The SIMIONE Advisor

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Where Experience Counts

The client newsletter for the home care industry

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Need Help?

Workflow Analysis: The Silver Lining…

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Your case mix has dropped. The PPS reimbursement rate has been cut. The 10% Rural Add-on eliminated. Agency costs are increasing with the implementation of HIPAA, OBQM, HHQI, and more. Predictions are for no increase in the PPS rate (best case scenario) or further ratcheting down of the current PPS rates on October 1, 2003. And, States are looking for cuts in their Medicaid rates. Is there possibly a silver lining in this cloud of bad news? Yes! As the leader of the organization, you can remove barriers to efficiency and obstacles to effective operations! A Workflow Analysis is the answer. A finely tuned organization, improved employee satisfaction, and lower agency costs will be the result.

A Workflow Analysis examines the internal flow of information, both clinical and financial, from referral intake to claim submission, looking for opportunities to streamline daily activities, avoid re-work, and eliminate "workarounds" in all areas and departments. Inefficient and ineffective workflow processes cost money.

How does an Agency make this happen? Scrutinize the Agency's operations to answer these questions:

- *Are operations running efficiently?*
- *Are deadlines being met?*
- *Does information flow smoothly throughout the Agency?*
- *Is everyone busy, but the work not getting done on time?*

A Workflow Analysis is a multi-faceted, objective, and critical analysis that inspects all work processes in the organization. Although a thorough analysis would include far more details than is possible to outline here, we have included the following operational areas to demonstrate the thought process involved.

- *Referral Intake*
- *Patient Admission Procedures*
- *OASIS Completion and Processing*
- *Therapy Utilization*
- *Billing and Collections*

Questions to Ask…

Referral Intake

Is the intake area customer-friendly?

The more efficient the intake staff, the more referrals that can be processed without an increase in FTEs. The referral process should be quick and painless for the referral source. Staff should have access to the tools and information that will facilitate the intake process. Phone calls should be answered immediately by staff members who are qualified to accept physician orders and trained to obtain complete and accurate referral information. Avoid transferring the call to other intake staff and/or putting the caller on hold.

Is the patient's insurance coverage verified and visits authorized before the referral leaves the intake area? And, does staff use HIQH/HIQA to verify Medicare eligibility?

This up-front verification prior to admission will reduce non-reimbursable visits to Medicare HMO patients and avoid Medicare secondary payer complications. Prior to leaving the intake area, intake information should be entered in to the agency's information system, insurance coverage and eligibility should be verified, and services authorized. The fiscal intermediary online system should be used to verify Medicare eligibility, beneficiary name and birth date, HMO enrollment, Hospice election periods, and Medicare secondary payer status.

Patient Admission Procedures

Is the referral information routinely communicated to the clinical areas on a timely basis?

If this is not happening, clinical and clerical staff may be working overtime to process the referrals. Clinical supervisors and staff must receive information in time to review the information, obtain additional physician orders if necessary, identify admission staff, schedule the visit, and notify the patient of the scheduled visit.

Do clinical supervisors or visit staff review the information prior to the visit for accuracy or specific requests such as visit time and date or need for medical supplies?

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A clinician making an admission visit with inaccurate and/or incomplete information may arrive to find the patient not home or not available. Or, the clinician arrives at the home without appropriate medical supplies and must return to the agency or area pharmacy to get them. This is an avoidable cost.

OASIS Completion and Processing

What is the error rate and compliance with the lock date?

Re-work is expensive. An escalating error rate delays OASIS submission. The clinician must be contacted, the errors corrected, the document reviewed, and forwarded for reprocessing.

Is the information on the OASIS supported by the plan of treatment and clinical documentation?

An OASIS Validation audit is an excellent way to identify discrepancies between the OASIS M0 item answers and the supporting documentation. Creating a "derived" OASIS based on clinical documentation will also answer questions about whether the case mix accurately represents the patient's actual condition and whether the agency is getting the reimbursement it deserves.

Who is involved in OASIS processing?

Identify all areas involved with OASIS processing such as clinical supervisors, direct care, quality review, data entry, and billing. Create a flow chart that identifies who receives the document and when and what activities are performed. This exercise generally reveals duplicate efforts, bottlenecks, and workarounds that could be eliminated.

Service Utilization

Does therapy staff perform the therapy evaluation visit within 24-48 hours of therapy referral?

Making the therapy evaluation visit within 24 hours of referral receipt is the Gold Standard. Certainly, the visit should be performed by the 48-hour point. If this is not the case, analyze the relevant time points to identify roadblocks to timely therapy evaluation visits.

TIME POINTS TO SCRUNTIZE

Date therapy referral requested

Date internal referral processing began

Date of referral receipt by therapy

Date of evaluation home visit.

