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the monthly update for executives and health care professionals

IN THIS ISSUE

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New ICD-9 codes are more specific, but will they mean more rejections?

More documentation will be required

Gather up all your ICD-9 cheat sheets, check your nurses' clipboards for notes about codes, get your new coding books, and make sure your staff know that as of this month, there are changes to a number of ICD-9 codes commonly used in home health.

"We haven't been using codes with this specificity and it is important for home health managers to make sure staff members understand that the new codes mean more documentation and more accurate diagnosis codes," says **Prinny Rose Abraham**, RHIT, a coding consultant with HIQM Consulting in Minneapolis. The new codes affect all health care providers, not just home health, and their development was driven by the need for more accurate data collected from diagnosis-related groups in hospitals, she explains.

The advantage of the new codes is the more specific, more accurate description of patients and their needs, says **Lynda Dilts-Benson**, RN, CRRN, CCM, CRNAC, clinical consultant for Reingruber & Co., a certified public accounting and health care consulting firm based in St. Petersburg, FL. Some of the codes may help justify the use of physical or occupational

CE testing process simplified

Beginning this semester, *Hospital Home Health* is simplifying its continuing education program by no longer requiring you to return a test form. Instead of completing a Scantron form as you have in the past, all you will need to do is complete a CE evaluation, which will be enclosed in your March issue. Upon receipt of your evaluation, your CE certificate will be mailed to you. It's that simple. CE questions will continue to be included in every issue. Answers to those questions will be printed in the issue as well, giving you the opportunity to reinforce the learning activity by immediately reviewing any missed questions. This process has been shown to be an effective adult education method and fits well with our commitment to provide you with quality continuing education activities that are designed to meet your needs. If you have any questions about this process, please call our customer service department at (800) 688-2421. ■

therapy for patients, she adds.

Although the implementation date for the new codes was Oct. 1, there is a three-month grace period during which you can submit claims with old codes and still receive payment, points out **Claudia E. Reingruber**, CPA, president of Reingruber & Co. This gives home health agencies that have not made the conversion to new codes some extra time to make sure coding cheat sheets, software programs, books, and other tools are updated and accurate, she adds.

Not only have some codes been deleted and additional digits added to other codes, but code titles have been changed as well, Abraham says. For this reason, it is not enough just to list the new codes without reviewing their proper application with staff members, she adds.

The key codes that will affect home health agencies are:

• **Neuropathy.** This new group of codes will affect clinical scores and prospective payment system reimbursement, Dilts-Benson says. These codes replace 357.8, which was used for other inflammatory and toxic neuropathy, and require more documentation, she adds. Chronic inflammatory demyelinating polyneuritis (357.81), critical illness polyneuropathy (357.82), and other inflammatory and toxic neuropathy (357.89) will help nurses more specifically describe the patient's condition. Remember that "other" is not the same as "unspecified," Abraham says. Unspecified neuropathy still is coded as 357.9, she adds.

• **Heart failure.** "We have always used 428.0 for every case of congestive heart failure in the past, but 11 new codes will force us to be more specific about the type of heart failure that is diagnosed," Abraham says.

The new codes (428.20-428.43) now distinguish between systolic and diastolic heart failure, chronic and acute, and combined systolic and diastolic. This makes it important for the person accepting the referral or the admission nurse to check with the physician for a specific diagnosis if it is not clear in the medical record, she adds.

• **Late effects of cerebrovascular accident (CVA).** "Home health nurses don't generally treat patients in the acute phase of CVA, but we've never had a code that accurately described what we do see," Dilts-Benson says. Now there are five codes that can be used more accurately: alterations of sensations (438.6), disturbance of vision (438.7), facial weakness (438.83), ataxia (438.84), and vertigo (438.85). "These codes will further support the presence of physical therapy and occupational therapy for the patient, although they don't add extra reimbursement," she says.

• **Post-phlebitic syndrome and venous hypertension.** The previous code for post-phlebitic syndrome (459.1) now is invalid, and five new codes that subdivide the diagnosis category have been added, Abraham says.

"The new codes are all five digits and range from post-phlebitic syndrome without complications to post-phlebitic syndrome with ulcer, inflammation, and other complications," she says. New codes 459.30-459.39 also describe chronic venous

CE *questions*

The CE testing procedures have been changed. For more information, see box on cover.

1. According to Prinny Rose Abraham, RHIT, a coding consultant with HIQM Consulting in Minneapolis, what is the significance of the deletion of 780.9, generalized pain?
   A. Nurses can no longer code pain as a diagnosis.
   B. Nurses need to use V-codes for pain.
   C. Nurses need to code pain specific to site or condition.

2. What role does Steven Christianson DO, MM, medical director of the Visiting Nurse Service of New York City say that home health agencies can play in the event of a smallpox outbreak?
   A. quarantine management
   B. vaccination of exposed people
   C. surveillance and reporting
   D. public education
   E. all of the above

3. What is the biggest danger of many herbal medications that home health patients take, according to Maria R. Toscano, PharmD, consultant with ProMedcare Solutions in Mineola, NY?
   A. Many popular herbals act as blood thinners.
   B. Herbals are very expensive.
   C. Herbals can increase the risk of incontinence.
   D. Herbals don't have any clinical merit.

4. Why does Linda C. Pearce, RN, C, BSN, a consultant with Diabetes Education Consulting in Blacksburg, VA, recommend that all diabetic patients have a $Hb1_{AC}$?
   A. It helps set daily monitoring schedule.
   B. Patients don't have to do it themselves.
   C. It gives an accurate picture of the hemoglobin level.
   D. A and C

Answers: 1. C; 2. E; 3. A; 4. C

hypertension in more detail.

• **Torus fractures.** Codes 813.45 (torus fracture of radius) and 823.40-.42 (torus fracture tibia alone, fibula alone, and fibula with tibia), require the nurse or staff member who is coding the claim to be sure that the correct part of the bone is identified, Abraham says.

"This requires specific documentation from the physician," she says. "In this instance, a coding book that includes pictures that clarify the location being coded may also be helpful."

• **Disruption of wound.** Codes 998.31 (disruption of internal operation wound) and 998.32 (disruption of external operation wound) replace 998.3, which was disruption of operation wound. "Once again, the home health nurse needs to be very specific and document carefully the basis for the code," Abraham explains.

