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INSIDE

APRIL 1999

VOL. 4, NO. 4 (pages 41-52)

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Controversy surrounds debate on the 'rapid decline' clause

'Clinical decline' could be new standard

The debate over local medical review policies (LMRPs) for non-cancer guidelines last year focused on whether the Washington, DC-based National Hospice Organization-driven policies were too restrictive. Today the debate focuses on a clause inserted in each of the LMRPs designed to reduce their insensitivity to terminal cases that don't meet the disease-specific criteria.

Often referred to as the "rapid decline" clause, it states: *Some patients may not meet the criteria, yet still be appropriate for hospice care because of other comorbidities or rapid decline. Coverage for these patients will be considered on an individual basis with adequate documentation.*

But the same clause that was intended to relieve the restrictive nature of the LMRPs may be too restrictive in its own right, the author of the NHO guidelines says. The term "rapid decline" is at issue because there isn't a true definition of what "rapid" means, says **Brad Stuart**, MD, hospice physician with Visiting Nurse Association (VNA) and hospice medical director of Home Hospice of Northern California in Emeryville.

Fiscal intermediary Wellmark in Des Moines, IA, recently made an attempt to clarify the vague language by drafting guidelines for determining terminal status due to rapid decline.

In December, **John Olds**, MD, FACP, regional home health intermediary contractor medical director for Wellmark, sent a draft policy of rapid decline criteria to NHO for review.

Wellmark's proposed criteria for hospices to indicate *rapid decline* as a reason for admission or recertification, in hierarchical order from most to least, are:

• **Change in Karnofsky Performance Index or Palliative Performance Scale/Adapted Karnofsky.** Documentation should show at least one stage decline in three months with baseline no more than 50.

• **Progressive weight loss.** Loss of weight should not be attributed to a reversible cause, such as depression. "Progressive" is defined as five pounds in 30 days or 10 pounds in six months. Other measures of weight loss suggested include skin fold measurement, bitemporal wasting, and

girth changes. If available, decreasing serum albumen or cholesterol levels could be used as surrogate indicators of weight loss.

• **Dependence in performing activities of daily living (ADL).** Patient must show a need for assistance in at least three of the following ADLs: feeding, ambulation, continence, transfer, bathing, and dressing.

• **Progressive dysphagia.** Patient should have documented difficulty swallowing leading to inadequate caloric intake. Documentation must include a 72-hour calorie count. Criteria can be used to claim rapid decline if dysphagia leads to recurrent aspiration.

• **Low systolic blood pressure.** If patient has a systolic blood pressure less than 90 when prior readings showed systolic pressure greater than 90, this criteria could be used to claim rapid decline.

• **Emergency room visits.** Patient is admitted increasingly to emergency rooms for conditions other than those considered minor or self-limited.

• **Functional Assessment Staging for Dementia.** Hospices would have to prove at least one stage of decline in three months with a baseline no less than stage five.

• **Pressure ulcers.** Persistence or progression of stage three or four pressure ulcers in spite of optimal care, such as nutrition and debridement.

To support a claim of rapid decline, hospices would not have to meet any specific number of criteria. However, two or three of the top-listed criteria or four or five of the lower criteria would be expected, notes Olds.

Case in point

In a written response to Olds' draft of rapid decline guidelines, Stuart described the following real-life scenario from a team meeting at VNA and Hospice of Northern California:

An 88-year-old woman's physical condition has been declining as a result of Alzheimer's disease. She suffers from dementia, but not enough to qualify under the newly adopted Alzheimer's LMRP criteria.

Her fluid and food intake has dwindled to a point where it barely sustains life. She has withered to 69 pounds, but in the last three months her weight has changed very little. The woman is cared for at home by her husband who is barely able to cope even with the assistance of a home health aide who visits seven times a week.

The woman does not meet the Alzheimer's LMRP requirement, and the hospice would be hard-pressed to prove rapid decline. Under the rapid decline guidelines, she would have to be discharged from care, leaving the husband to provide care he is incapable of providing.

"We elected to keep her on service because we expect her to die within a month or two," Stuart wrote. "We are able to document *clinical decline* in good faith, but under the draft criteria the patient does not come close to manifesting evidence of *rapid decline.* We would be compelled to discharge this patient or risk denial of our claim, a claim that on clinical and prognostic grounds is entirely justifiable. The scenario would characterize the majority of end-stage debilitated patients for whom we provide hospice services." **(See related story on documentation on p. 43.)**

'Clinical decline' recommended

In addition, Stuart notes the rapid decline guidelines would lead to denial of claims in cases where patients are obviously dying, but fail to exhibit enough decline during a benefit period.

