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IN THIS ISSUE

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Fixing what the BBA broke: A review of 2000's home care legislation

The 106th Congress leaves some questions unanswered

As an election year, 2000 was politically charged in a multitude of arenas, with health care taking top billing among the "star" issues. A White House fact sheet released earlier this year revealed that only 4 million Americans have some form of private long-term care insurance. That's a mere 1.5% of the population, and with nursing home costs well exceeding $50,000 annually, home care will become increasingly important.

For those lucky enough to qualify for home care, now there is the fear that their home health care agencies can no longer afford to stay in business, let alone keep them on as patients. Not surprisingly, from the home care perspective, the most important legislation was a bill that tried, once again, to remedy the damage inflicted by the Balanced Budget Act of 1997 (BBA). **(See box, p. 135.)**

Tim Brown, acting director of public relations for the National Association for Home Care (NAHC) notes, "BBA-fix legislation and PPS- [prospective payment system] related issues, such as the bundling of medical supplies, dominated the political landscape this year."

One such piece of legislation is HR 4727, the Equal Access to Medicare Home Health Care Act of 2000, identical Senate / House bills that are geared to helping home health care agencies recoup some of the losses they have incurred as a result of the BBA. (At press time, neither of these bills had passed.) The bill calls for the Health Care Financing

New business report coming to *HHH*

In 2001, *Hospital Home Health* will introduce a new supplement, *Home Health Business Quarterly*, which will detail financial and corporate happenings in the home health and assisted living industries. Mergers and acquisitions; earnings reports; news from Washington, DC, on regulatory issues and legislative action; and company and personnel profiles all will be part of this helpful new resource for the home health executive. Look for the first installment in January's issue. ■

Administration (HCFA) to revisit the subject of the financial burdens that accompany the revised PPS regulations.

Other provisions in the bill include:

• elimination of the 15% cut in home health spending mandated by the BBA, a rural security cost add-on of 10% to the episodic base payment under PPS for patients in rural areas and to reimburse providers for the costs of security services in high-risk areas;

• overpayment relief, which would have provided for repayment of interim payment system overpayments without interest for three years, and thereafter at an interest rate lower than currently mandated;

• telemedicine, whereby such services would be considered a legitimate Medicare home health service, the costs included in the agencies' cost report.

Perhaps most important is that at press time, Congress still was unable to reach a conclusion on the Medicare provider "give-back" package. The bill, HR 5612 (the House Democrat version) the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Beneficiary Protection Act of 2000 and HR 5543 (the House Republican version), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

Passage of the legislation is being held up because of the inability of the two political parties to agree upon the terms.

As the package currently stands, Republican leaders in the House and Senate have included these items:

• a one-year delay in the automatic 15% reduction (until Oct. 1, 2002);

• a full marketbasket adjustment for FY 2001;

• a temporary two-month extension of periodic interim payments (PIP) through December 2000;

• a marketbasket adjustment for hospice;

• clarification of the use of telehealth in the delivery of home health services;

• a General Accounting Office (GAO) study on the bundling of nonroutine medical supplies in the PPS base rate;

• prohibition against the sole use of distance or time as criteria for branch office, and GAO study on supervision of home health care provided in rural areas;

• a Medicare Payment Advisory Commission (MedPAC) study of low volume, isolated rural health care providers, including home health agencies;

• a provision allowing home health patients to attend adult day care without loss of their homebound status. (This last provision would add $300 million to the total cost of the bill and increase home health's share of the approximately $31 billion package to about $1.5 billion over five years.)

Democrats, meanwhile, support President Clinton's stated intention to veto, arguing that the package does not include enough funding for ailing fee-for-service providers such as home health agencies, nor does it require greater accountability from managed care plans.

"The home care industry," says Brown, "has come out strongly in favor of three provisions in the Senate Finance Committee's Medicare bill, namely removal of medical supplies from PPS and payment on a fee schedule, increased funding for outlier patients, and an add-on to the base payment for rural patients." Unfortunately, those provisions were not included in the GOP version of the bill.