• **Pain.** The code for generalized pain, 780.9, has been deleted. "Home health nurses now need to look up pain specific to the site or condition," she points out.

As you work your way through this coding change deadline, you also can start preparing for Oct. 1, 2003, when V-codes can be used as primary diagnoses, Dilts-Benson says. "You can use V-codes on the UB-92 and 485 Plan of Care now, but after Oct. 1, 2003, they'll also be accepted on [Outcome and Assessment Information Set] forms and for reimbursement," she says.

Don't assume that your software vendor already has updated codes in your system, Abraham says. "Coding updates come from third-party suppliers and are not always high on a software vendor's priority list," she says. After you've bugged your software vendor, be sure to check all point-of-care devices, laptop programs, lists that sit on billing department desks, cheat sheets on nurses' clipboards, and any other place where an employee may keep reminders, she says. "Make sure the complete set of up-to-date codes and descriptions are available and understood by everyone."

Once the three-month grace period is up, be sure to check your intermediary system frequently for on-line billing, Reingruber says.

"There are some agencies that are so focused on getting current claims filed that they forget to see what is happening with denials or down-coded claims," she says. "I suggest checking daily, so you can catch problems with the new codes in a timely manner to recoup lost reimbursement and prevent denials in the future."

[For more information about home health coding, contact:

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For a list of the new codes, deleted codes, and description changes, go to:

- *www.cms.hhs.gov/medlearn/icd9code.asp.]* ■

Home health could play role in smallpox outbreak

Education and quarantine management suggested

[Editor's note: This is the first of a two-part series on how home health agencies should address the threat of bioterrorist events. This month, we look at the most recent information from the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) in relation to vaccination for smallpox and first-response teams. Next month, we'll look at how home health agencies should incorporate bioterrorism into their emergency response plans.)

Although the ACIP recommendations for the use of smallpox vaccine don't specifically mention the use of home health personnel, it is a logical assumption that home health will play a key role in the event of a smallpox outbreak, according to **Steven Christianson**, DO, MM, medical director of the Visiting Nurse Service of New York in New York City.

"Home health is one of the only groups of health professionals that practice in all areas of our communities," says Christianson, who testified at the May meeting of ACIP as the recommendations were being developed.

The recommendations that were released for comment in June, but not approved at press time, call for vaccination of response teams and health care professionals that will come into contact with

(Continued on page 113)

ACIP suggestions for smallpox preparation

With risk 'low,' Joe Public is out for now

On June 20, 2001, the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) made recommendations for the use of smallpox vaccine to prepare for a possible bioterrorism attack. As *Hospital Home Health* goes to press, the following recommendations remained under review by the U.S. Department of Health and Human Services. Therefore, these key recommendations, summarized below, may be subject to change. For updated information, consult the web site: www.cdc.gov/nip/smallpox/default.htm.

✔ **Smallpox transmission and control**
Smallpox is transmitted from an infected person once a rash appears. Transmission does not occur during the prodromal period that precedes the rash. Infection is transmitted by large droplet nuclei, and only rarely has airborne transmission been documented. Epidemiologic studies have shown that smallpox has a lower rate of transmission than diseases such as measles, pertussis, and influenza. The greatest risk of infection occurs among household members and close contacts of people with smallpox, especially those with prolonged face-to-face exposure. Vaccination and isolation of contacts of cases at greatest risk of infection has been shown to interrupt transmission of smallpox. However, poor infection control practices resulted in high rates of transmission in hospitals. The primary strategy to control an outbreak of smallpox and interrupt disease transmission is surveillance and containment, which includes ring vaccination and isolation of people at risk of contracting smallpox. This strategy involves identification of infected people through intensive surveillance, isolation of infected people, vaccination of household contacts and other close contacts of infected people (i.e., primary contacts), and vaccination of household contacts of the primary contacts (i.e. secondary contacts). This strategy was instrumental in the ultimate eradication of smallpox as a naturally occurring disease, even in areas that had low vaccination coverage.

✔ **General population**
Under current circumstances, with no confirmed smallpox and the risk of an attack assessed as low, vaccination of the general population is not recommended, as the potential benefits of vaccination do not outweigh the risks of vaccine complications. Recommendations regarding pre-outbreak smallpox vaccination are being made on the basis of an assessment that considers the risks of disease and the benefits and risks of vaccination. The live vaccinia (cowpox) vaccine virus can be transmitted from person to person. In addition to sometimes causing adverse reactions in vaccinated people, the vaccine virus can cause adverse reactions in the contacts of vaccinated people.

✔ **Smallpox response teams**
Smallpox vaccination is recommended for people pre-designated by the appropriate bioterrorism and public health authorities to conduct investigation and follow-up of initial smallpox cases that would necessitate direct patient contact. To enhance public health preparedness and response for smallpox control, specific teams at the federal, state, and local levels should be established to investigate and facilitate the diagnostic work-up of the initial suspect case(s) of smallpox and initiate control measures. These smallpox response teams might include people designated as: medical team leader, public health advisor, medical epidemiologists, disease investigators, diagnostic laboratory scientist, nurses, personnel who would administer smallpox vaccines, and security/law enforcement personnel. Such teams also may include medical personnel who would assist in the evaluation of suspected smallpox cases. ACIP recommends that each state and territory establish and maintain at least one smallpox response team. Considerations for additional teams should take into account population and geographic considerations and should be developed in accordance with federal, state, and local bioterrorism plans.

✔ **Health care workers at designated hospitals**
Smallpox vaccination is recommended for selected personnel in facilities pre-designated to serve as referral centers to provide care for the initial cases of smallpox. These facilities would be pre-designated by the appropriate bioterrorism and public health authorities, and personnel within these facilities would be designated by the hospital. As outlined in the CDC *Interim Smallpox Response Plan and Guidelines*, state bioterrorism response plans should designate initial smallpox isolation and care facilities (e.g., type C facilities). In turn, these facilities should pre-designate individuals who would care for the initial smallpox cases. To staff augmented medical response capabilities, additional personnel should be identified and trained to care for smallpox patients.

Source: Centers for Disease Control and Prevention; Advisory Committee on Immunization Practices, Atlanta.

infected people. **(See ACIP recommendations, p. 112.)**

"The current CDC plan calls for quarantine of people exposed to but not symptomatic of smallpox in their homes," he says.

