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# Home Health Line™

Regulatory news, benchmarks and best practices

## In this issue



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*Regulatory update*

## Waiver for face-to-face encounters via telehealth ends as budget talks stall

You can no longer accept a telehealth face-to-face encounters, effective Oct. 1, 2025.

The popular pandemic-era waiver provided an important opportunity to connect homebound patients with their providers for a visit that meets CMS' face-to-face encounter requirements. But, with the budget impasse in Washington, the waiver that allowed for telehealth use for these visits expired Sept. 30.

Face-to-face encounters are a top reason for denials under medical review, leading to lost reimbursement. Ending the telehealth access for these visits increases the challenges of getting a patient scheduled with their provider in the allowed timeframe.

The waiver may return through a new budget resolution or through separate legislation. You'll want to carefully monitor updates from CMS and your Medicare Administrative Contractor for details about any extension or resumption of the waivers.

Past budget resolutions, most recently in March, included "removing geographic requirements and expanding originating sites for telehealth services."

Without that waiver, the patient's home doesn't qualify as an originating site for telehealth use.

This also means that the waiver that allows hospice providers to use a telehealth visit for the recertification of hospice eligibility has expired. — *Greg Hambrick* (*greg.hambrick@decisionhealth.com*) ■

*Survey preparations*

# Stress proper glove use in wound care to get ahead of survey citations

Ensure staff members are appropriately navigating infection control standards during wound care, as this is an area for frequent citations, especially during field visits.

Wound care is one of those scenarios where hand hygiene and glove use routinely trips up clinicians, says Mary McGoldrick, a home care and hospice consultant with Home Health Systems and author of the *Home Care Infection Prevention and Control Program* manual.

The Accreditation Commission for Health Care (ACHC) recently shared its top infection control citations in home health and wound care was among the most frequent.

It's a high-risk area as surveyors are likely to observe dressing changes and review documentation, ACHC notes. "Expired supplies, incorrect or missed dressing changes and lack of proper technique for wound care often trigger citations."

## Understand the patient risks

"During home health and hospice mock surveys, I always request to make a home visit with a nurse performing wound care, as it is a high-frequency procedure that is commonly problematic," McGoldrick says.

Breaches in infection prevention and control practices can contribute to the patient developing a skin and soft tissue infection that they did not have at the time of admission, she stresses.

Clinicians will frequently fail to change soiled gloves when indicated, McGoldrick says. And, when they do remove their gloves, they fail to perform hand hygiene immediately afterwards.

During complex wound care, glove changes may be necessary multiple times, she says.

"However, glove changes are often missed, and hand hygiene is skipped, leading to the use of a new pair of gloves without first performing hand hygiene."

## Supplies also tripping up nurses

Regarding ACHC's point on expired supplies, McGoldrick notes expiration dates on supplies are labeled with the month and year, and are considered expired on the last day of the month.

To manage supplies efficiently, clinicians should use the items that are about to expire first. Inventory should be kept at a minimum and restocked frequently to avoid wastage, McGoldrick says.

Supplies also need to be stored properly — sterile products, such as those used during wound care, should be stored between 68°F to 77°F and in an environment with 30% to 60% relative humidity, she says. "That's not often the case when stored in a trunk." — *Greg Hambrick* (*greg.hambrick@decisionhealth.com*) ■


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**Home Health Line** Tool

# Glove and hand hygiene guidance

Use this tool to remind clinicians of CMS' guidance to surveyors and the Centers for Disease Control & Prevention's (CDC) guidance for health care workers on hand hygiene and glove use.

## CMS' guidance to surveyors

**G682 — §484.70(a) Standard: Prevention**

The agency must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.

**Interpretive guidance**

Federal and state agencies such as the CDC and state departments of health, national professional organizations, have all developed infection prevention and control standards of practice. Examples of organizations that promulgate nationally recognized infection and communicable disease control guidelines, and/or recommendations include: the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC), and the Society for Healthcare Epidemiology of America (SHEA).

An agency should identify the source of its infection prevention and control standards (CDC, state departments of health or other professional organization) and be capable of explaining why those standards were chosen for incorporation into the agency's program.

Standard precautions — those applying to all patients regardless of suspected or confirmed infection status — must be used to prevent transmission of infectious agents.

Hand hygiene is cited as one of six core practices identified by the CDC.

The survey guidance notes that agencies and surveyors are advised to review the CDC's current hand hygiene recommendations for correct procedures.

