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Home Health Care Oversight: From Burden to Opportunity

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The management of complex chronic disease and fraud are among the two largest drivers of rising home health care (HHC) costs.[1,2] In an effort to rein in costs, the Affordable Care Act included provisions that increased physician responsibility for overseeing the utilization of ongoing HHC services. While HHC services are important for implementing care plans that are developed in the office setting, we found that residents and their supervising attending physicians who work in our resident continuity clinic (RCC) were frustrated with the complexity of the oversight process and infrequently billed for the oversight services they provided. Developing efficient and instructive workflows has helped our practice save time, reduce frustration, and improve financial performance.

Form 485, usually referred to as simply "485," is the Home Health Certification and Plan of Care Form. This is the primary means by which physicians and HHC agencies communicate orders and care plan updates for their patients. An attending physician's signature is required on the 485 for a HHC agency to bill for the services they provide. Renewal of services must be approved by a physician every 60 days. It is the physician's responsibility to review diagnoses, orders, and patient updates located in the 485 and, based on his/her knowledge of the patient, determine whether the services are appropriate.[3]

However, HHC agencies are reimbursed for the complexity of the care they provide, and they have become adept at detailing patients' complex medical conditions and the services they provide in the 485s. From 2000 to 2007, 90% of the case-mix complexity increase observed in patients receiving HHC services was related to changes in coding practices as opposed to increases in complexity of care.[1,4] This translates to more complex 485s and greater challenges for physicians who try to provide appropriate oversight. The Healthcare Common Procedures Codes G0180 (physician certification of HHC services) and G0179 (physician recertification of HHC services) are meant to help reimburse physicians for their time spent establishing HHC care plans, communicating with HHC agencies regarding patient care, and reviewing 485s. Estimated reimbursement for G0180 is $50 to $60 while G0179 reimburses between $40 and $50.[5]

In our RCC, more than 250 patients receive HHC services. Additionally, many patients receive services from multiple agencies. As a result, we estimate that physicians and staff associated with the RCC process more than 2,000 HHC-related forms annually. This is in addition to work associated with filtering duplicate forms and responding to phone calls from HHC agencies. However, when polled in August of 2014, only 30% of our preceptors stated that they were billing for HHC services; 37% of preceptors stated that they did not know that billing was possible. The lack of adequate office visit note documentation supporting a patient's need for continuing HHC services was frequently cited as a reason not to bill for oversight services. As a first step, we focused on improving the documentation of patients' HHC needs by leveraging tools within the electronic health record (EHR). Our EHR has a problem list available for documenting patients' active problems. This is a universally accessible and editable list. For every patient receiving HHC services, residents are asked to update the problem list to reflect that the patient is receiving HHC services. Within the HHC section of the problem list, residents are asked to include information detailing why the patient is homebound, why the patient needs HHC services, what services the patient is receiving, and the last date HHC was addressed in an office visit. During an office visit, residents are asked to verify and include this information in their office visit note and indicate whether HHC services should continue. After an office visit in which HHC services are discussed, the information in the problem list is updated by the resident. Patients receiving HHC services have complex medical conditions, and routine follow-up for these conditions is often warranted every three to six months. If it is noted that a patient has not been seen in more than six months, outreach to the patient or HHC provider is performed to ensure that the patient is medically stable and to arrange a follow-up visit. This system allows for regular review and documentation of the patient's ongoing HHC needs. With improved documentation and education, attending physicians felt more comfortable billing for their oversight services (Table 1).

Improved documentation led to improved billing practices in our RCC but did not necessarily decrease resi-

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Table 1. Home Health Care Oversight Billing

	Recertification # G0179 Billed	Certification # G0180 Billed	Total
June-July 2014	33	3	36
August-September 2014	91	19	110
October-November 2014	100	37	137
December-January 14/15	113	33	146
February-March 2015	144	25	169
Total	**481**	**117**	**598**

dent and faculty frustration with the volume of work associated with overseeing HHC services. In the past, 485s were not tracked as they passed among office personnel. Subsequently, duplicate forms were often processed when one member of the team was unaware that another member of the team already completed the work. Additionally, HHC agencies frequently called asking for 485 completion status updates, which resulted in redundant messaging among staff, residents, and preceptors.

Our solution to these problems was to develop a process that allows all members of the clinic to know the completion status of the documents at any given time. Additionally, with revenue generated from improved HHC billing, we were able to justify assigning a member of the clinic staff to assist in overseeing this administrative process. When a 485 comes into the office, it is first passed to the clinic staff member. This person is assigned to monitor the completion status of the forms and is also responsible for ensuring that the HHC agency listed on the 485 is the correct agency based on our records. Checking to make sure that the form is not a duplicate and identifying the last office visit in which HHC services were addressed are key functions of this individual. If it has been greater than six months since the last office visit, a note is sent to a medical assistant to schedule an appointment for the patient. The staff member then creates a note in the EHR that includes this information and passes the EHR note (electronically) and the 485 (paper mailbox) to the resident. As personnel complete their work on the HHC document, they update the EHR note and pass the 485s to the next member of the team. A complete cycle includes the note and the 485 passing from the staff member to the resident, to the attending, to the staff member, and finally to the clinic manager for billing. The EHR notes are viewable by all members of the clinic, thus allowing others to know the completion status of the documents at any time. This process has cut down on duplicate work and the game of phone tag that often occurred when HHC agencies inquired about the completion status of these forms

In order to help residents understand how to best utilize HHC services and how the HHC workflows can help them monitor the services their patients are receiving, we have developed an HHC curriculum that is delivered annually through didactic sessions. In these sessions, we review how the HHC can be used to help patients, the structure of 485s and the information included in them, documentation required to receive HHC services, signs of fraud when reviewing HHC services (i.e. changes in start of care dates, unexpected changes in HHC agencies, documentation of services provided for conditions that have resolved, and unexpected changes in diagnoses that could justify prolonged services), and understanding the basics of HHC waiver programs. Waiver programs often provide patients with a greater intensity of service than would be typically allowed or provide services to patients who would not qualify for HHC services based on typical requirements (i.e. need to be homebound or need for skilled services).

After implementing this workflow and the educational programming, 85% of residents stated that they felt more confident in monitoring and managing HHC services. Additionally, 100% of faculty stated that they were aware that they could bill for HHC oversight services, and 92% of faculty stated that they billed for these services regularly. Our clinic staff member tasked with overseeing this workflow states that the process is easy to follow. Call center

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staff state that they are able to more easily handle queries from HHC agencies asking for updates on form completion and can avoid sending messages to residents.

Oversight of HHC services is complex and time consuming, yet the inappropriate utilization of HHC services is costly, and inadequate oversight can lead to poor patient care. In a large practice with many new physician learners who are caring for a highly complex population, creating a standardized process that allows for maintenance of learner autonomy and preceptor supervision, safe patient care, and decreased clinical resource utilization is important. We have described one model for managing oversight of HHC services that has been well accepted by physicians and staff and has resulted in positive financial gains.

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