These people would need to be evaluated on a regular basis for signs of fever or rash throughout the 15-day incubation period, he adds. "Home care personnel could handle this task with minimal changes to their regular routine to meet CDC criteria."

Christianson proposed the use of home care personnel in four areas:

1. public health education;
2. community surveillance and reporting;
3. quarantine management;
4. vaccination health screening and vaccinations.

Although ACIP recommends vaccination of health and law enforcement personnel who would come into contact with infected people in case of a bioterrorism event, the recommendations do not call for vaccination of members of the general public with no known exposure. "More people died from the vaccination rather than smallpox in the 1947 New York City public initiative that immunized 6.7 million persons against smallpox," Christianson says.

According to the ACIP report, "The live smallpox vaccine virus can be transmitted from person to person. In addition to sometimes causing adverse reactions in vaccinated persons, the vaccine virus can cause adverse reactions in the contacts of vaccinated persons." Because of the known risk of adverse effects, ACIP does not recommend vaccination of the general population.

Although the risk of a bioterrorist attack with smallpox is considered small, Christianson points out that home health agencies should take a look at their emergency preparedness plans now to make sure they address bioterrorist attacks of any type.

"Even if your agency has addressed how to handle quarantine issues, vaccinations, and reporting of outbreaks, do other public health and safety organizations in your community have their plans in place? If so, do your plans mesh with their plans?" he asks.

[For more information on smallpox and how home health is affected, contact:

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Mosquito bites are major irritation all over the U.S.

Southern states lead nation in West Nile virus

Everyone agrees that mosquitoes are annoying. They can ruin camp-outs, picnics, outdoor sporting events, and just hanging out with friends.

Most of the time, mosquito bites itch, swell slightly, and generally stop bothering you after a short time. As of press time, however, there are 1,438 people in 39 states this year that have been concerned with more than an itchy bump on their arm.

These are the confirmed or probable cases of human West Nile virus reported to the Centers for Disease Control and Prevention (CDC) in Atlanta. Of these reported cases, a total of 64 deaths have occurred.

Encephalitis is the most serious manifestation of West Nile virus, causing inflammation of the brain. Most infections are mild, with symptoms such as fever, headache, and body aches. **(See Q&A for more symptoms, p. 114.)**

Louisiana has the highest number of reported cases with 238 people infected and eight deaths. "Our state health department has been very active with reports and educational briefings that are sent to health organizations," says **Warren Hebert**, executive director of the Home Care Association of Louisiana, based in New Iberia. "As an association, we distribute by fax or e-mail, the notices to all of our members," he adds.

The best protection against West Nile virus is to avoid mosquito bites by using repellent, wearing long sleeves and pants, and avoiding the outdoors at dawn and dusk, the two times of day mosquitoes are most active.

Public health officials also recommend that any standing water around a house or yard be eliminated because it provides a breeding ground for mosquitoes.

"The media has done such a good job of informing the general public about the risk of West Nile virus and mosquitoes that we've not had a lot of questions from our patients," says **Karen B. Utterback**, MSN, RN, vice president of operations for Southern Mississippi Home Health in Hattiesburg.

"We are concerned for one of our clerical employees who is waiting on lab results to let her know if she has the virus," she adds.

West Nile Virus Q&A

The Centers for Disease Control and Prevention in Atlanta has set up a web site (www.cdc.gov/ncidod/dvbid/) devoted to information on West Nile virus. One section includes the following commonly asked questions about the virus and its transmission.

Question: Who is at risk for getting West Nile encephalitis?
Answer: All residents of areas where virus activity has been identified are at risk of getting West Nile encephalitis. People older than 50 have the highest risk of severe disease. It is unknown if immunocompromised people are at increased risk for West Nile virus disease.

Question: What are the symptoms of West Nile encephalitis?
Answer: Most infections are mild, and symptoms include fever, headache, and body aches, occasionally with a skin rash on the trunk of the body and swollen lymph glands. More severe infection may be marked by headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, paralysis, and in rare cases, death.

Question: What is the incubation period in humans (i.e., time from infection to onset of disease symptoms) for West Nile encephalitis?
Answer: Usually three to 15 days.

Question: How long do symptoms last?
Answer: Symptoms of mild disease generally will last a few days. Symptoms of severe disease may last several weeks, although neurological effects may be permanent.

Question: I think I have symptoms of West Nile virus. What should I do?
Answer: Contact your health care provider if you have concerns about your health. If you or your family members develop symptoms such as high fever, confusion, muscle weakness, and severe headaches, you should see your doctor immediately.

Question: How do health care providers test for West Nile virus?
Answer: Your physician first will take a medical history to assess your risk for West Nile virus. People who live in or have traveled to areas where West Nile Virus activity has been identified are at risk of getting West Nile encephalitis. People older than 50 years of age have the highest risk of severe disease. If you are determined to be at high risk and have symptoms of West Nile encephalitis, your provider will draw a blood sample and send it to a commercial or public health laboratory for confirmation.

Question: How is West Nile encephalitis treated?
Answer: There is no specific therapy. In more severe cases, intensive supportive therapy is indicated, often involving hospitalization, intravenous fluids, airway management, respiratory support (ventilator), prevention of secondary infections (pneumonia, urinary tract, etc.), and good nursing care. ■

"Our hospital has sent out information to all home health staff members that helps us educate our patients and caregivers about the precautions they should take," says **Claudia Kammer**, RN, administrator of Women's Health Home Care in Baton Rouge, LA.

"We have a special challenge because 90% of our patients are pediatric patients and newborns," she adds. "The insect repellents that are recommended for adults to use cannot be used safely on our pediatric patients.

"We emphasize that parents keep the babies covered when they leave the home and follow their pediatricians' advice for protection," Kammer says.

(For more information about West Nile virus, go to the CDC web site for West Nile virus at www.cdc.gov/ncidod/dvbid/. The site contains updated information on the outbreak, information on symptoms, prevention, surveillance, and clinical guidelines.) ■

Know supplements to avoid interactions

Check herbal use, interaction with prescriptions

Improve your memory. Enjoy a higher level of energy throughout the day. Sleep better at night. Relieve anxiety.