"Often functionality, weight, and other draft policy parameters are preserved until shortly before death, whereupon they decline precipitously," Stuart says. "The clinical course of end-stage heart and pulmonary disease are both characterized by long periods of stability, punctuated by unpredictable downturns. It is very unusual for these patients to progress smoothly in a downward trajectory consistent with the demands of the draft policy."

By simply replacing *rapid decline* with *clinical decline*, Stuart observes, the restrictive language of the proposed guidelines would be alleviated, but still require hospices to document decline. In a February conference call between fiscal intermediaries' medical directors, NHO representatives and Stuart, fiscal intermediaries were receptive to Stuart's suggestions, he says.

If fiscal intermediaries incorporate the suggested modifications, the criteria set forth by Olds would remain essentially the same. References to *rapid decline* would be eliminated and replaced with *clinical decline.*

Using the 88-year-old woman, Stuart cited as an example of how the guidelines were too restrictive, the *clinical decline* requirements would allow the hospice to keep the patient, he notes. Instead of having to show the 69-pound woman had lost five pounds in the previous 30 days, the hospice would have to document subtle changes

in weight or other measures of functional status in addition to an irreversible terminal prognosis.

According to Stuart, the changes he suggests in the proposed guidelines have the following advantages over the *rapid decline* criteria:

• emphasizes standards of documentation and enables hospices to agree on parameters of decline;

• gives reviewers specific domains of decline for hospice documentation;

• allows hospices to document more subtle evidence of decline, especially during the late stages of a terminal illness;

• forms a base for research on the domains of decline to better understand their relationship to terminal prognoses.

Whether fiscal intermediaries will incorporate the suggested changes in their own LMRPs, isn't known, says **Chris Cody**, director of NHO's National Council of Hospice Professionals. "Whatever goes to the intermediaries is up to the medical directors."

However, the process requires medical directors to submit their proposed policies to their respective fiscal intermediaries for advisory committee review.

Stuart says he remains optimistic that medical directors will adopt changes preventing decline criteria from being too restrictive, thereby preserving hospices' intention of treating the terminally ill until the very end of life. "Under the changes, hospices won't have to prove rapid decline," Stuart says. "That's excellent. Hospices won't have to refuse patients who are not declining fast enough." ■

Living with LMRPs requires good documentation

Tell the patient's clinical story to avoid denials

Now that local medical review policies (LMRPs) for non-cancer diagnoses have either been implemented by fiscal intermediaries or are in the process of being phased in, hospice providers must prove their patients meet LMRP criteria.

Fiscal intermediaries began implementing the eight disease-specific policies last September, leaving hospices little choice but to go along. Although the National Hospice Organization in Washington, DC, and fiscal intermediaries still are defining the term *rapid decline*, changes in wording will not change the fact that solid documentation of a patient's condition and subsequent decline is required. **(See related story on p. 41.)**

Documenting patient condition and care for Medicare is nothing new, but experts say hospices must sharpen their documentation skills, especially with the Baltimore-based Health Care Financing Administration trying so hard to sniff out fraud and abuse. The development of LMRPs is a direct result of HCFA's effort to make it more difficult for hospices to defraud the federal government. In the process, however, the work of honest hospices has become more difficult with the latest emphasis on documentation.

"The intent was to ensure appropriate admissions to hospice," says **Margaret Clausen**, CAE, executive director of the California State Hospice Association in Sacramento. "We also think it will help physicians make a diagnosis of six months or less to live and admit patients to hospice."

Why documentation is important

Hospices will be expected to use the LMRPs as guidelines for admitting patients with the eight diagnoses covered in the policies. Those are:

• HIV;
• pulmonary disease;
• heart disease;
• dementia;
• stroke and coma;
• liver disease;
• renal disease;
• amyotrophic lateral sclerosis.

The policies give specific tests and scales to be used in determining the prognosis before admitting a patient to hospice.

LMRPs will allow fiscal intermediaries to:

• Characterize their entire hospice provider populations.

• Target those providers who have the highest proportion of lengthy-stay, non-cancer patients compared to the fiscal intermediaries' overall provider population.

• Focus medical review on appropriate providers.

As a result, hospices can expect to receive additional documentation requests from HCFA. Specifically, though, fiscal intermediaries will be looking for the following reasons for additional document requests (ADRs).

• The provider is already on a corrective action plan.

• The provider has a high non-cancer length of stay (NCLOS) rate relative to other hospice providers in the fiscal intermediary's population.
• A beneficiary specific edit.
• A CFO edit.

Learning the hard way

As hospices improve their documentation, their goal should be to tighten documentation in admission criteria by being as specific and accurate as possible.

Hospice administrators at Hospice of Palm Beach County in West Palm Beach, FL, put their documentation to the test when the hospice was placed under focused medical review in 1998. The hospice survived the intense review of patient records with only 15% denials and learned first hand the required elements of solid documentation.