How is therapy utilization tracked?

Therapy utilization and awareness of the therapy threshold are central to an accurate case mix and reimbursement. Without consistent tracking and reporting mechanisms, the agency can financially "shoot itself in the foot." Monitor the percentage of therapy cases that meet the threshold each month. Compare the therapy utilization projected on the plan of treatment to the projection noted on the OASIS M0825. Look for patterns and trends of discrepancies between actual utilization, plan of treatment utilization, and projected utilization on the OASIS. Therapy adjustments require additional time on the part of billing staff, cut into staff productivity, and could result in lost of revenue from overlooked therapy upcodes.

What form of routine communication, if any, is there between nursing and therapy staff?

Communication between all clinicians regardless of discipline is critical to efficient workflow and the provision of the highest quality care. Often the nurse completes the OASIS and answers the therapy utilization question without input from therapy staff. Therapy input is critical as therapists frequently have a different approach to patient assessment, using a "show me - don't tell me" approach. Some helpful hints to encourage communication between nursing and therapy include:

- *Initial review of the OASIS document by a therapist to verify that patient's condition supports the answer given for anticipated therapy utilization.*
- *Therapist completes revlent portions of the OASIS on the initial therapy visit (within 24 hours of the start of care)*
- *Telephone call by nurse to the therapist following the initial visit to discuss patient's status and appropriate utilization of therapy.*
- *Use of diagnosis-driven care plans with established therapy parameters.*
- *Education for nursing staff related to patient's functional status as determined by the OASIS data set and the utilization of therapy services.*

Billing and Collections

Does your claim submission process include a review of all SCIC episodes to ensure they are billed appropriately?

We recommend implementing a process to identify and review all SCIC adjustments prior to claim submission to determine appropriateness for billing. A clinical review should occur when an improvement is indicated, and a financial review should occur when deterioration is indicated.

How many claims are denied due to failing to send in medical records by the 30 deadline (denial code 56900)?

It is critical that billing staff make ADR processing a priority. This includes implementing a tracking system for ADRs and checking for ADRs online on a daily basis. It is important to identify claims in this category and that agency personnel gather, process, and mail the medical record on a timely basis. Putting efficiencies in place for ADR processing can save the agency time and money and facilitate timely payment for submitted claims.

This is just a sample of the types of questions addressed in a workflow analysis. Only by investigating how you are doing things in all areas of your agency, can you successfully improve efficiencies and remove barriers.

There are many circumstances that are beyond our control in home health: how well the agency performs is not one of them. A Workflow Analysis will spotlight where operations are losing effectiveness and help turn the agency into a more enterprising and vigorous organization!

Acquisitions From A Buyer's Perspective

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To Buy or Not to Buy… That is the Question?

The answer of course, will not be found in Shakespeare's Hamlet, but may be found with Simione Consultants.

The market for buying and selling has heated up. Currently, it appears to be a sellers market as more buyers are looking to acquire home care, hospices, medical equipment and home infusion companies. With a sellers market comes premium prices; therefore, the acquire needs to be extra careful in the valuation and due diligence phases.

❶ *What to Buy*

There are two (2) ways to acquire a business: Asset purchase or Stock purchase. Buyers usually prefer asset transactions in order to attempt to avoid the assumption of unknown liabilities, mostly relating to compliance issues, billing practices and Medicare and other third party regulations. In a stock transaction the corporation itself and all its unknown liabilities gets transferred to the buyer. One particular asset is the seller's provider agreement and number. Should the buyer take assignment of this provider agreement? There are advantages and disadvantages in doing so and each should be analyzed and assessed. Of course all of these unknown liabilities should be addressed in the Purchase and Sale Agreement under indemnification. In addition, a financial and operational due diligence should be performed in order to determine that all facts presented are accurate and liability situations are exposed.

❷ *Structure of Purchase*

In a purchase transaction, the buyer needs to assess both liability exposure and tax implications when deciding on what type of entity should make the acquisition. If the buyer is assuming the Provider Agreement, this becomes even more critical. Liability is one of the key issues in any business takeover. Should it be a partnership, "S" Corp, "C" Corp, or limited liability corporation?

❸ *Price*

Usually a "Letter of Intent" or "Letter of Interest" (LOI) is submitted by the buyer outlining the offering terms, including price and how it is to be paid. The LOI is a formal indication that both parties are serious.

A valuation process should be performed to establish an offering price based on what is being acquired. Price is calculated based on the assets and risks associated with the purchase.

❹ *Timing*

It is important to maintain the momentum of a deal to make sure that the seller sees that you are serious and want the deal to close. Usually included in the LOI is the timing of the due diligence process and the expected closing date.