The promises are attractive. Even better for consumers, the products no longer are hidden in natural food stores. No, these herbal medications and vitamins that improve our lives are on grocery store shelves, so they are easy to pick up along with your bread and milk.

The use of herbal medications and nutritional supplements has risen from 20% of adults in the United States in 1998[1] to 49% of adults in 2000.[2]

Many of these people do enjoy the benefits advertised by the manufacturer. Home health

Ask carefully to get thorough information from patients

There's a balance when asking about supplements

The last thing you want to do when you inquire about your patients' use of herbals, vitamins, or dietary supplements is to ask in a manner that will make them think you don't approve of their use, says **Dennis Callahan** RPh, staff pharmacist at St. Mary's Health Center Pharmacy in Jefferson City, MO.

Be sure that you don't act negatively when patients say they are using herbals, vitamins, or supplements, Callahan says. "We need to recognize the patients' right to take responsibility for their care, but we also need to explain the importance of working together to make sure one thing doesn't cancel the effect of something else," he says.

One good way to find out what patients are using is to ask a series of questions that focus on symptoms or conditions rather than specific medication use, suggests **Maria R. Toscano**, PharmD, consultant with ProMedcare Solutions in Mineola, NY.

The types of questions might include:

- **What do you use to treat constipation?**
- **How do you treat an upset stomach?**
- **Are you taking any vitamins? Why?**
- **What do you take for pain?**

As you get answers to each of these questions, be sure to ask about prescription medications, over-the-counter medications, and herbals or vitamins, Toscano suggests. By making it clear that you are trying to get an accurate overall picture rather than pointing out what might be right or wrong, you'll get truthful answers that will help you help your patients, she says. ■

nurses, however, need to be diligent about evaluating their patients' use of herbals, vitamins, and other natural medicines because they can interact with prescription medicines and aggravate some health problems, says **Maria R. Toscano**, PharmD, consultant with ProMedcare Solutions in Mineola, NY.

"The biggest problem with herbal medication and elderly or ill patients is that many of them thin the blood," Toscano says. Popular herbals such as ginkgo, ginseng, and garlic are blood thinners and cannot be used in conjunction with prescription blood thinners such as warfarin, she says.

The challenge for the home health nurse is that patients and their family members do not always think about telling their physician or nurse about an herbal medication, says **Dennis Callahan**, RPh, staff pharmacist at St. Mary's Health Center Pharmacy in Jefferson City, MO. A family member might suggest an herbal medication or vitamin because the patient seems depressed, doesn't eat well, or has trouble sleeping, he says.

"The home care nurse needs to specifically ask the patient or caregiver about herbals, vitamins, and dietary supplements to make sure potential interactions can be identified," he says. **(See suggested questions, at left.)** Callahan also recommends that the nurse ask about dietary habits as well, since foods high in certain vitamins also can interact with medications. For example, a patient who likes to eat a lot of spinach is absorbing a lot of vitamin K, which can block the blood-thinning effect of warfarin, he explains.

The most common herbal medications and their potential interactions with medications typically used by home health patients include:

- **St. John's Wort.** This popular herbal medication is used as an antidepressant and causes many problems for patients on prescription medications, Toscano says. "It reduces the effect of digoxin by 25%, decreases the effectiveness of anti-rejection drugs used by transplant patients, reduces the effect of drugs used to treat AIDS patients, reduces the efficacy of warfarin, and increases the side effects of any other antidepressant medication the patient may be taking," she explains.
- **Ginkgo.** Ginkgo is taken to increase blood circulation and to improve memory and mental alertness, but it also acts as a blood thinner, she points out. If the patient also is taking a blood thinner such as warfarin or an aspirin each day, the additional use of ginkgo will exacerbate the medication's effect and could even cause a brain hemorrhage, Toscano adds. "Ginkgo may also decrease the effect of medications used to control seizures and lower the seizure threshold to the point that the prescription medication does not control seizures."
- **Saw Palmetto.** Typically used to treat benign prostate enlargement or other urinary inflammations, saw palmetto should not be used by patients undergoing treatment for prostate cancer because it decreases the effect of medications used to treat cancer, she says. Women who are taking estrogen as part of hormone replacement therapy should not use saw palmetto because it increases side effects, including breast tenderness.
- **Melatonin.** Commonly used to treat insomnia, melatonin can decrease blood pressure so patients already taking blood pressure medication should not use it, Toscano says.

• **Soy.** Although patients will add soy to their diet without thinking of it as a chemical that can alter prescription medication, it does affect medications designed to control thyroid function, she says. Often added to the diet for the estrogen-like qualities that prevent bone loss and menopause symptoms, a physician needs to know how much soy the patient is ingesting so the thyroid medication dosage can be changed accordingly, she says. Patients who are taking tamoxifen should not take soy since it reduces the effect of tamoxifen, Toscano says. "Iodine levels also need to be monitored since soy contains iodine. If iodine levels become too high, the patient needs to cut back on the amount of soy they take."

• **Ginseng.** Ginseng is taken to increase physical stamina and mental concentration. Unfortunately for diabetic patients, it also decreases blood sugar, which can lead to hypoglycemia, she says.

• **Kava and Valerian.** Both kava and valerian are taken to relieve anxiety and aid sleep, as well as a muscle relaxant. "Both herbals increase liver toxicity and should not be used in conjunction with prescription medications such as benzodiazepines and barbiturates, since the combination causes excessive sleepiness and lethargy," Toscano says.

"About 60% of patients don't tell physicians they are taking additional vitamins, supplements, or herbal medications," she says. "They don't think it's important and don't realize that they can affect other medications," she adds. Vitamin E is a good example, she says. "[More than] 400 IU of vitamin E decreases the effect of warfarin, and [more than] 800 IU can affect the level of good cholesterol."

Because it's important for home health nurses and physicians to know about everything the patient is taking, education is essential, Callahan says. "People point out that herbals have been used for centuries with no problems in other countries, but I also point out that even today in third-world countries, the people using herbals are not taking them in conjunction with prescription medications, and it's the combination that causes the interactions," he adds.

Many patients also don't realize that herbals, vitamins, and dietary supplements are not regulated by the Food and Drug Administration, which means that there are no standards for formulations or quality, Callahan says.