Senate versions of this legislation have been rolled into a general appropriations bill, says **Ann Howard**, executive director of the American Federation of Home Health Agencies in Silver Spring, MD. So broad in scope is the general bill, that Howard refers to it as the "minimum wage-tax cut-Medicare" bill. This bill, she says, "will be contentious. So contentious, in fact, that I don't see how the issues will be resolved. Presumably, they might be able to sort through it and get an agreement, but that will take through Christmas

(Continued on page 136)

COMING IN FUTURE MONTHS

- Are you doing enough to protect yourself from airborne and bloodborne diseases?
- Pressure ulcers gaining more attention in home care: What's behind the hype?
- Pressure ulcer protocol: How to treat patients who enter home care with them
- When would-be caregivers refuse: Tips on how to handle unwilling families
- Making advertising work for you on a home care-sized budget

Waiting for action: Bills introduced, but not passed, in 2000

- ✔ **HR 3872 "Long-Term Care and Reimbursement Act of 2000":** To allow individuals a deduction for long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a tax credit for individuals with long-term care needs.
- ✔ **HR 4028 "Alzheimer's Disease Medicare Home Health Care Benefit Clarification Act of 2000":** To allow those with Alzheimer's Disease or related dementia to participate in an adult day care program without forfeiting their Medicare home health benefit.
- ✔ **HR 4219 "Home Health Fairness Act of 2000" (companion bill to S.2365):** To amend Title XVIII of the Social Security Act to eliminate the 15% reduction in payment rates under the prospective payment system for home health services.
- ✔ **HR 4623 "Medicare Home Health Assistance Act of 2000":** To amend Title XVIII of the Social Security Act to revise the calculation of base payment rates for the prospective payment system for home health services furnished under the Medicare Program.
- ✔ **HR 4727 "Equal Access to Medicare Home Health Care Act of 2000":** To eliminate the additional 15% cut in home health services, provide an add-on to the home health prospective payment system (PPS) base payment for patients in rural areas and a pass-through for security costs, provide interim payment system overpayment relief, and recognize telemedicine as a legitimate means of delivering home health services.
- ✔ **HR 5163 "Home Health Refinement Amendments of 2000":** To eliminate the 15% reduction in payment rates under PPS, provide additional payments for outliers and additional payments in rural areas and security services, exclude nonroutine medical supplies under PPS for home health services, and provide a study for telehomehealth services.
- ✔ **S 2298 "Homebound Clarification Act of 2000":** To base homebound determination solely on the existing standard of whether leaving home requires considerable or taxing effort, eliminating the number or length of absences as criteria.
- ✔ **S 2365 "Home Health Payment Fairness Act of 2000":** To eliminate the 15% reduction in payment rates under the prospective payment system for home health services.
- ✔ **S 2766 "Equal Access to Medicare Home Health Care Act of 2000":** To eliminate the additional 15% cut in home health services, provide an add-on to the home health prospective payment system (PPS) base payment for patients in rural areas and a pass-through for security costs, provide interim payment system overpayment relief, and recognize telemedicine as a legitimate means of delivering home health services.
- ✔ **S 2835 "Medicare Home Health Refinement Act of 2000":** To provide emergency cash-flow assistance for home health agencies, reimbursement of home health agencies for unfunded PPS-related costs, OASIS labor costs, and nonroutine medical supplies furnished by home health agencies.
- ✔ **S 2999 "Health Care Provider Bill of Rights":** To reform the Health Care Financing Administration's regulatory processes, appeals, overpayment procedures, voluntary disclosure, criminal enforcement, and provider education.
- ✔ **S 3034 "Home Health Refinement Amendments of 2000":** To eliminate the 15% reduction in payment rates under PPS, provide additional payments for outliers and additional payments in rural areas and security services, exclude nonroutine medical supplies under PPS for home health services, and provide a study for telehomehealth services.
- ✔ **S 3077 "Balanced Budget Act Refinements of 2000":** To completely eliminate the additional 15% cut in the Medicare home health benefit and provide a 10% add-on for 2 years to the PPS base payment for rural patients; eliminate the bundling and consolidated billing of nonroutine medical supplies for 18 months to give the Secretary of Health and Human Services time to study whether bundling and consolidated billing are appropriate for medical supplies; help to clarify branch office rules; provide full market basket updates in hospice payments for fiscal years 2001 and 2002 and a 10% upward adjustment in the underlying hospice rates; provide full inflation update payments for medical equipment, oxygen, and other supplies; provide that regular attendance at adult day care by those with Alzheimer's disease or other dementia would not result in a loss of homebound status.

Source: National Association for Home Care, Washington, DC; http://Thomas.loc.gov.

and [Congress] already is not happy about having to come back."