❺ Due Diligence

There are several levels of due diligence which should be performed. They include financial, operational and legal due diligence. The objectives of a financial and operational due diligence include:

- *Identifying "Deal Breakers" which, if unresolved, could preclude pursuing the transaction any further;*
- *Verifying the information and representations received from the seller;*
- *Obtaining a more detailed understanding of the business and identifying key managers and employees;*
- *Developing information which will be vital to negotiating a transaction, obtaining financing, getting board of directors approval, establishing tax and accounting basis of the assets, and integrating the acquired entity into the buyer's business.*

The due diligence team will make sure that no "deal breakers" are surfacing, and that the proper level of attention is being devoted to each area. Information obtained during the due diligence process will be the foundation for negotiations with the seller, and will contribute to answering the ongoing question of whether you should "do the deal". Remember, far more deals fall apart than are completed, even after the signing of letters of intent. Any embarrassment of walking away from a deal is of far less consequence than the potential cost and losses from completing a bad deal. At all times be prepared to walk away from a deal. Although investors don't make money by not doing deals, they don't lose money by not doing them either. Nobody ever went broke by walking away from a deal.

In our next issue we will look at this from a Seller's Perspective.

CAN YOU FIND FOURTEEN WORDS RELATED TO HIPAA?

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W C G J U T D V U J R A D E R
G F N M T R E A T M E N T C L
P P P E R D S L B N C S X A P
T H R I K L F E D I B U Y D L
S H I P A A P L D F R E S S K
P L V R S W S N B C U I G Y B
S A A P L I O H M O K F I S U
R D C S F I F N I P L O N D S
D T Y J F R F H N S N P D O I
R T A U T H O R I Z A T I O N
T U K G D F K U M N C B V S E
E N T H D Y K S U L K T I Y S
T G V C B D O G M I N A D E S
A R P D E I S E N L O P U G A
R E F V U S E P E K W D A D S
G L P M X C S T C P L U L E S
N A S D C L D E E P E G P F O
W O N K P O R D S M D D D H C
R P T A S S D D S C G F R E I
W E C I B U S D A F E Y D S A
P R O K C R D H R M M N E V T
T A H H P E A S Y D E L K U E
P T R U F S D E A D N A S R E
R I T Y P A Y M E N T M P W S
Y O K J S W A N E P L J H R E
I N C G E S C H J T E S A C R
Y S S D E Y G H J D S V R D R
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Check Your PEPs!

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ON HOLD FOR NOW

The PEP Recovery project was initiated by CMS to recoup overpayments for Medicare episodes that should have been paid as Partial Episode Payments. CMS has instructed the RHHIs to process small batches of PEP adjustments each week, to mitigate the cash flow impact that the project will have on agencies. This gradual recovery process will continue until all the PEP adjustments, estimated at $1,300 per claim, have been processed. CMS expects that this project could continue for up to a year.

Agencies are finding that not all claims were prorated correctly. For example, these questionable claims fall into two main categories for New England providers:

1. Patients discharged with a "moved out of service area" reason that the Common Working File shows were not picked up by another agency.

2. For patients who were discharged with goals met and readmitted before day 60, the system has PEP'ed both episodes, not just the first one.

Agencies are strongly urged to allocate internal or external resources to perform a thorough review of all individual claims identified in the PEP recovery project to determine that reimbursement was appropriate. For inappropriate recoupments, agencies should take action to correct the problem.

THE SIMIONE ADVISOR

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EVOLUTION (ev´a lo͞o′shən) ***n.*** **A gradual process in which something changes, especially into a more complex form, as in HOMECARE.**

Just When You Figure It Out... It Changes again.

Can you afford not to be ready for tomorrow?

Our team of experts can help you get there. *TODAY.*

"No matter how bad things get it gives me great comfort to have your business card hanging on my wall"

Laurie Neander, Executive Director,
At Home Care, Inc., Oneonta, New York

Contact us today to gain the leading edge for tomorrow.

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PRESENTATION SCHEDULE

Have You Seen Your Budget Lately?
Ron Barrera
Association for Homecare and Hospice of Raleigh, North Carolina **5/19 - 5/20/2003**

HIPAA Privacy for Home Health
Laura Gramenelles
Eli Home Care Week Teleconference
5/29/2003

What Makes Them Tick? - Betty Gordon
Eli Home Care Week Teleconference
6/18/2003

OASIS Validation - Carol Conrad
Eli Home Care Week Teleconference
8/18/2003

Establishing and Operating a Hospice Facility - Susan Sanfacon *with*
Gail Spera*,* VP Merrimak Valley Hospice
National Hospice and Palliative Care Organization, Phoenix, AZ
9/7 - 9/9/2003

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