Hand Hygiene should be performed:

- Before and after contact with a patient.
- Before performing an aseptic task (e.g., insertion of IV, preparing an injection, performing wound care).
- After contact with blood, body fluids or contaminated surfaces.
- After contact with the patient's immediate environment.
- When moving from a contaminated body site to a clean body site during patient care.
- After removal of personal protective equipment (e.g., gloves, gown, facemask).

The term "hand hygiene" includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water.

The agency must ensure that supplies necessary for adherence to hand hygiene are provided.

## CDC's guidance for glove use

**Gloves are not a substitute for hand hygiene**

- If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings.
- Always clean your hands after removing gloves.
- Remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil hands.

**When to wear gloves**

- When needed for Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment).
- When needed for transmission-based precautions.

**When to change gloves and clean hands**

- If gloves become damaged.
- If gloves become soiled with blood or body fluids after a task.
- If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs.
- If moving from care on one patient to another patient.
- If they look dirty or have blood or body fluids on them after completing a task.
- Before exiting a patient room.

## CDC's guidance for hand sanitizer vs. hand washing

Unless hands are visibly soiled, alcohol-based hand sanitizer is preferred over soap and water in most situations because it:

- Is more effective at killing germs on hands than soap.
- Is easier to use when providing care, especially when moving from soiled to clean activities on the same patient or when moving between care of patients in shared rooms.
- Results in improved skin condition with less irritation and dryness than soap and water.
- Improves hand hygiene adherence.

*Marketing*

# Reframe your value when speaking to non-traditional referral partners

When looking beyond physician and hospital partners for new non-traditional referral sources, limit jargon and instead focus on storytelling when communicating your successes. Organizations that present their services in a more accessible way can improve trust with these partners while gaining new connections with potential patients/clients and their caregivers.

Non-traditional referral sources — like community organizations, senior centers and churches — represent a huge growth opportunity for providers of home health and private duty services, especially as health care shifts toward value-based care and community health programs, says Greg Bean, vice president of revenue cycle management for AxisCare Home Care Software, based in Waco, Texas.

Non-traditional partners often have trusted relationships with individuals who may not frequently engage with hospitals, physicians or case managers, especially in rural or underserved areas. Building partnerships with local organizations enhances visibility and community reputation, which supports long-term growth and brand trust.

While these partners allow your agency to access a previously untapped pool of potential clients, they'll likely require a different marketing approach than traditional referral partners, says Melanie Stover, owner of Home Care Sales of Fairhope, Ala.

It will likely involve communicating your value in terms they understand and care about instead of the clinical language you typically use with providers, she explains. "These sources often have deep relationships with families before a health crisis hits, positioning them as trusted advisors during vulnerable moments."

These partners may not understand the scope of services, such as skilled versus nonskilled or home care versus home health, Bean says. They may also find benefit availability or terminology confusing, he adds. "Without structured processes or understanding of urgency, referrals may be sporadic, incomplete or delayed."

You can overcome those boundaries and build trust by following up on communication and making sure that these referral partners know they made a difference, Bean adds.

## Defining your team's successes

Home health providers have mastered the art of communicating with doctors, discharge planners and skilled nursing facilities, Stover says. Unlike health care professionals who understand clinical outcomes, non-traditional referral sources care about different success metrics, she notes.

For example, Stover explains that marketers communicating with these organizations may find increased success when they focus on:

- Family peace of mind rather than readmission rates
- Helping the patient maintain independence instead of functional improvements
- Quality of life rather than OASIS scores
- Safety and reliability over clinical indicators

Those who work directly with seniors will place increased value on patients' ability to age in place, Stover says. Staying in the home longer, maintaining routines and avoiding institutional care are key indicators of success to these partners, she notes.

Similarly, community organizations and social workers worry about preventing crisis situations, Stover says. It can help to emphasize medication safety and fall prevention, as well as the steps that your agency takes to catch early warning signs before they become ER visits, she adds.

## Show how you can offer relief

Agencies hoping to boost their marketing efforts with non-traditional referral sources could benefit from implementing the following tips:

- **Focus on storytelling.** Clear, story-based communication builds trust more effectively than clinical data alone, Stover says. "Non-traditional referral sources connect with narratives about real people, not percentages."

  There are several tactics that your team can use to build an effective marketing framework, Stover says. Include relatable problems like falls, medication confusion or family stress; explain how your team provided a solution in concrete, understandable terms; and showcase the outcome by explaining measurable improvements in everyday language, she suggests.

Consider how your team can reframe the clinical language around a patient who demonstrated improved gait stability and reduced fall risk through the implementation of evidence-based intervention protocols, Stover says. She notes that community-based referral sources may better understand a version that sounds like: "Mrs. Johnson was falling twice a week and was afraid to walk to her mailbox. Our physical therapist taught her simple strength exercises and safety techniques. Now she walks to the corner store independently and hasn't fallen in three months."