"We learned a lot by going through this process," says **Susan Rasimas**, RN, with Hospice of Palm Beach County. "We found that utilizing these [non-cancer diagnosis guidelines] in admission criteria is a winner. If you have this information in your chart they can't deny you."

One lesson Rasimas learned was that without adequate documentation, even the most obvious cases still may lead to denials. "Even if a patient dies five days after admission, if you don't have the proper documentation you still can be denied," she says.

Rasimas offers these tips for documentation success:

• Note the dates of service on the ADR request.
• Including any assessment from all disciplines involved in patient's care to demonstrate an interdisciplinary approach.
• Include volunteer notes.
• Include chaplain's notes.
• Book the order promptly.
• Obtain a verbal certification of terminal illness from the medical director within two days of admission or recertification.
• Obtain signed certification of terminal illness from medical director.
• Include supporting documentation, such as initial certification, pathology report, doctor's orders and physician-ordered changes in medication, progress notes, home visit notes, etc.
• Include medical necessity documentation.
• Provide comparisons to show rapid or clinical decline.

Rasimas notes chart audits also are useful. Hospices should consider taking a sample of charts and reviewing them to see whether documentation of the above items meets the guidelines spelled out in each of the LMRPs.

Chart audits show trends in documentation errors common throughout the hospice and identify clinical staff who consistently fall short of the needed documentation standards, she explains.

"We went right into chart audits," Rasimas says. "We saw patterns, nurses who were generic documentors. You have to start doing chart audits on current records. If you notice system-wide problems, have an inservice."

Tell the patient's story

Take the comparison requirement, for example. Simply noting a patient's difficulty to swallow on two different occasions does not allow for a comparison to be made, she notes. However, a detailed description of how the difficulty has prevented the patient from eating properly and documenting the patient's resulting caloric intake over time does meet the criteria.

"Very clearly they [HCFA] want comparisons," Rasimas says. "If your patient is O2 PRN and that is all you write in your notes, it doesn't tell them anything. They want things that are measurable and comparable. For example, if your patient in the beginning is using O2 after he's had a shower or gone to the mall because he's exhausted, write that he used O2 after minimal exertion. Try to be as specific as you can.

"I like it when people start their notes by writing, 'Visited patient in own home. Found patient sitting in the chair watching TV.' Right away you have a picture of someone who is up and dressed. You'll start to see a story, not just notes."

Clausen provides this example of a nurses' notes during a visit with a patient who fell under the heart disease LMRP:

"Heart disease: Increased dyspnea and chest pain with attempts at ambulation, relieved with morphine sulfate 25 mg prior to exertion."

The notation is sound because it includes the primary diagnosis and noted pain alleviation, Clausen notes. To further bolster the documentation, she suggests the writer reference the specific LMRP criteria which allows for admission or recertification.

Nurses, social workers, therapists, and chaplains are accustomed to taking notes and putting them in the patient chart. However, time is the enemy of accurate documentation. Failing to

enter notes into a patient chart immediately following a patient visit creates the risk of forgetting details, which dulls the clarity of story the clinician is trying to portray, according to Rasimas.

The five "W's" — who, what, where, when, and why — provide another angle in which to look at story telling in documentation. Like a reporter, hospice workers should look at their chart notes and supporting documentation to ensure those five elements are included.

For example, documentation must indicate the need for a specific discipline. The question is *who* delivered the care and *why*. Educational material provided to hospices in the wake of LMRPs by Woodland Hills-based fiscal intermediary Blue Cross of California suggest hospices document answers to the following:

- *Who*, which professional, a nurse, social worker, chaplain, physical therapist, rendered services?
- *What* services were provided under the treatment plan and the factors that led to any care outside the treatment plan?
- *Why* were services rendered necessary?
- *When* were services rendered, including date and time?
- *Where* did the care take place? If care took place in a setting other than the patient's home, such as an emergency room, or inpatient hospice, document *why*.

In addition, the same Blue Cross of California guidelines note that telling the story in a manner that fiscal intermediaries will respond to requires hospices convey the following:

- evidence of patient decline as a result of the disease process;
- evidence of symptom control;
- evidence of terminal condition.

The fiscal intermediary says hospices must document care promptly. In addition, hospices must accurately record care that was ordered, the patient's behavior toward care, the patient's compliance with designated care, and rapid decline. Documentation should make it easy to identify the patients' physical and emotional problems, environmental changes that effect treatment and other characteristics that have a bearing on treatment.