The lack of regulation makes it even more important for home health nurses to stay on top of what patients are taking and what side effects they experience, Toscano says. "This is an ever-changing field, and it requires us to learn new things each week," she says. **(For sources of information, see box, above.)**

"Herbals can be good things," she points out. "There's nothing wrong with a patient taking them as long as the home health nurse, patient, and physician work together to avoid interactions."

[For more information about the interaction of

Herbal Medication Resources

The following sources offer information about herbal medications, vitamins, and nutritional supplements:

- **Natural Medicines Comprehensive Database**. Comprehensive, literature-based reviews of more than 1,000 herbal products and supplements. Cost for either web access or the book version of the database is $92 per year. If you order the book and web access for one year, the cost is $132. Web: www.naturaldatabase.com.
- **National Center for Complementary and Alternative Medicine**. CAM Citation Index. Web: www.nccam.nih.gov/nccam/databases.html. Literature citations, with abstracts, of all aspects of alternative medicine are included — no cost.
- **NIH Office of Dietary Supplements**. IBIDS Database. Web: ods.od.nih.gov/databases/ibids.html. Literature citations, with abstracts, of dietary supplements including vitamins, minerals, and botanicals. This is a free database.
- **American Botanical Council**. Web: www.herbalgram.org. A nonprofit educational organization that offers on-line herbal monographs as well as books, software, video, and audiotapes. Also includes listing of herbal education programs and referrals to government resources.
- **Herb Research Foundation**. Web: www.herbs.org. The site of this nonprofit, educational and research organization includes a Q&A column, a list of recommended books, a hotline service for calls on herbal questions, a custom herbal research services and information packets on common herbs.
- **The Natural Pharmacist**. Web: tnp.healthgate.com/about.html. This site offers a database of current, evidence-based information on more than 440 herbs and supplements, 325 health conditions, and 1,000 drug-herb and drug-supplement interactions. A section for health professionals contains clinical monographs and drug interactions geared toward the health practitioner.

herbal medications and prescription medications in home health patients, contact:

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Diabetes management is crucial for good outcome

Monitoring, education improve patient's life

(Editor's note: This is the first of a two-part series that takes a look at diabetes management for home health patients. Next month, we'll look at how exercise, diet, and smoking should be addressed in home health diabetic patients.)

Your patient may be referred to home care as a result of stroke, cardiovascular disease, or kidney disease, but the patient also has diabetes. As you develop your care plan, be sure to include monitoring, treatment, and education about diabetes if you want good outcomes, say experts interviewed by *Hospital Home Health.*

"In many home care patients, a disease such as cardiovascular disease may be a complication of diabetes," says **Linda C. Pearce**, RN, C, BSN, a consultant with Diabetes Education Consulting in Blacksburg, VA. "If you neglect the diabetes, you are putting your patient at risk to develop other diabetes-related complications," she adds.

The good news about the prospective payment system (PPS) is that the reimbursement hasn't changed for diabetes care, but a registered dietitian now is able to visit the patient and develop a plan to monitor and control diabetes, says **Faith Thibodeau**, MS, RD, LD, CDE, a diabetes educator for Visiting Nurse Service in Saco, ME.

The advantage of including a registered dietitian on the patient's care team is that the dietitian has specific knowledge of how nutrition and other lifestyle factors interact to aggravate diabetes, she explains.

There are two types of diabetes. Type 1 usually is diagnosed in children and young adults and previously was known as juvenile diabetes. Type 2 diabetes usually is diagnosed in older adults, Pearce says. **(For complete definitions, see box, p. 118.)**

During the assessment of a patient with diabetes, it's important to make sure a HbA_{1C} (glycolsylated hemoglobin) test is run, Pearce says. "This lab test is not typically ordered for elderly people, but it is the best way to get an accurate picture of the hemoglobin level," she says.

Because glucose sticks to red blood cells, even as they are dying, the HbA_{1C} can provide an average hemoglobin level for a 90-day period, Pearce points out. While testing blood sugar prior to and after meals is important, the HbA_{1C} is a better way to evaluate control of blood sugar, she says.

"If the result is less than 7, one HbA_{1C} per year is enough. But if the result is above 7 or seems to be creeping up with each annual test, consider running the test every three months until it stabilizes or drops," Pearce adds.

Even with the HbA_{1C}, patients need to monitor blood sugar daily, Thibodeau says. A post-meal blood sugar should be taken two hours after a meal, she says.

Other times, patients should monitor blood sugar are at bedtime, when they are ill, when they "feel funny," and when they wake up, Pearce says. The first test after waking up gives the patient a "fasting" blood sugar level, she adds.

Blood sugar monitoring not always is done as often as needed, Pearce contends. In fact, 16% of Type 1 patients never monitor blood sugar, and 20% of Type 2 patients never monitor blood sugar,[1] she says. One reason is the cost of supplies, she explains.

"To save on supplies, have the patient monitor different times each day. One day, the patient monitors the fasting blood sugar; the next day, test blood sugar after a meal; and the next day, test a bedtime blood sugar." As long as the patient tests at different times each day, and as long as the patient is stable, once-a-day testing is sufficient, she adds.

Monitor the patient's blood pressure as well, Pearce says. By lowering blood pressure from 140/90 to 130/85, the onset or progression of

Types of Diabetes

There are two types of diabetes that occur, and it is necessary to know which type your patient has in order to properly manage the disease, says **Linda C. Pearce**, RN, C, BSN, a consultant with Diabetes Education Consulting in Blacksburg, VA.

TYPE 1

This is a disease in which the body does not produce any insulin, most often occurring in children and young adults. People with Type 1 diabetes must take daily insulin injections to stay alive. Type 1 diabetes accounts for 5% to 10% of diabetes.

TYPE 2

This ia a metabolic disorder resulting from the body's inability to make enough, or properly use, insulin. It is the most common form of the disease. Type 2 diabetes accounts for 90% to 95% of diabetes. Type 2 diabetes is nearing epidemic proportions, due to an increased number of older Americans and a greater prevalence of obesity and sedentary lifestyles.

complications can be delayed, she explains.

Education is the key to making sure your patients are monitoring and controlling their diabetes, Pearce says. "Education enables the patient or family caregiver to become self-sufficient and able to make decisions," she says. The nurse should not automatically test the patient's blood sugar or give an insulin injection, she explains. Instead, have the patient or family member do it while the nurse watches, she adds.