Howard says she holds out a small bit of hope that the Medicare portion may be broken out of the larger piece of legislation to stand on its own. "So then the issue is: Can Medicare be passed on its own? The answer is yes. It's possible, but on the other hand, there's a lot not to like in it," she says.

"For one thing, there's the $30 billion directed to HMOs. Secondly, Clinton very well might veto it if it were to pass because he doesn't like all the money going to HMOs," she continues. "Then there are a lot of senators who won't like it because it means money for HMOs. Those senators might not have any in their state and will [end up] paying for HMOs but seeing nothing done about their rural hospitals. I don't know whether Medicare will be strong enough to stand."

Howard says that the home care industry does like some parts of the legislation, despite its flaws. "We like what is in there for us, but, really, it's a nickel and a dime being thrown at an $80 billion wound. Nothing is returned of $80 billion that was taken from us. That's a sad situation."

"Where is all that money going? A big chunk of it is going to HMOs. Frankly, it's my contention that this money is payment of tribute in the old-fashioned sense of the word to keep the HMOs in the Medicare program so that if Republicans sweep Congress and the White House, [HMOs] will be there to privatize Medicare on their willing backs." (As *Hospital Home Health* went to press, the outcome of the presidential election was not decided.)

In other congressional action, the House voted 203 to 220 earlier this fall not to delete a provision from the House Labor Health and Human Services FY 2001 appropriations bill that would prohibit the Occupational Safety and Health Administration (OSHA) from releasing its ergonomic standards. If the motion had passed, it would have meant that an amendment preventing OSHA from implementing its proposed ergonomics standards before the end of the year would have been removed from the FY 2001 appropriations bill.

If it passes, HR 987 — the Workplace Preservation Act — would require the secretary of Labor to wait for completion of a National Academy of Sciences study before promulgating a standard or guideline on ergonomics. NAHC, says Brown, is against the mandatory imposition of ergonomic requirements and suggests establishing a voluntary program. As it stands now, a compromise has been reached between Republicans and Democrats in the House that would delay the implementation of ergonomic rules until six months into 2001, allowing the incoming president to determine whether the standard should be imposed.

Howard agrees that the delay can only be a good thing. And while she sees "some reasons for implementing ergonomics plans," she doesn't think forced regulations are good for home health agencies. "The evidence is not in. We're still waiting for studies from National Academy of Sciences as to the benefits. The Labor Department really jumped the gun on this one."

For those home care industry professionals looking to tip the scales of justice in their favor, notes Howard, there is S 2999, the Health Care Provider Bill of Rights. "It's a very, very far-reaching bill that would protect the rights of home care providers. It would even the scales between providers that have been treated poorly by federal government and their representatives and the government itself."

[For more information, contact:

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Part I of a series

Needlestick prevention again in the spotlight

The recent passage of the Needlestick Safety Prevention Act has once again brought needlestick prevention into the spotlight, and for health care professionals, such media attention cannot come often enough. Although the general public's awareness of the dangers of needlesticks was heightened some 20 years ago with the onset of the AIDS epidemic in North America, the recent successes with drug cocktails have lulled much of society into a false sense of security.

Some people may believe that even if they contract the human immunodeficiency virus (HIV), medical science can prevent it from developing into full-blown AIDS. The reality, of course, is that HIV / AIDS still has no cure, and for that

Why Needlestick Legislation?

The facts listed below illustrate the dramatic effect that needlesticks and sharps injuries have on health care workers each year.

NEEDLESTICK INJURY

- ☐ Health care workers (HCWs) suffer between 600,000 and 1 million injuries from conventional needles and sharps annually. These exposures can lead to hepatitis B, hepatitis C, and human immunodeficiency virus (HIV), the virus that causes AIDS.
- ☐ At least 1,000 HCWs are estimated to contract serious infections annually from needlesticks and sharps injuries.
- ☐ Registered nurses working at the bedside sustain an overwhelming majority of these exposures.
- ☐ Needlestick injuries are preventable. More than 80% of needlestick injuries could be prevented with the use of safer needle devices.
- ☐ Less than 15% of U.S. hospitals use safer needle devices and systems.
- ☐ In 1992, the Food and Drug Administration (FDA) issued an alert to all health care facilities to utilize needleless IV systems wherever possible. This alert was merely a recommendation, not a mandate. Therefore, health care facilities are under no legal obligation to comply.
- ☐ The first safe needle designs were patented in the 1970s, and the FDA has approved more than 250 devices for marketing as safety devices.
- ☐ More than 20 other infections can be transmitted through needlesticks, including tuberculosis, syphilis, malaria, and herpes.