Hospices' documentation should also be able to justify admission and recertification. This is done by recording any actions taken that are part of the patient's plan of care, or supporting documentation, such as physician orders, for care that may be considered an addition to the original treatment plan, according to Blue Cross of California. Tests that may substantiate decline should also be included as well as the patient's response or lack of response to treatment such as chemotherapy and radiation. ■

Communicate better to get paid faster

Most MCO payment delays can be avoided

Every provider doing business with managed care organizations (MCOs) has complained about slow payment. It isn't uncommon for claims to sit unpaid for weeks only for the MCO to send the claim back because of missing paperwork or a dispute over services.

After the claim has completed its odyssey, the money, or perhaps only a portion of it, may have taken six months or more to make into the hospices' account.

Hospice providers share the same reimbursement frustrations as other health care providers contracting with MCOs, but they also share some of the responsibility for their own delayed payment, say hospice administrators. If current managed care claims are sitting in accounts receivable for six to nine months, it's a clear sign your hospice could benefit from improved communications between the clinical and billing sides of your organization.

Addressing communication issues can speed up payment by as much six months. While MCOs have their own processes that can lead to delays in payment, poor claims, denials, and appeals are largely the reason payment is delayed, says **Jenny Schrom**, RN, CRNH, director of Hospice Alliance of the National Capital Area in Falls Church, VA. The Hospice Alliance is a group of 13 Washington, DC-area hospices joined for the purpose of managed care contracting.

To speed up payment and improve cash flow, a hospice must examine its internal processes. What many hospices find, Schrom says, is within the hospice walls very little is known about managed care. Before your processes can improve, you must educate your staff about managed care. And, your Introduction to Managed Care class should be followed by an education on the specific managed care contracts your hospice signed with MCOs.

Schrom suggests hospice administrators explain the different types of MCOs and the

various relationships that can exist between hospices and MCOs. For example, explain the differences between health maintenance organization (HMOs), preferred provider organizations (PPOs), independent practice associations (IPAs), and Medicare-risk plans.

Explain the subtle financial relationships that can occur, such as how a physician group may act as the payer for services provided to patients enrolled in an HMO, she suggests.

"There needs to be a better understanding of managed care," Schrom says. "When we talk about managed care we're not talking about just HMOs. It's a fairly complex monster these days."

Preparations prior to admission

If your hospice is negotiating a contract with an MCO, key staff should be kept abreast of the kinds of requirements the contract specifies. A billing department manager, for example, can provide the necessary input to facilitate error-free claims.

"I can't stress this enough," says **Mark Fields**, chief financial officer for Hospice of Northern Virginia in Falls Church, VA, which is a member of the Hospice Alliance. "Clearly, whoever is negotiating contracts with a hospice may not be aware of the hospice's billing capabilities. They could impose a fee schedule the billing department cannot follow."

If a hospice's billing capabilities don't meet the schedule required by the MCO, the hospice could be required to make costly revisions or bill manually, which could lead to errors.

Billing staff must become familiar with each contract's language. They should also be involved in contract negotiations by questioning the payer about specific claims submission requirements. For example, billing staff should find out whether an HMO requires claims to be submitted on a Uniform Bill 1992 (UB92) or if the HMO has its own form, and what documentation must accompany the claim.

After the contract has been signed, billing representative should meet quarterly with the payer to discuss any system changes, address changes, and personnel changes that could potentially lead to a claims error.

Admissions staff is another example of key personnel that should be included in negotiations. Information from negotiations will provide admissions nurses with pertinent information, including:

- Whether the hospice is at risk for the cost of care.
- Whether that risk is shared with another provider.
- Whether the MCO is assuming financial risk.

Here is a scenario that could lead to payment delays:

Hospice A has a contract with Physician Group B to provide services to patients it refers to the hospice for end-of-life care. The patients are enrolled in Health Plan C which has entered into a capitation arrangement with Physician Group B to provide prepaid care to its enrollees. In this situation, Physician Group B becomes the payer, because it has assumed financial risk for the care of the patient.

Unfamiliar with Physician Group B's contract, the hospice admissions nurse assumes that because the patient is an enrollee of Health Plan C, the MCO is the payer. She calls the case manager at Health Plan C for approval of services. The services fall under the health plan's coverage guidelines. The case manager at Health Plan C approves the services and the patient is admitted. But when the time comes to submit the bill, it is rejected by the health plan because claims administrators learn that Physician Group B is at risk for the patient and has already received a per-member-per-month payment for any and all services provided to that patient.

The claim should have been sent to Physician Group B. On top of the already-delayed payment, the hospice faces further delays from Physician Group B because proper authorization for services was not obtained from its case manager.

Sending the claim to the wrong payer and other errors can be avoided if everyone understands the benefits and requirements of each MCO. To help inform staff about the requirements of each MCO, Schrom recommends developing a payer matrix that can be used by all staff members, especially the admissions nurse.