By watching patients inject themselves, the nurse can make sure that changes in vision or manual dexterity are not affecting the ability to inject insulin correctly, Pearce adds. "Also, look carefully at the patients' log books where they list blood sugar levels," she suggests. "If the book is messy, blood-stained, and lists results in different ink colors, the patient is truly monitoring blood-sugar levels," she says. If, however, the log is neat, you might suspect that the patient is not monitoring on a regular basis, and just fills in the book prior to your visit, she suggests.

Ask patients to tell you how they addressed high or low blood-sugar readings, Pearce suggests. Staff need to check the patients' ability to make decisions as well as perform the tests, she adds.

"It's hard for elderly [patients] to recognize the signs of hypoglycemia, or low blood sugar, so make sure you give them cues in language they can understand," Pearce suggests. Use words such as silly, irritable, shaky, nervous, sweaty, or point out that vision changes, headaches, panic attacks, or any behavior change might indicate a need to check blood sugar, she says.

If the drop in blood sugar levels happens while sleeping, which it does about 50% of the time, the patient will wake up sweating or following a nightmare, Pearce explains. "I tell my patients to keep a small, about 4 ounces, box of apple juice, or three or four glucose tablets in a resealable baggie on their nightstand," she says. "We don't recommend orange juice because it causes allergic reactions in many people," she explains.

"It's harder for elderly patients to recognize hyperglycemia, or high blood sugar," Thibodeau says. "Hunger, thirst, frequent trips to the bathroom, dizziness, vision problems, and headaches are the most typical symptoms, but they vary from person to person," she explains. It is important to have the patient or caregiver note the symptoms that occur during both low and high blood-sugar episodes so they will recognize the pattern and be better able to administer insulin or glucose, she adds.

The most important thing to communicate to your diabetic patients is that diabetes is a progressive condition that continually changes, Pearce says. For this reason, it's important to teach the patient to recognize signs of complications such as foot sores, nausea, diarrhea, redness, or swelling following an injury. "When the patient notices any changes, the physician should be called immediately," she adds.

Physicians are becoming more aware of the need to control the diabetes as well as treat the complications of diabetes, but a home health

COMING IN FUTURE MONTHS

- Are your patients immunized? Tips for making sure
- Market your agency through community involvement
- Help patients handle their gaps in coverage
- Family caregiver education: What they need to know
- Tips on addressing bioterrorism in your emergency plans

nurse can play an important role in the ongoing education of both physicians and their patients, Pearce suggests.

"Because we have the opportunity to observe the patients in their homes as they test their blood sugar and make decisions based on those test results, we can identify gaps in education and we can let the physician know exactly how the patients are doing," she says.

[For more information on diabetes and home health management of the disease, contact:

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For more information about diabetes, as well as publications for health professionals, contact:

- ***The American Diabetes Association**, 1701 N. Beauregard St., Alexandria, VA 22311. Telephone: (800) 342-2383 or (703) 549-1500. Web site: www.diabetes.org.]*

Reference

1. Evans JM, Newton RW, Ruta DA, et al. Frequency of blood glucose monitoring in relation to glycemic control: Observational study with diabetes databases. *BMJ* 1999; 319:83-86. ■

LegalEase

Understanding Laws, Rules, Regulations

Modifications to fraud and abuse compliance plans

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

As many providers know, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) is the primary enforcer of fraud and abuse prohibitions. As part of its 2002 work plan, the OIG intends to review agencies' compliance efforts under the prospective payment system (PPS). Depending upon the results of this review, additional enforcement action may be initiated.

Agencies that do not yet have fraud and abuse compliance plans should proceed to implement a plan as soon as possible. Agencies that previously implemented plans should review them to make certain that they reflect potential areas of fraudulent and abusive conduct under the PPS reimbursement system.

Specifically, agency compliance plans should now target these additional areas to reflect PPS:

- Classification of patients in the appropriate home health resource group.
- Modifying items on Outcomes and Assessment Information Set to obtain higher reimbursement rates for patients.
- Inaccurate coding.

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THOMSON
AMERICAN HEALTH CONSULTANTS

- Discharging patients before plans-of-care goals have been met in order to increase agencies' profits.
- Cutting services without physicians' orders.
- Performing more than 10 therapy visits of medical necessity or appropriateness in order to obtain a higher reimbursement rate.
- Providing more than four visits to patients in order to obtain a rate of reimbursement that is higher than a low utilization payment adjustment.
- Giving beneficiaries misinformation about what Medicare covers in order to reduce utilization and/or as a basis for refusing medically necessary services.

Although data regarding PPS still should be characterized as anecdotal at this time, it appears that agencies are experiencing considerable financial success under this system of reimbursement.

Profitability certainly is an appropriate goal under the PPS system. But agencies also must remember that fraud and abuse enforcement has not been fully implemented yet under the PPS system. Without properly maintained compliance plans that reflect PPS, agencies still are vulnerable to financial loss based on fraud and abuse enforcement activities. In short, agencies should be using some of the profits they realize from the PPS program to develop or shore up compliance activities. Compliance plans that reflect PPS reimbursement no longer are a luxury that agencies can ignore based upon inadequate financial resources. They are a necessity that agencies ignore at their risk.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

Clarification

In the *Hospital Home Health,* August 2002, cover story, "Higher risk of medication errors for seniors: Home health bigger challenge," the lead investigator of the medication research project described in the article was **Wayne Ray**, PhD, of Vanderbilt University in Nashville, TN. **Dennee Frey**, PharmD, was a co-investigator and project director of the Los Angeles site. The project was funded by the John A. Hartford Foundation in New York City. ■

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. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

THE EXECUTIVE'S SUPPLEMENT TO *HOSPITAL HOME HEALTH*

HOME HEALTH BUSINESS QUARTERLY

New SEC rules keep companies from 'cooking the books'

On Aug. 29, new Securities and Exchange Commission (SEC) rules governing disclosure in the wake of the Sarbanes-Oxley Act went into effect.