HEPATITIS B

- ☐ Hepatitis B is now preventable due to the vaccine that must be offered to HCWs and is given to children at birth.
- ☐ Regulatory and legislative efforts were largely responsible for the reduction of deaths from hepatitis B as a result of vaccine programs.
- ☐ Following these regulatory and legislative efforts, including the Occupational Safety and Health Administration Bloodborne Pathogens Standard, cases of hepatitis B in health care workers have dropped from 17,000 annually to 400 annually and continue to drop.
- ☐ Transmission rate: 2% to 40%

HEPATITIS C

- ☐ Testing for hepatitis C after needlestick injuries was recommended first in 1998. It is a silent epidemic. There could be thousands of nurses with occupationally-acquired hepatitis C who do not know it.
- ☐ Hepatitis C is the most frequent infection resulting from needlesticks and sharps injuries. Of health care workers who become infected, 85% become chronic carriers.
- ☐ Chronic carriers have the potential to spread the disease to others, including their partners.
- ☐ Drugs that slow the progression of hepatitis C are available, but cost an average of $1,700 each month.
- ☐ Hepatitis C leads to liver failure, liver transplants, and cancer of the liver. A liver transplant costs $500,000.
- ☐ At least 4 million Americans are infected with hepatitis C.
- ☐ Transmission rate: 2.7% to 10%

HIV

- ☐ HIV is the virus that causes AIDS, a fatal disease.
- ☐ Advances in treatment prolong the time before HIV becomes AIDS. The drug treatment can cost up to $6,000 per month.
- ☐ 16,000 of the 600,000 to 1 million yearly needlestick injuries result in HIV exposure.
- ☐ There are more than 54 documented cases of HCWs with occupationally-acquired HIV, and at least 133 cases of possible transmissions of HIV.
- ☐ There are 35 new cases each year. One in 300 contaminations stems from HIV.
- ☐ Transmission rate: .2% to .4%

Source: American Nurses Association, Washington, DC. Web site: www.nursingworld.org.

matter, neither do many of the diseases that can be contracted from a single, accidental needlestick. **(See box, above.)**

In October, the bill passed the U.S. House of Representatives unanimously by voice vote, and on Nov. 6, President Clinton signed the act into law. Introduced by Rep. Cass Ballenger (R-NC), chairman of the House Education and the Workforce Subcommittee on Workforce Protections, and Rep. Major Owens (D-NY), the subcommittee's ranking Democrat, the bill requires hospitals to use safety needles that retract or blunt their points after usage to prevent injuries.

The legislation also requires nursing personnel to take part in selecting the safety devices to be purchased. Finally, the new law, expected to take effect in nine months, will require employers to maintain a sharps injury log.

The log will be required to contain, at a minimum, this information:

❒ the type and brand of device involved in the incident;

❒ the department or work area where the exposure incident occurred;

❒ an explanation of how the incident occurred.

The information will be recorded and maintained in a way that will protect the confidentiality of the injured employees and will be a source of data for researchers to determine the relative effectiveness and safety of devices now on the market and those that may be developed in the future.

Each year, between 600,000 and 1 million health care workers are accidentally stuck by a needle or sharp. While many of these incidents give the health care professional nothing more than a serious scare, the number of those whose lives are irrevocably damaged cannot be understated. **Lynda Arnold**, RN, the founder of the National Campaign for Health Care Worker Safety, knows on a personal level just how devastating the consequences of an accidental needlestick can be. Arnold was infected with HIV from a 1992 incident. "I'm living proof that needlesticks do happen and their consequences last a lifetime," she says.

Today, Arnold and others who have become ill from an accidental needlestick tirelessly lobby the government to pass legislation such as the recently passed bill. Professional organizations, such as the American Nurses Association (ANA), also are committed to the cause of needlestick prevention. The ANA recommends that health care professionals interested in taking up the fight in their communities become educated about the dangers of accidental needlesticks and about the ways they can be prevented. In a satellite teleconference (sponsored by ANA and the University of Vermont) earlier this year, **Mary Foley**, MS, RN, president of the ANA, addressed the problem. "Nurses need to be informed about what equipment is out there and learn to differentiate the best devices."