This is either a computer-generated or hard-copy chart that lists each contracted MCO at the top of each column and important contract topics in the far left of each row. Topics might include authorization contacts, billing addresses, and reimbursement type. Billing staff should receive a similar document with more detailed information.

Admission staff should next obtain a copy of the beneficiary's insurance card. The back of patient insurance cards identifies the payer and also indicates the correct claim filing address. The admissions staff should check the payer matrix to determine whom to contact for authorization. With appropriate parties properly notified of a

patient's admission and the agreed upon care, the hospice has made solid first steps to a clean claim.

Case manager takes over

Following a patient's admission, the hospice case manager begins coordinating patient care. In addition, the hospice case manager should establish and maintain constant contact with the case manager from the MCO.

Case managers are not new to hospice, but those dedicated to managed care contracts are a recent innovation. "I don't think you can effectively treat and manage a managed care patient without a managed care case manager, Schrom says.

Keeping the lines of communication open between the internal hospice case manager and the external MCO case manager ensures both parties are in agreement about care, which prevents disputes over unauthorized care when the claim is submitted.

Just as important, it allows the hospice to develop working relationships with the MCO. "It gives hospices well-established contacts with the MCO, a person who can intercede on their behalf," Schrom says. "Having someone who can intercede for you is a huge asset."

Just as admission staff needs an education in current contracts, case managers must also have a working knowledge of the hospice's MCO contracts. The case manager acts as a link between clinical activity and the financial requirements of the MCO.

Key points an internal case manager must know about each contract include:

• **Authorization process.** The case manager should be clear on who to call and when in the event a patient requires care outside the agreed-upon care. For example, changes in care may occur when a physician, after consulting with a therapist, orders therapy services after admission.

• **Required information.** Making sure a claim is accompanied by the proper documentation also prevent delays in payment.

In addition, for internal case managers to perform their job properly, the admission staff needs to communicate the following information to the case manager:

• Which payer is responsible for the patient's care?

• What level of care the provider was authorized to deliver?

• Who to contact for further authorization?

Meetings between internal case managers and external case managers should occur regularly. This normally occurs during weekly case review meetings or telephone conference calls to discuss individual cases. These meetings also should include other members of the care team, such as RNs, therapists, social workers, and chaplains. Team members can provide useful insight when discussing a patient's current status and any changes to a patient's care.

The number of case managers a hospice needs depends largely on the number of managed care contracts it takes on. As managed care becomes a larger part of their business, hospices will have a greater need for a full-time managed care case manager. The traditional hospice model of using the director of nursing to track patients will leave the head of your nursing staff awash in paperwork in addition to supervisory duties.

Handing off to billing staff

Communication doesn't end with the case manager. When a hospice prepares to submit a claim, the case manager must communicate the care provided and dates of service that must be billed to the MCO.

The billing staff should remind the case manager of the proper documentation needed to submit a clean claim. This exchange could take place during a pre-bill audit, an action that home health agencies and skilled nursing facilities do with their managed care contracts.

"The pre-bill audit is an interesting idea that could work, but I don't know of any hospices that do it," says **Lisa Spoden**, MS, partner in Columbus, OH-based consulting firm Strategic Health Care. Spoden is also the chairwoman of the NHO's managed care task force. "But hospice staff might be too busy for that."

However it is done, billing staff must know what documents must be attached to the claim and communicate to the case manager so the proper documents are provided when the claim is prepared.

Spoden suggests the payer matrix also include a checklist of required documentation and codes for each MCO with which the hospice contracts.

Once the bill is submitted, the billing department must aggressively follow up on unpaid claims. Allowing claims to sit in accounts receivable without question allows payments to be delayed further. "You have to take an activist approach," Fields says.

Hospices need to develop an intervention plan

Cast aside old managed care model

It's time to move away from accepting managed care patients on a case-by-case basis, hospice experts say.

"Get a contract with a managed care company and begin establishing a relationship," says **Lisa Spoden**, MS, partner in Columbus OH-based consulting firm Strategic Health Care. Spoden is also the chairwoman of the Washington, DC-based National Hospice Organization's managed care task force.

This relationship can only come if the two sides are bound by a contract that cements a partnership, explains Spoden. Without a contract, hospices that do business with managed care organizations (MCOs) are not afforded the same considerations given to their contractual partners.

"With a contract you're an established partner with a managed care company," agrees **Jenny Schrom**, RN, CRNH, director of Hospice Alliance of the National Capital Area in Falls Church, VA. The Hospice Alliance is a group of 13 Washington, DC-area hospices joined together for the purpose of managed care contracting.

Entering into a contract gives hospices a chance to develop relationships with MCO case managers and claims personnel that can benefit when questions about claims or benefits arise.

"Having a well-established contact in provider relations to intercede for you is a huge asset," Schrom says.