- **Frame successes around family relief.** "Community organizations see stressed families daily," Stover says. Emphasize the role that your agency plays in reducing family caregiver burden and providing education and training, she suggests. Partners will also benefit from knowing that your services allow caregivers to call the agency with questions, even after hours.
- **Replace clinical jargon.** Simplify your language when communicating with non-traditional referral partners, Bean recommends. It can help to explain your services in terms of problems solved rather than diagnoses or procedures, he notes. These organizations may also benefit from receiving short and engaging one-page materials with information on who qualifies for care and how to refer.

  While traditional referral sources would understand the successes behind an agency whose OASIS functional improvement scores exceed national benchmarks, this may not be as significant to those who don't understand clinical expectations and processes, Stover says. Instead, stress that your clients gain independence with daily activities like bathing and cooking within 30 days of care, she suggests.

  Another example would be to note how your nurses help dangerous medication mix-ups that send people to the ER instead of saying that medication adherence protocols reduce adverse events, Stover says. Or, instead of describing your agency's reduction in unplanned hospital readmissions, explain the proportion of families you serve that are able to avoid unexpected trips back to the hospital, she recommends. — *MaryKent Wolff* (*marykent.wolff@decisionhealth.com*) ■

*Quality outcomes*

## Target patient knowledge deficits, ADL gaps with high-acuity patients

Plan beyond the home health episode when working with patients whose assessments indicate high acuity or frailty levels. Agencies that prepare patients and caregivers for life post-discharge can boost independence and limit rehospitalizations.

Higher levels of patient frailty are linked with increased chances of rehospitalization, especially among patients discharged to home health compared to skilled nursing facilities, according to a study published in the Journal of the American Geriatrics Society on Aug. 6.

Frailty is commonly defined as a clinically recognizable state of increased vulnerability due to age-related declines in functioning, says Amanda Gartner, senior education manager of Corridor in Overland Park, Kan.

The frailty phenotype includes five key indicators:

- Exhaustion
- Low physical activity
- Slowness (e.g., gait speed)
- Unintentional weight loss
- Weaknesses (e.g., grip strength)

These patients are at an increased risk for having poor outcomes, says Diane Link, owner of Link Healthcare Advantage in Littlestown, Pa. They're also more likely to face other high-risk issues that can impact outcomes, such as lack of caregivers, unstable finances or housing instability, she notes.

Agencies can target patient frailty by tackling knowledge deficits like a patient's understanding of disease and medication management, Link says. It can also help to address ongoing ADL issues, then consider long-term interventions that can provide support even after the home health episode concludes, she notes.

Another way to tackle patient frailty is by making rehospitalization part of your agency's quality assurance and performance improvement (QAPI) efforts, says Apryl Swafford, QA manager for SimiTree, based in Hamden, Conn. Agencies can reduce these hospital stays by reviewing charts for all the hospitalized patients and trending their diagnosis, then seeing what your team can do to reduce those stays, she notes. Each

discipline can play a role in helping to keep the patient at home and out of the hospital, she adds.

## Assessments that identify frailty

Frailty, a term synonymous with acuity, is addressed with several OASIS items, Swafford notes. For example, M1033 (Risk of Hospitalization). This item can give a glimpse into acuity levels by showing the patient's risk for rehospitalization. The more items that apply, like falls over the last 12 months and current day risk factors such as exhaustion, the more likely the patient is to have a higher acuity or frailty level, she notes.

M1400 (Dyspnea) is another area that can help determine the level of acuity for a patient, Swafford says. A patient who is dyspneic at rest, especially if also on oxygen, is limited in their ability to ambulate and perform ADLs and other basic tasks safely due to their respiratory status, she explains.

While OASIS does not have a dedicated 'frailty' item, several sections indirectly assess frailty-related domains, Gartner says. These items, which can be used to triangulate frailty risk and inform care planning, include:

- Section G (Functional Status): ADLs like dressing, bathing, toileting and ambulation.
- Section GG (Functional Abilities and Goals): Mobility, transfers and self-care.
- Section J (Health Conditions): Pain, falls and other frailty-related risks.
- Section K (Nutrition): Swallowing and weight loss.
- Section I (Active Diagnoses): Chronic conditions contributing to frailty.
- Section N (Medications): Polypharmacy and medication management.

OASIS items aren't the only way to gauge frailty, Swafford adds. For instance, providers can review a patient's permitted activities, she notes. If the patient is chairbound or bedfast, this usually means they are at a greater acuity than those who are able to ambulate.