[In January, Hospital Home Health *puts a face to the dangers of accidental needlesticks through interviews with nurses who have contracted HIV and hepatitis C from on-the-job needle injuries. Information will be given on developing a needlestick prevention program and what can be done on a community level to promote needlestick prevention.*

For more information on needlesticks, contact:

*• **American Nurses Association**, 600 Maryland Ave., S.W., Suite 100 W., Washington, DC 20024. Telephone: (202) 651-7000.]* ■

Not as easy as it looks: Lessons for new managers

Make the transition to management painless

For many people, a managerial position might seem part of a normal career progression: moving from a position of receiving orders to one giving orders. However, telling people what to do is not the same as getting them to do it. In fact, sometimes telling people what to do is something to be avoided.

Managing is not about giving orders so much as it is about getting people to work independently and cohesively for the common good. It's doubtful that there are those who set out to be bad managers, but the reality is that the road to good management is rife with detours and problems. Many well-intentioned new managers have found that the job is not easy.

Henry Wolford, owner of Wolford & Associates, a management consultant firm in Irvine, CA, explains a manager's primary function. "Your No. 1 role as a manager is to help your people succeed. The definition of a manager is someone who gets work done through the efforts of others. If you try to do everything yourself, you will achieve as much as one person can. But if you can help team members achieve as much as they can, your success multiplies by their numbers."

Managing employees is made even more difficult when someone enters the field from a position where he or she held a great deal of personal autonomy, such as home care nursing, or when an individual really doesn't enjoy management-oriented tasks.

"Not everyone is suited to being a manager. Some people are excellent technicians, and they love being in the trenches," notes Wolford. "I really have to admire people who say, 'No. That job is not for me.'"

Deciding who is ready to become a manager, or for that matter who should ever become one, is not an easy job. Wolford says he has found a way of at least initially screening those who may be ready for a management position. He says the key to being a successful manager is understanding that when you make a decision, you're not

The Management Commandments

These ten commandments can help anyone be a better manager.

1. Don't ask others to do what you have not or will not do yourself. When your employees see you roll up your sleeves and get your hands dirty, they are less likely to complain when you ask them to do the same.
2. Treat your customer service personnel as you want your customers treated. If you have a gorgeous customer waiting area stocked with coffee and donuts, don't have an employee lounge with a wobbly, folding card table and a leaky water cooler.
3. Look for the good things. Take the time to find the good things that went right and use them to praise employees with the same fervor you save for browbeating the monumental screw-ups. They'll remember the praise even longer.
4. Don't be afraid to take advice from your employees. No matter how much time you spend in the office, no matter how good your reporting systems are, no matter how many meetings you hold, no one is closer to the job than the people doing it every day.
5. Remember no one is indispensable, especially you. If you think the world can't go on without you, think again. Disposing of dead wood in an organization allows others to grow. If you hired a loser, forgive yourself, make the cut, and move on to other more fertile ground.
6. Remember no one is infallible, especially you. Mistakes happen. Fix the problem and move on. Be supportive, not vindictive. If you support your employees when they make mistakes, you can expect them to support you when the shoe is one the other foot.
7. Make what you do match what you say. If you require everyone to park in the rear of the building, you should too. If you have a business dress code, don't show up in jeans and cowboy boots just because you can. If you expect employee morale to be high, don't walk around with a chip on your shoulder.
8. Find ways to reward besides handing out money. A pat on the back can go a long way. Even better is a group pat on the back. Successful team efforts deserve a celebration for all, not just the team leader.
9. When delegating, be specific and generous with authority. Don't tell someone to do a job without passing along enough power to get it done. But be specific with the limits. Telling your secretary to use her best judgment to get papers to the Honolulu office might mean her return two weeks later with a great tan.
10. If you want others to follow, you must lead. Followers want four things from a leader: The constancy that you are in control no matter what happens. The consistency that you do what you say you'll do. The support you give them knowing trouble must first get past you to attack them. The trust they place in the faith of your words and deeds.

Source: Wolford & Associates, Irvine, CA. Web site: www.hmeconsultant.com.

making it for just yourself but for everyone in the company — as well as their families. "If you make a bad decision, it affects their lives." He says that if a person is not willing to take on this extended responsibility, he or she is not ready to be a manager.

For those who feel up to the task, there are some general management commandments to help them stay on track. **(See box, above.)** According to Wolford, first-time managers should "sit down and develop basic guidelines for how they will do this job. List your criteria and then try to live to that standard. Winging it is not such a good idea."