The partnership between an MCO and hospice also can be used to promote hospice care, Spoden notes. The partnership allows hospices to educate the MCO on the benefits of hospice, while MCOs can use hospice workers to introduce the concept of palliative care to its patients. **(For more information on how to work with MCOs, see story on p. 45.)** ■

for claims payment. A claim should be followed at least 90 days after submission, notes Fields. If problems with a claim occur, billing personnel are charged with correcting the error and working with the MCO to ensure prompt payment, he adds.

Fields says billing staff must find out who within the MCO can make claims decisions so they can go directly to a decision maker. "They have to know who to talk to," he says. "They have to learn to work the account and communicate with the managed care company." ■

Surety requirements still on hold

HCFA: Those without bonds face no penalties

The Baltimore-based Health Care Financing Administration's Feb. 15 target to have final rules outlining surety bond requirements for home health providers has passed, and officials still aren't sure when the rules will be published in the *Federal Register*.

According to HCFA's press office, the final rules won't be posted until the General Accounting Office (GAO), an independent investigative arm of Congress, completes its own report on surety bonds in home health.

"The GAO is currently reviewing it," a HCFA spokeswoman says. "When we get the GAO report, then the final rules will be published. You're not going to see anything in the *Federal Register* for a while."

When the rules are eventually published, hospices that provide care in their patients homes will have 60 days to comply with the new rules.

With the latest postponement, HCFA says those providers with surety bonds will not face penalties. Those that have secured bonds can contact their fiscal intermediary and apply for a refund with the surety bond company.

The original deadline for home health agencies to secure surety bonds dates back to January 1998. But pressure from Congress led to a postponement and provider difficulty in securing bonds under the proposed rules has led to a further series of postponements.

Now, HCFA is unable to give a definitive answer as to whether the regulation will be reinstated or what changes it might face.

The surety bond requirement calls for home health providers to secure the larger of a $50,000 surety bond or one equal to 15% of annual Medicare reimbursement. Many home health providers, especially small or rural agencies, have

been unsuccessful in meeting HCFA's requirement and complained it was an unfair financial burden.

The provision was originally designed to fight the existence of fly-by-night home health operators seeking to defraud Medicare, but grew into an indemnity policy against overpayment. The net effect, its critics claimed, was that instead of weeding out fraudulent home care providers, the new rule appears so restrictive that surety bond companies are reluctant to provide bonding. These conditions have the potential of wiping out small agencies that are finding it difficult to find companies to underwrite the bonds, critics say. According to HCFA, 60% of home health agencies have yet to purchase bonds.

As of mid-November, 3,686 home health providers out of the 9,440 home health agencies serving Medicare patients have secured bonding. The small agencies —those with less $200,000 in annual Medicare reimbursement — are having the toughest time. HCFA reports 968 small home health agencies out of a total of 2,966 (32.6%) have obtained surety bonds.

Agencies with annual Medicare reimbursement greater than $1 million have been more successful in meeting the surety bond requirement. HCFA reports 46% of the 3,814 large agencies have received bonds.

As HCFA awaits the GAO assessment of its proposed surety bond requirement, critics are weighing in on HCFA's rule-making process, and the surety bond issue is being used as a case in point.

Hospice Management Advisor's sister publication, *Home Health Business Report,* reported in its Feb. 22, issue that the home health industry is increasingly filing lawsuits against HCFA, claiming the government agency has abused the rule-making process. Critics say HCFA bypassed the rule-making process when it implemented the surety bond requirement and major provisions of the interim payment system. ■

GAO: HCFA faces numerous challenges in 21st century

Report says complexities will increase

The year 2000 (Y2K) bug, the Balanced Budget Act (BBA), the Health Insurance Portability Act, and the daily challenges of running the nation's largest health insurance program has the Baltimore-based Health Care Financing Administration (HCFA) limping into the 21st century. In addition, HCFA has had few resources to devote to other pressing issues such as streamlining its work force and updating antiquated computer systems.

A recent General Accounting Office (GAO) assessment of HCFA painted a troubled picture for the agency as it heads into the new millennium.

"As HCFA moves into the 21st century, its challenges will continue to become more numerous and complex," said **William J. Scanlon**, director of health financing and public health issues for the health education and human services division of the GAO, during congressional subcommittee testimony Feb. 11.

"Once it has finished preparing for Y2K, HCFA must face tasks it has had to put aside or not fully addressed. Several immediate challenges lie ahead. HCFA must finish and then refine program changes to fully realize the benefits expected from the Balanced Budget Act. It also needs to renovate antiquated and streamline redundant computer systems. Furthermore, it needs to strengthen its financial management and efforts to preserve program integrity."