Agencies should also use validated tools to screen for frailty levels, Gartner says. She provides the following examples:

- The FRAIL Scale, which includes five yes/no questions on fatigue, resistance (stairs), ambulation, illnesses and weight loss.
- Clinical Frailty Scale (CFS), which ranks frailty from 1 (very fit) to 9 (terminally ill).
- Edmonton Frail Scale, a multidimensional tool that measures cognition, mood and social support.
- Short Physical Performance Battery (SPPB) to measure balance, gait speed and chair stands.
- Otago Exercise Program, which is used to reverse frailty through tailored strength and balance training.

## Planning ahead is essential

While it's not always possible to decrease a patient's frailty level, agencies can proactively identify areas where the patient is at risk and work to make targeted modifications, Swafford says. Examples of ways to tackle these concerns include:

- **Think past the initial episode.** Pre-planning is essential to keeping patients out of the hospital and helping them age in place, Link says. This process should include identifying potential issues that could occur based on the patient's chronic conditions or socio-economic concerns after the episode concludes, she recommends.

  Discharge plans should include exercises that help maintain function and guidelines around scheduling follow-up visits with a physician, Link suggests. Agencies could also benefit from incorporating advanced care planning into their considerations. Knowing the patient's end-of-life wishes in the event of further deterioration is important, she stresses.
- **Check in often.** Increased frailty often calls for more frequent visits from the agency, Swafford says. Patients with higher acuity shouldn't have one skilled nursing visit a week, she notes.

  Contact the patient's caregiver and family regularly, Swafford suggests. Keeping these lines of communication open can help your team keep an eye on the patient's status and identify any additional educational needs that they may have, she notes.

  Clinicians should also talk to caregivers about long-term planning, how to prevent further decline and what could occur if a patient's condition worsens, Link says. "Having family members involved in discussions regarding long-term planning, whether that be private caregivers or facility placement when needed, will prevent potential rehospitalizations following discharge from home health."

- **Make use of available resources.** Provide patients and their caregivers with information about community resources that can assist with finances, meal preparation and social engagement after discharge, Link suggests. Addressing these issues can help reduce frailty by tackling identified deficits like transportation issues, food insecurity or isolation, she notes.

  Don't forget about your social workers, Swafford says. "They have so many resources and can help the family get the help they need in many instances."

  Implementing modifications that provide caregiver support is also key to providing high-quality care when a patient has a high acuity level, Swafford says. Higher frailty levels are often associated with increased caregiver burdens, but agencies can mitigate burnout by connecting caregivers with resources. For example, a mechanical lift to assist with getting the patient from the bed to the wheelchair.

  "While we may not be able to amend the fact that the patient is non-ambulatory at 98 years old, we can get some assistance to help the family with transfers while making the transfers less traumatic to the patient," Swafford notes. — *MaryKent Wolff* (*marykent.wolff@decisionhealth.com*) ■

*ICD-10 coding*

# New codes for postprocedural open surgical wounds proposed

Coders may have a way to capture surgical wounds that are temporarily left open at the end of a procedure if a proposal is approved as presented during the September ICD-10 Coordination and Maintenance Committee meeting, held Sept. 9 and 10.

This would be a patient who has a large wound left open to heal, oftentimes to not trap in infection, explains Sherri Parson, CEO of Infusion Health in Ypsilanti, Mich.

While this is a clinically significant concept, there is currently no way to account for it in ICD-10.

"When we see these patients in home health, they require lots of resources such as wound vacs and negative pressure treatment," Parson adds. "Having a diagnosis to track the resources required for an organization may help with future efforts to recoup some of the resources agencies utilize."

This proposal was previously presented at the September 2024 meeting and contains some updates.

The updated proposal would add a subcategory **Z98.88** (Postprocedural open surgical wound) under **Z98.8** (Other specified postprocedural states).

This is one of more than 50 proposals presented during the two-day meeting.

Note: All of the proposals, unless otherwise specified, are being considered for an Oct. 1, 2026, implementation date. Any new ICD-10 codes that will be implemented on April 1, 2026, will be announced in November 2025.

## Skin changes due to skin failure

Another updated proposal calls for new codes to capture skin changes due to skin failure.

In October 2023, CMS implemented new guidance in the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual for Section M stating that: "Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M."

"Numerous ICD-10-CM categories exist to properly classify various types of organ failures for the body's major organs, but no category exists for failure of the largest organ of the body, the skin," the proposal states.

With this CMS guidance recognizing that skin failure and end-of-life wounds are not pressure ulcers, the proposal points out that there are currently no diagnosis codes to classify the condition.