One of the easiest pitfalls for a manager is using information as a power tool. "It is usually used [in that way by] someone who is managing from a weak personal position," Wolford notes. Nevertheless, it has a damaging effect on employees. Aside from eroding morale, lording information over employees makes them mistrustful of what a manager is telling them, even when it's the truth.

He says managers should share information whenever possible. "As a manager, you become privy to more information than before, some of it secret or sensitive. Share what you can with your employees, and when you can't share information you are asked about, politely and tactfully tell them you will share it as soon as you possibly can."

Wolford also cautions against sharing information with a select few. "Some managers will share with their favorites but not with the others. It really needs to be shared with everyone or with no one."

Another common management trap springs open when it comes time to discipline employees.

Case management caseloads: How much is too much?

American Health Consultants, publisher of *Hospital Home Health*, and the Case Management Society of America in Little Rock, AR, are collaborating on a unique caseload survey. Case managers in both the payer and provider settings will be surveyed as we compile the first national database on setting and managing appropriate caseloads across the care continuum. If you are a case manager, please visit our Web site at www.ahcpub.com/cmcaseload.html, or complete the fax-back survey inserted in this issue. In return for your participation, you will receive, free of charge, an executive summary of the results of this national survey when they are released in the spring of 2001. ■

New managers and experienced managers alike frequently fail the measured-response test. They'll ignore bad behavior until the problems get to a size where everyone can see them, he explains. By then, it's too late. "If you see a small error or behavior, your response, if done immediately, can be a small one. For example, 'Please don't do that again. Here's a better way of solving that problem.'"

Wolford likes to fall back on the "rule of ignoring" when it comes to meting out praise and punishment. "If you ignore a good behavior, you'll get less of it. If you ignore a bad behavior, you'll get more of it."

Deliver praise and punishment with equal enthusiasm, he says. "It's easy to flaunt your authority and new-found power by lashing out at wrongdoers, [but] managing through fear only makes people work carefully and cautiously. By tempering necessary punishment with similar or larger doses of encouragement, your workers become eager and avidly attack their work."

There are times, too, when a new job is made additionally taxing because one friend is put in charge of managing another. How does a manager go about tempering the demands of a new job with the strength of a good friendship?

First, Wolford suggests, "draw a clear line between where being a friend ends and being a manager begins. Your old friends will expect special favors or a sympathetic ear now that you are their boss, but remember that your function as a manager in the workplace supercedes friendship on the job.

He illustrates his point with an example from his own experiences. "When I was a sales manager, I had reps across three states, but there was one who lived in my city. I made it a point that I never went to lunch with that person any more than any of the others."

For those cases where a friendship is already established, he advises that the two parties sit down and have a heart-to-heart talk about how openly displaying their friendship will have an effect on the workplace and other employees. "Let the other person know that by being openly friendly, he or she will be perceived as the boss' pet. Talk about how the two of you can work together and still remain friends."

This problem is aggravated when the other party is a relative. In this instance, Wolford recommends a proactive stance. "Take the helm and acknowledge right off the bat that this person is a relative. Then tell your employees that you will show them through your actions that you will not be more or less fair to this person than to anyone else. Then do it. They'll look skeptically at first, but they'll come around if your deeds confirm what you have said."

Whether friend, relative, or both, Wolford advises that both of you are sure you know the limits. Becoming a manager doesn't make someone better than their co-workers, just different. "You were not magically transformed with the promotion. You are the same person today as you were yesterday. You simply have a new set of priorities and responsibilities to perform," he adds.

[For more information, contact:

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Reference guides for PPS

As of Oct. 1, 2000, all home health care providers began billing their services to homebound fee-for-service Medicare beneficiaries under the home health prospective payment system. (PPS)

Two charts **(see boxes, pp. 141 and 142)** can be found on the Baltimore-based Health Care Financing Administration's (HCFA) Web site (www.hcfa. gov).