The GAO is concerned that while HCFA has made progress in addressing its highest priorities, many problems still remain. For example, The GAO pointed out that while HCFA is spending considerable resources to bring its billing systems into Y2K compliance, much of the computer systems used for that billing system would be obsolete shortly after 2000. In essence, HCFA is expected to spend millions in renovating its systems only to have to replace them a few short years later.

Scanlon was also critical of HCFA implementation of BBA and Health Insurance Portability and Accountability Act (HIPAA). "HCFA has completed many major tasks this past year and implemented significant portions of the HIPAA and the BBA, but progress remains slow," Scanlon told legislators.

Like their nursing home and home health colleagues, hospices of all types face prospective payment mandated by the BBA. But the complexity of the Y2K problem stalled implementation of the prospective payment system for home health agencies.

Scanlon credits HCFA with trying to address its shortcomings, but says it failed areas such as financial management and routine oversight to ensure provider compliance. The GAO also criticizes HCFA's lack of planning, blamed largely on

the crisis atmosphere created by Y2K, BBA, and HIPAA. "In our interviews and focus groups, a pervasive theme was the need to work in crisis mode, made worse by a lack of planning," Scanlon told subcommittee members.

"HCFA's continuing challenges are taxing — strong leadership and management will be required to meet them," Scanlon said. "More effective planning, new staff with needed skills, and better accountability could help HCFA address these challenges and better ensure quality health care for the elderly, poor, and disabled."

(Editor's note: A complete copy of HCFA Management: Agency Faces Multiple Challenges in Managing its Transition to the 21st Century *can be found at the GAO Web site, www.gao.gov.)* ■

News From Home Care

NAHC wages war on HCFA

The National Association for Home Care, in Washington, DC, has filed several lawsuits challenging the Health Care Financing Administration's (HCFA) implementation of the interim payment system (IPS). The suits charge that the federal agency overstepped its rule-making process when it required the new payment system.

Home Health Business Report, a sister publication of *Hospice Management Advisor,* reported on Feb. 22 that NAHC officials believe if they can prove HCFA violated its own rule-making process, it would open the door to similar lawsuits aimed at other HCFA-imposed regulations, such as the OASIS regulations applied to non-Medicare patients and other rules that have heaped "unreasonable or unnecessary burdens" on home care agencies.

"We think the best solution to IPS problems lies with Congress," NAHC President **Val Halamandaris** tells *HHBR*. "However, we believe HCFA has gone beyond the powers provided by Congress with these arbitrary regulations."

The lawsuits include:

• A federal suit seeking to invalidate HCFA's IPS regulations on the grounds they constitute arbitrary and capricious interpretations of Congress' original intentions from the Balanced Budget Act.

• A class action lawsuit challenging HCFA's recoupment of overpayments resulting from IPS. The suit argues the repayment of funds by home health violates a longstanding Medicare provision stating repayment isn't necessary if the provider is not at fault.

• A suit filed on behalf of disabled Medicare beneficiaries challenging HCFA's requirement that patients be homebound to be allowed home health benefits. The suit alleges many disabled Medicare beneficiaries have been disallowed or will be disallowed home care coverage due to the homebound requirement. ■

Aromatherapy means more than fresh flowers in a vase

San Antonio hospices routinely use herbal scents

Hospices have a good opportunity to try an alternative medicine practice such as aromatherapy, because hospice staff focus entirely on symptom management.

"You can't treat diseases with aromatherapy, but you can treat symptoms," says **Irene Gilliland**, MSN, RN, clinical nurse specialist, who also is an instructor at the University of the Incarnate Word in San Antonio.

Gilliland has provided aromatherapy training to nearly all of the hospices in San Antonio, and she uses aromatherapy in her work with AIDS-afflicted

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children with at Providence Home in San Antonio. She also gave a seminar on aromatherapy at the National Hospice Organization's 20th Symposium and Exposition in Dallas last November.

"People think of aromatherapy as a 'feel good discipline' because it uplifts moods and spirit and has some physiological effects as well," Gilliland says.

Gilliland trained in aromatherapy about five years ago through courses held by the American Holistic Nursing Association in Flagstaff, AZ. She also has an interest in herbal medications and teaches about herbs as a complimentary therapy. Gilliland has also taught Spanish translations of herbal remedies so the area's large Hispanic population may learn more about them.

Aromatherapy sometimes can help patients when more standard treatment is not available, Gilliland suggests.

For example, when the Washington, DC-based Food and Drug Administration (FDA) removed the Scopalamine patch from the market after hospices had been using it to treat patients' terminal secretions, some hospice nurses were without an easy alternative. About that time, Gilliland was traveling and met an English nurse whom she asked what they used to treat terminal secretions. The nurse told her they put juniper in an oil and rub patients' feet with the mixture.