The act, signed July 30, establishes federal oversight of public auditors through a Public Company Accounting Oversight Board and new auditor independence rules, disclosure requirements applicable to public companies and insiders, restrictions on loans and stock transactions involving insiders, and strong civil and criminal penalties for those responsible for accounting or reporting violations.

"This law says to every dishonest corporate leader: You will be exposed and punished; the era of low standards and false profits is over," said President George W. Bush upon signing the bill. "This law says to honest corporate leaders: Your integrity will be recognized and rewarded, because the shadow of suspicion will be lifted from good companies that respect the rules."

"We are determined to give real teeth and meaning to the protections of the new law," said **Harvey Pitt**, chairman, at an open meeting announcing the new rules.

Under the SEC directive:

- Executives and directors must report within two days when they buy or sell company stock (formerly they had until the 10th day of the month after the transaction occurred).
- By July 2003, inside trade details (Form 4) must be filed electronically.
- Public companies must file quarterly reports (Form 10-Q) within 35 days of the end of the quarter (formerly 45 days).
- Annual reports (Form 10-K) must be filed within 60 days (formerly 90 days).
- Companies must disclose whether they provide free access to reports on their web sites as soon as practicable after electronic filing.
- Principal executives and financial officers must certify that their companies have internal controls to protect against inaccurate financial disclosures.
- Beginning in 2003, executives at registered investment companies must certify their biannual SEC reports are accurate to the best of their knowledge.

The deadlines and phase-in periods were altered after the SEC considered more than 300 comments from both investors and companies. The new report-filing deadlines at first only will apply to companies that have been reporting for at least 12 months, have previously filed an annual report, and have market values of more than $75 million. The deadlines will be phased in over a period of three years. ■

COMPANIES IN THE NEWS

HealthSouth sued over alleged disclosure

Shareholders of HealthSouth Corp. of Birmingham, AL, have filed a lawsuit alleging that the company failed to disclose that the Centers for Medicare & Medicaid Services (CMS) had reclassified some categories of Medicare reimbursements, which will hurt company profits.

The suit deals yet another legal blow to the company, which has experienced its share of litigation. In May, the company was sued for allegedly submitting false reimbursement claims to Medicare. **(See *Home Health Business Quarterly*, July 2002, "Justice Department joins suit against HealthSouth," p. 1.)**

The complaint, filed by the law firm of Milberg,

Weiss, Bershad, Hynes & Lerach, claims that Richard Scrushy, company chairman and CEO; Weston Smith, CFO and executive vice president; William Owens, chief operating officer; and George Strong, director, sold millions of shares at artificially inflated prices.

The plaintiff class comprises people who bought HealthSouth shares between Jan. 14 and Aug. 26, 2002.

HealthSouth shares fell 44% the day the suit was filed — an estimated $2 billion loss in market value. The complaint charges that the defendants violated Sections 10(b) and 20(a) and Rule 10b-5 of the Securities Exchange Act of 1934 by issuing false and misleading statements to the market during the time frame above.

During that time, the suit alleges, HealthSouth announced favorable revenue and earnings growth in press releases and SEC reports, and it assured the market it would meet financial targets for 2002.

However, these statements did not disclose a CMS mandate to bill certain patient care at lower group rates rather than individual rates, which would impact the business negatively.

The complaint alleges that the defendants knew about this for many months, but did not disclose the information in order to sell company shares at a higher value.

The company also began a $998 million note exchange / offer on more favorable terms than disclosing the reimbursement changes would have allowed, according to the complaint. The exchange / offer began Aug. 27 — the day before HealthSouth disclosed in a press release that the CMS directive of July 1 could result in a $175 million shortfall in EBITDA (earnings before interest, taxes, depreciation, and amortization) from previous predictions for 2002, and that, as a result, the company would not issue further predictions for 2002 and 2003.

The company also announced it would restructure to deal with these developments by spinning off its surgery center division by early 2003 and replacing Scrushy as CEO with Owens. Scrushy will become chairman of the surgery center division. Splitting off the surgery centers, the company said, would allow that business to grow without being affected by government reimbursements for rehabilitation care.

HealthSouth operates 1,427 outpatient and 118 inpatient rehabilitation facilities. The independent surgery center company will have annual revenue of about $1 billion from 209 facilities, the company said. ■

ResMed claims mask maker infringed patent

ResMed Inc. of San Diego has filed a lawsuit in U.S. federal district court against Fisher & Paykel Healthcare for infringing ResMed's patented mask technology. ResMed manufactures medical equipment for diagnosing and treating sleep-disordered breathing, and sells its products in more than 60 countries. Fisher & Paykel Healthcare, one of New Zealand's top-10 listed companies, makes similar products.

The ResMed complaint not only alleges that ACLAIM and ACLAIM 2 masks from Fisher & Paykel infringed its patents and copied proprietary technology, but claims trade dress and common law violations regarding the products' appearance. "We are prepared to protect our investment. We will not tolerate the copying of our products by competitors," **Peter Farrell**, ResMed CEO, said in a press release.

Fisher & Paykel said ResMed's claim is without merit and promised to "vigorously" defend itself if the suit proceeds. However, the company said it would like to resolve the dispute without unnecessary litigation. ■

Option Care acquires infusion pharmacy co.

Option Care of Buffalo Grove, IL, has acquired the home-infusion pharmacy of Allina Hospitals & Clinics, based in Minneapolis. The infusion pharmacy serves about 1,500 patients in Minnesota and Wisconsin.

The acquisition is expected to generate $17 million in annual revenue for Option Care and to add 7 cents per share in 2003.

"Allina is our fourth such acquisition over the last 18 months," says **Raj Rai**, Option Care's president and CEO. "We will gain access to a premier health system with 15 hospitals and many new managed care relationships."

Option Care provides pharmacy and related services to patients at home or at alternate-site settings on behalf of managed care organizations and other third-party payers through a nationwide network of 133 owned and franchised pharmacy locations. ■

MAMSI receives excellent accreditation for HMOs

Two HMOs under Mid Atlantic Medical Services Inc. (MAMSI) of Rockville, MD, were granted Excellent Accreditation from the National Committee for Quality Assurance (NCQA) for their HMO and point-of-service products.

MD-Individual Practice Association Inc. and Optimum Choice Inc. achieved top scores in the categories of access and service, qualified providers, staying healthy, getting better, and living with illness.