(Continued on page 142)

Quick Reference Guide for Home Health Agencies on Billing Supply/Item Line Items on HCFA-1450 (UB-92) Claims After 10/01/00

TYPE OF LINE ITEM	DME*** (non-implantable, other than Oxygen & P/O)	Oxygen & P/O (non-implantable P/O)	Non-routine**** Medical Supplies	Osteoporosis drugs	Vaccines	Other Outpt. Items (antigens, splints & casts)
CLAIM CODING	**Current revenue codes 29x, 294** for drugs/supplies for effective DME use w/HCPCS	**Current revenue codes 60x** (Oxygen) **and 274** (P/O) w/HCPCS	**Current revenue code 27x** or **62x** w/ or w/o HCPCS, (wound-care supplies only: 623)	**Current revenue code 636 & HCPCS**	**Current revenue codes 636** (drug) and HCPCS, **771** (administration)	**Current revenue code 550** & HCPCS
TYPE OF BILL (TOB)	**Billed to RHHI on 32x* if 485**, 34x** if no 485	**Billed to RHHI on 32x* if 485**, 34x** if no 485	**Billed on 32x* if 485**, or 34** if no 485	**Billed on 34x** only**	**Billed on 34x** only**	**Billed on 34x** only**
PAYMENT BASIS	**Fee Schedule**	**Fee Schedule**	**Bundled into PPS payment if 32x*** (even LUPA); paid in cost report settlement for **34x****	**Cost**, and paid separately with or without open HH PPS episode	**Paid as part of Outpatient PPS**, and paid separately with or without open HH PPS episode	**Paid as part of Outpatient PPS**, and paid separately with or without open HH PPS episode
PPS CLAIM?	**Yes, Claim only** [34x** no POC/non-PPS]	**Yes, Claim only** [34x** no POC/non-PPS]	**Yes, Claim only** [34x** no POC/non-PPS]	**No** (34x** claims only).	**No** (34x** claims only)	**No** (34x** claims only)

* NOTE: For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328); *TOB 33x (claims x=7,8 or 9) will still be processed if received.*

** 34x claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for same beneficiary is open on CWF.

*** Other than DME treated as routine supplies according the Medicare FI (Sec. 3629) and Home Health (Sec. 473) Manuals.

**** Routine supplies are not separately billable or payable under Medicare home health care.

***** **Important Note: This page does not contain HCFA final manual instructions. All content is subject to change.**

Source: Health Care Financing Administration, Baltimore.

The charts give home health care providers an easy, at-a-glance reference guide for billing visit/service items and visit/supply items under the new PPS system using either the paper or electronic version of Form HCFA-1450 (UB-92).

Whether home health professionals need clarification for durable medical equipment, a nonroutine medical supply, a vaccination, an outlier visit, or other information, these charts give information on coding, what type of bill to use, the basis for payment and whether the claim qualifies as a PPS claim. ■

FI encourages electronic signature use

The Internet has, in theory at least, made life a little easier for all of us. Barring computer viruses, Internet-server provider problems, and other unforeseen mishaps of the computer age, the Internet has allowed us to communicate seamlessly in real-time. The business world clearly has benefited from these advances and so, too, has the health care sector.

Quick Reference Guide for Home Health Agencies on Billing Visit/Service Line Items on HCFA-1450 (UB-92) Claims After 10/01/00

TYPE OF LINE ITEM	Episode	Services/Visits	Outlier
CLAIM CODING	**New 0023 revenue code** with new HIPPS code (HHRG) on HCPCS field of same line	**Current revenue codes 42x, 43x, 44x, 55x, 56x, 57x w/Gxxxx HCPCS for increment reporting** *(NOTE revenue codes 58x and 59x not permitted for HH PPS)*	Determined by Pricer — **NOT billed by HHAs**
TYPE OF BILL (TOB)	**Billed on 32x only*** (have 485, patient homebound)	**Billed on 32x ONLY* if POC**; 34** if no 485	**Appears on remittance only for HH PPS claims** (via Pricer)
PAYMENT BASIS	**PPS episode rate:** (1) full episode w/ or w/out **SCIC** adjustment; (2) less than full episode w/**PEP** adjustment; (3) **LUPA** paid on visit basis; (4) therapy threshold adjustment	**When LUPA on 32x**, visits paid on adjusted national standardized per visit rates; **paid as part of Outpatient PPS for 34x****	**Addition to PPS episode rate payment only**, NOT LUPA, paid on claim basis, not line item
PPS CLAIM?	**Yes, RAPs and Claims**	**Yes, Claims only** [34x** no 485/non-PPS]	**Yes, Claims only**

*NOTE: For HH PPS, HHA submitted RAP TOB must be 322 — may be canceled by 328; Claim TOB must be 329 — may be adjusted/canceled by 327, or 328. TOB 33x for RAPs and claims (x=2,7,8 or 9) will still be processed if received.

** 34x claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on CWF (some exceptions apply).

***** Important Note: This page does not contain HCFA final manual instructions. All content is subject to change.**

Source: Health Care Financing Administration, Baltimore.