Gilliland returned home and decided to try a mixture of juniper, lemon, and frankincense. "I didn't like the smell of juniper, so I combined it with lemon and frankincense," she says.

She chose frankincense because it has been used in various religious rituals for thousands of years, and to people who practice certain Eastern religions, it is believed to open the crown chakra, a doorway to a person's higher being or spirit.

The foot rub also served two other purposes: One, it would allow the nurse or family member to rub portions of the patient's feet that corresponded to the lungs, as in reflexology, and secondly, it would give the family a way to touch and connect with their dying loved one.

"It helps families with the helplessness they feel about the person who is dying," Gilliland says. "It gives them a way of connecting and makes it a very spiritual, sacred experience."

Sometimes the foot rubs mean so much to the family members that when Gilliland returned to pick up the scented oil, families would ask her if they could keep it because it reminded them of their deceased loved one.

And the oil, for whatever reason, appeared to work in reducing terminal secretions, she adds.

Gilliland offers these "recipes" for aromatherapies that may help relieve various symptoms for hospice patients:

To reduce terminal secretions: five drops of frankincense, five drops of juniper, and five drops of lemon placed in a sweet almond oil.

To relieve arthritis symptoms: Place a few drops of peppermint, black pepper, or wintergreen in a lotion or body oil, and apply to the area where the patient feels pain.

To reduce swelling: Juniper is a powerful diuretic. Nurses could use just a drop of juniper in 10 cc of a sweet almond oil or another type of oil

Hospice Management Advisor (ISSN# 1087-0288) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com) **Hours**: 8:30 a.m.-6:30 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $299. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $179 per year; 10 or more additional copies, $120 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $50 each. (GST registration number R128870672.)

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and apply it to the swollen area. "One woman had swollen arms because of a bilateral mastectomy, and after putting juniper oil on her, she could use her hands again," Gilliland says. "Another case was a pregnant woman who couldn't get her rings off and was going to have them cut off her fingers, so we put some juniper in sweet almond oil, and she could get her rings off."

For antibacterial purposes: Some hospice nurses have used aromatherapy to help patients with methicillin-resistant *S. aureus* (MRSA) infection. "A few hospice nurses have used them for bladder and wound irrigation of all kinds for people who are MRSA positive," Gilliland says. "There are about 25 oils that have been effective for MRSA, and tea tree is one."

For treating nausea: A little peppermint in oil may help.

For headaches: "The headaches I usually come across are caregiver headaches from caregiver strain," Gilliland says. "So I say, 'Just sit down and let me rub your neck and back,' and I use one or two drops of peppermint in a carrier oil to help them with tension."

To treat itchy dry skin: Gilliland uses a type of lavender called angustifolia, which is a completely harmless herb that can be directly placed on the skin, or a person can bathe in it. If it's rubbed over the dry area, she recommends the nurse place it in jojoba oil.

To treat itchy moist skin: "If the person's skin isn't dry, I put it in aloe vera gel." Gilliland once helped a hospice treat a patient whose legs were so dry that the patient had scratched them raw. The physician wanted to use a steroid cream, but the hospice suggested they first try some aromatherapy oils, so they did, and the patient's skin cleared up.

Gilliland recommends that all nurses using aromatherapy, especially if it's being used in oils that are directly applied to someone's skin, first make sure the patient is not allergic to a particular herb.

For example, people who are allergic to Christmas trees might have a difficult time with juniper. And people who have ragweed allergies might not tolerate chamomile very well.

Hospice nurses typically will do a little swatch test of putting a dilute form of the herbal oil on the person's skin and leave it there for 15 minutes before applying the aromatherapy treatment.

"We do that routinely, and so does every member of a hospice team, including the social worker and chaplain when they use aromatherapy oils," Gilliland says.

Another precaution has to do with citrus oils. If these are applied directly to a person's skin then the person should avoid exposing those areas to the sun because they could form brown spots.

Aromatherapy also may be used without direct skin application. Some herbs may be placed in a diffuser or a couple of drops could be put on a light bulb or in a pot of boiling water. "Just smelling it helps," Gilliland says.

For example, inhaled frankincense may help protect people against viruses, which was how the herb was used thousands of years ago in Jewish temples, she adds.

Hospice nurses also typically ask the patient and family directly if they would be interested in aromatherapy, rather than seeking the physician's advice. Some hospices have even invested in aromatherapy oils and training for their entire staff, Gilliland says.

For hospices that would like to learn more about aromatherapy, Gilliland recommends they read *Aromatherapy for Health Care Professionals*, written by Shirley Price and Len Price. The hardcover book is scheduled to be published in June 1999.

The Prices also have written a book called *The Aromatherapy Workbook: Understanding Essential Oils from Plant to Bottle*, published in May 1994 by Thorsons Publishers. ■