted | 5CFNP/5FFNP | 48 | 8% |
| Initial Certification Not Timely | 5CFH6/5FFH6 | 34 | 6% |

*Source: Palmetto GBA*


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