"Excellent" accreditation goes only to health plans that deliver the highest quality of services and whose clinical and administrative systems meet or exceed NCQA's requirements for consumer protection and quality improvement.

MAMSI subsidiaries operate in Maryland, Virginia, North Carolina, Pennsylvania, West Virginia, Delaware, and Washington, DC. ■

Baxter stockholders file securities class action

People who purchased or acquired Baxter International securities between Jan. 25 and July 18, 2002, may join a class action suit against the company. The suit charges that Baxter, its CEO and Chairman, Harry Jansen Kraemer Jr., and Brian Anderson, CFO, violated Sections 10(b) and 20(a) and Rule 10b-5 of the Securities Exchange Act of 1934 by making materially false and misleading statements to the market between those dates.

According to the complaint, during that period, Baxter announced in press releases that its bioscience and renal divisions would grow their earnings significantly, without disclosing that those divisions were experiencing serious problems. It charges that the assurances of continued growth were lacking in any reasonable basis when made. During the class period, Baxter insiders sold 435,700 common shares for gross proceeds of more than $23.7 million. On July 18, Baxter announced disappointing sales growth for the bioscience division and a decline in sales for the renal division. It took a $51 million charge in connection with an acquisition and a $70 million impairment charge reflecting a decline in the value of some company investments. In response to the announcement, the price of Baxter common stock fell 36.5%.

Baxter International develops, manufactures, and distributes biopharmaceuticals, vaccines, biosurgery products, transfusion therapies, medication delivery systems, and renal therapy for markets in more than 100 countries. ■

CORPORATE LADDER

Apria Healthcare Group of Lake Forest, CA, which provides home infusion and respiratory therapy, has elected **Vicente Anido Jr.** as the eighth member of its board of directors. Anido, with more than 26 years of general management experience in health care, currently is president and CEO of ISTA Pharmaceuticals.

Stephen Mengert is the new CFO and vice president of finance for Matria Healthcare Inc. of Marietta, GA, which provides disease management programs. Mengert replaces George Dunaway, who will remain with the company during a two-month transition period. Mengert is partner with Tatum CFO Partners LLP, and was its CFO for client companies in the technology and health care sectors. He has been senior vice president of finance and CFO of Pediatric Services of America and senior vice president of finance and CFO of Rehability Corp., which operates outpatient and hospital clinics providing occupational, speech, and physical therapies. ■

ASSISTED LIVING UPDATE

Emeritus gains time to meet AMEX standards

Emeritus Assisted Living of Seattle, which holds interests in 157 communities with about 14,000 units in 31 states and Japan, has received an extension of time to regain compliance with the American Stock Exchange's listing standards. The company had fallen below the guidelines that require shareholder equity of at least $6 million if a company has had losses from continuing operations in its five most recent fiscal years. During the plan period, Emeritus will be subject

to periodic review by the exchange, and failure to regain compliance could results in its being delisted. ■

Sunrise enters $17.5M sale/manage back deal

Sunrise Assisted Living Inc. of McLean, VA, announced a $17.5 million sale/long-term manage back agreement for an assisted living community in California. The Beach Cities Health District will acquire an 80% interest. Sunrise will maintain a 20% interest and will operate the property, which has a resident capacity of 96, under a long-term management agreement.

Including this sale, the company will have added the sale/long-term manage back of 15 properties for $244.2 million in 2002, according to Paul Klaassen, chairman and CEO, resulting in a debt reduction of $158.5 million and pretax proceeds of $60.7 million. Sunrise has more than 220 homes either open or under construction in the United States, United Kingdom, and Canada, with a combined resident capacity more than 17,000. ■

FINANCIAL RESULTS

American Retirement Corp. of Nashville, TN, reported second-quarter revenue of $82.6 million, an increase of 27% over last year's second quarter. Community net operating income was $22.1 million, compared with $18.8 million in the second quarter of 2001. EBITDAR (earnings before interest, taxes, depreciation, amortization, and rent) was $15.9 million, compared with $13 million for the corresponding 2001 period.

The company reported a loss of $19.4 million or $1.12 per share, compared with a loss of $4.6 million or 27 cents per share for the same 2001 period.

The company said noncash charges related to its refinancing plan contributed to quarterly losses, which included $7.1 million of additional lease expense and $2.3 million of accelerated leasehold amortization expenses.

Under the refinancing plan, the company has entered several transactions involving nine communities since March 2002.

These transactions raised gross proceeds of approximately $170 million, of which $151 million was used to pay debt associated with the properties. Of that $151 million debt repayment, approximately $123 million had maturity dates during 2002.

American Retirement currently operates 65 senior living communities in 14 states, with an aggregate resident capacity of 14,400.

ARV Assisted Living Inc. of Costa Mesa, CA, announced second-quarter net income of $200,000 or 1 cent per share on total revenue of $39.7 million, compared with net income of $800,000 or 5 cents per share on total revenue of $35.9 million for the 2001 quarter.

Excluding a $1.6 million one-time gain in the second quarter last year, the company said 2002's second-quarter results represent a $1 million or 6-cent-per-share improvement. The revenue increase reflects the acquisition of two assisted living communities in December 2001.

For the six-month period, total revenue was $79.5 million, compared with $71.3 million for the same period last year. Applying Statement of Financial Accounting Standards No. 142, which halts the amortization of goodwill, net income for the six-month period would have been $2.8 million or 15 cents per share.

ARV operates 59 assisted living communities with about 7,000 units in 11 states.

Emeritus Assisted Living of Seattle, announced second-quarter revenue of $34 million, compared with $35.2 million for the second quarter of 2001. Net loss to common shareholders was $5.7 million, compared with a $3 million loss for last year's quarter.

The decrease in revenue reflects a deferral of $1.8 million related to resident move-in fees. Without it, the company said, revenue increased $600,000, and net loss to common shareholders was $3.9 million, compared with $3 million for the second quarter of 2001.

For the first six months, the company reported revenue of $70.2 million, compared with $70 million for the 2001 period. Net losses were $9 million, compared with $6.8 million in the comparable period.

In the second quarter, the company began managing eight facilities in Texas and Louisiana, previously operated by Horizon Bay Management, and it announced plans to lease 24 communities from a private entity that will buy them from Marriott International Inc. subsidiaries. ■