One area that has seen a great deal of recent innovation is that of electronic signatures. As reported in *Hospital Home Health*'s October issue, regional fiscal intermediaries (FIs) are now accepting electronic signatures. But in case you're still a little confused as to what you should be doing, let alone why you should be doing it, *HHH* spoke with **James W. Cope**, MD, medical director of United Government Services LLC (UGS) on how his Milwaukee, WI, company has implemented e-signature programs.

He points out that the benefits of using e-signatures really are clear. First is the ease of documentation, "and certainly from our point of view, electronic records are easier to read. Poor handwriting isn't just a doctor problem. E-signatures allow for less chance of error. On top of everything, it's easier for our providers to get records to us. The whole deal is easier — less storage and fewer trees dying. In this day and age, there really are no cons to using an electric signature."

That, of course, is provided that all the proper policies and procedures are in place. What are those policies and procedures? Home care providers should refer to HIM-11 section 204.2(H) for guidance in establishing policies and procedures related to electronic signatures. In particular, policies should address:

- authentication and dating of signatures, which may include signatures, written initials, or use of a unique identifier;
- prevention of unauthorized access;
- procedures for rebuilding records if the system breaks down.

UGS, as Cope points out, has delineated its electronic signature from those policies and "we have towed the line pretty closely."

To those agencies who are interested in implementing an e-signature program, he recommends that they start in one of two ways. They may, of course, "write us saying they have a new procedure in place and [ask] how [to] get approved for it," Cope says, adding that such a step would be the exception rather than the rule. "In most cases, people develop a procedure based on Section 204.2 and start using it. When we receive documents they have submitted with an electronic signature, we check our records to see if they are on the list of providers approved to use e-signatures. If not, we immediately call them and ask for verification of the policies and procedures they have put in place to safeguard the system.

"Once we receive the appropriate documentation, and it's usually by fax to save time, we make sure it contains [information] required by 204.2," Cope continues. "If it does, then they are as of that moment approved. Providers can even be approved retroactively."

UGS has sent out explanatory materials in some of its recent publications. Still, he says that if an agency has questions, it is encouraged to call the company. "I'm sure our nurses will be more than happy to guide them along if they have particular questions related to that section."

Just as the e-signature policy guidelines are among the clearest written, Cope notes that the five intermediaries are striving to smooth regional differences. In the case of e-signatures, in particular, he points out that "all five of the regional intermediaries do accept electronic signatures in essentially the same manner." This is one of the few areas where there is national unity and not regional differences, he says.

"We are trying to do things and make policies

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as uniform as possible. We are starting to move away from regional differences in medical care. I think this is a little step in the right direction."

[For more information, contact:
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NAHC announces new board members

The Washington, DC-based National Association for Home Care's (NAHC) board of directors and nominating committee have announced the winners of the association's recent elections.

NAHC Board of Directors

• Chair, Mary Suther, Dallas
• Secretary, D.J. "Sam" Chapman, Lancaster, OH
• Director, Region II, Michele A. Quirolo, Mount Kisco, NY
• Director, Region IV, Trudi Webb, Boca Raton, FL
• Director, Region VI, John L. Indest, Lafayette, LA
• Director, Region VIII, Jonelle "Jo" Burdick, Fargo, ND
• Director, Region X, Sheila Masteller, Spokane, WA
• Director, Corporate Provider Section, Cathy Nielsen, Minnetonka, MN
• Director, Home Care Aide Section, Ken Wessel, Paterson, NJ
• Director, Institution-Sponsored Section, Pam Matthews, Albany, OR
• Director, Voluntary Section, Joanne Handy, Boston

2001 Nominating Committee

• Official Representative, Nancy Bottomley, Charlevoix, MI
• Pediatric Representative, Karen A. McKinney, Southfield, MI
• Voluntary Representative, Marnie F. Frey, Athens, OH
• Proprietary Representative, George E. Hutchinson, Montgomery, AL
• Hospice Representative, Mary K. Sheehan, Evanston, IL
• Institution Representative, Jean Hunhoff, Yankton, SD
• Corporate Representative, Cynthia Campbell, Westchester, IL
• Home Care Aide Representative, Virginia Pinkerton, Irvine, CA.
• Private-Not-for-Profit Representative, Mary L. Lenzini, Waterford, CT
• State Forum Representative, Virginia Humphrey, Wallingford, CT ■

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

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