Parson is excited to see these changes proposed.

"These ulcers, better known as Kennedy Terminal Ulcers, happen in patients usually within a few weeks of death," she notes. "They often look like pressure ulcers but are not caused from pressure and shear but rather blood flow to the skin."

Having a way to specifically capture this type of ulcer and etiology will help with treatment, she adds. "Kennedy ulcers will never heal and that would not be the objective since the skin is failing."

## Other proposed tabular changes

These code changes are being proposed for an. Oct. 1, 2026, implementation date:

- Under **D05** (Carcinoma in situ of breast), delete the "Excludes 2" note and add an "Excludes 1" note for malignant neoplasm of breast (C50.-).
- Under **F05** (Delirium due to known physiological condition), delete the "Excludes 1" note for delirium NOS (R41.0) and add inclusion term "Delirium NOS."
- Under **J42** (Unspecified chronic bronchitis), add a "Code also, if applicable" note for chronic respiratory conditions due to chemicals, gases, fumes and vapors (J68.4) — *Megan Perry* (*megan.perry@decisionhealth.com*) ■

**Editor's note:** To view all of the September proposals, visit *https://tinyurl.com/3b5hanta*. Coders can read more about the proposed updates in an upcoming issue of *Diagnosis Coding Pro*, a sibling publication of *Home Health Line*.

## Benchmark of the week

# Agencies getting the hang of discharge function

Six months into public reporting on the Discharge Function Score, agencies nationally have shown that new attention to the GG items is paying off. Forty-nine of 50 states saw an improvement in the average Discharge Function Score from January to July. The three states seeing the biggest change were Vermont, Alaska and Indiana. The most recent data are based on OASIS assessments submitted from October 2023 through September 2024.

| State | Jan. 2025 | July 2025 |
|---|---|---|
| Nationally | 67.15% | 68.62% |
| Alabama | 65.18% | 67.43% |
| Alaska | 64.89% | 67.68% |
| Arizona | 67.17% | 68.25% |
| Arkansas | 70.52% | 71.87% |
| California | 60.03% | 61.26% |
| Colorado | 71.56% | 72.22% |
| Connecticut | 74.76% | 76.39% |
| Delaware | 70.91% | 72.6% |
| District of Columbia | 69.76% | 70.39% |
| Florida | 66.04% | 67.86% |
| Georgia | 63.40% | 64.93% |
| Hawaii | 55.61% | 57.85% |
| Idaho | 71.71% | 72.98% |
| Illinois | 68.34% | 70.03% |
| Indiana | 71.71% | 74.44% |
| Iowa | 76.21% | 78.63% |
| Kansas | 67.83% | 69.25% |
| Kentucky | 70.39% | 71.64% |
| Louisiana | 62.55% | 65.17% |
| Maine | 75.14% | 75.88% |
| Maryland | 69.58% | 70.91% |
| Massachusetts | 75.22% | 76.74% |
| Michigan | 68.93% | 70.31% |
| Minnesota | 70.58% | 72.25% |
| Mississippi | 59.15% | 60.44% |
| Missouri | 75.16% | 76.5% |
| Montana | 69.38% | 69.99% |
| Nebraska | 72.03% | 73.71% |
| Nevada | 66.46% | 68.4% |
| New Hampshire | 75.02% | 76.91% |
| New Jersey | 70.51% | 72.19% |
| New Mexico | 64.46% | 64.97% |
| New York | 68.62% | 70.46% |
| North Carolina | 68.07% | 69.42% |
| North Dakota | 76.86% | 78.01% |
| Northern Mariana Islands | 55.61% | 57.85% |
| Ohio | 71.61% | 72.51% |
| Oklahoma | 63.29% | 65.26% |
| Oregon | 65.47% | 66.93% |
| Pennsylvania | 71.75% | 73.46% |
| Puerto Rico | 56.12% | 56.29% |
| Rhode Island | 77.76% | 78.05% |
| South Carolina | 70.06% | 71.88% |
| South Dakota | 82.75% | 84.52% |
| Tennessee | 64.96% | 67.13% |
| Texas | 55.78% | 57.91% |
| Utah | 75.39% | 77.67% |
| Vermont | 71.60% | 75.36% |
| Virginia | 70.75% | 72.32% |
| Virgin Islands | 45.33% | 42.96% |
| Washington | 64.35% | 65.95% |
| West Virginia | 69.72% | 71.97% |
| Wisconsin | 76.19% | 77.2% |
| Wyoming | 70.49% | 69.77% |

*Source:* CMS Provider Data Catalog