OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

April 2015 | Volume 11, Issue 4

OASIS submission

Expect more ADRs as CMS begins matching process for HIPPS codes on claims, OASIS

Make sure your agency has a process for submitting timely OASIS assessments to prevent future additional documentation requests (ADRs) that CMS will be better able to detect as a result of its new system.

CMS' new claims processing systems will begin April 1 to compare the Health Insurance Prospective Payment System (HIPPS) code on a Medicare home health claim to the HIPPS code generated by the corresponding OASIS assessment before the claim is paid.

(*see* ***Submission***, *p. 8*)

Denials management

Improve your ADR success by keeping a summary on file of all the relevant information

Make sure the person responsible for overseeing your agency's responses to additional documentation requests (ADRs) writes a summary of each patient's episode that includes the reasons for homebound status and medical necessity.

Turn the summaries in to auditors with the episode's records and keep them easily accessible among the patient's medical and other records at your office — either physically or electronically with the

(*see* ***Denials***, *p. 10*)

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In This Issue

Care transitions

Look for key information on hospital physical therapy evaluations to reduce readmissions

Make sure your agency has a process in place to ensure therapists closely examine specific patient information such as whether an orthopedic surgeon performed an anterior or posterior hip replacement surgery, to help them gain a complete view of a patient's range of motion or weight-bearing restrictions.

Doing so will help physical therapists (PTs), for instance, craft a plan of care that more accurately reflects a patient's ability to improve over the episode, improve care transitions, patient outcomes related to activities of daily living (ADLs) and reduce readmissions, says Karen Stasium, quality reviewer at the Walpole Area Visiting Nurse Association, Walpole, Mass.

As more patients are discharged from the hospital with increasingly acute and complex medical conditions, therapists need to focus more of their attention on care transitions to keep patients healthy and from returning unnecessarily to the hospital, says Jody Schmucker of Universal Rehabilitation Services, a home health therapy staffing company based in North Canton, Ohio.

The strategy of gathering more detailed information relevant to PTs helped the agency where Stasium recently worked as a director of rehab, Steward Home Care, of Westwood, Mass., maintain its unplanned emergency room visits measure on Home Health Compare at 11%, better than the state and national average of 12%, Stasium says.

For example, if a patient has had an anterior hip replacement surgery, the PT does not have the same precautions to follow as she would if the patient had a posterior hip replacement, she says. In the latter case, PTs can't bend the hip past 90 degrees, can turn the patient's toes inward and can't have the patient cross his legs over the mid-line, Stasium says.

The hip could be dislocated if any of these motions happened, so knowing this information makes the PT's patient education more specific and relevant to the patient, and can result in a better patient outcome, she says.

Likewise, PTs should check discharge summaries for PT or occupational therapy (OT) evaluations completed in the hospital or other facility to craft their initial plans of care, she says. For example, a PT could reasonably expect a patient who made good progress while in the hospital would do so at home.

Evaluate the impact of medications

Understanding how certain medications such as narcotics affect patients' ability to perform ADLs and to respond to therapy is also an important part of therapists' roles in care transitions, Stasium says.

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If a patient is taking narcotics, for example, the therapist may want the patient to lie down during blood pressure readings, as the medications can cause dizziness and the patient could pass out or fall if he or she stands, she says. Narcotics also frequently cause painful constipation that in turn can affect the plan of care as the doctor may need to switch drugs.

The drug Sinemet, used to treat Parkinson's disease, can slow the initiation of movement, so therapists need to understand that progress for some motion training could be slowed, Stasium says.

PTs should also pay close attention at the onset of care and make sure their patients' physical environment is safe enough to allow for ADLs and prevent falls, says Laurie Dennis, owner of Universal Rehabilitation Services.

For example, a patient on diuretics to treat high blood pressure may have to go to the bathroom multiple times a day, but the path to the bathroom may be too long or filled with obstacles, Dennis says. The PT can remove those obstacles and/or request bathroom equipment be moved closer to the patient's bed.

Communicate like Sherlock Holmes

Therapists don't always receive all the relevant information they'd like from referral sources, so they're often acting like a detective to glean details they need immediately from a patient's medical records and personal history and communicating that information to home health colleagues to smooth care transitions, Schmucker says.

For example, a patient's chart may say he had surgery and was discharged from the hospital for a knee replacement, but also has CHF, is on an active breathing treatment and has had a stroke in the past, she says.

The PT needs to decipher what's relevant to the current episode and what's not, Schmucker says. That's why it's imperative to speak with the patient and his caregivers to determine if the stroke he had 10 years ago is still causing residual weakness on the same side he had his recent knee replacement. If so, it may limit the range of motion the patient will achieve during the home health episode.

Also, the CHF may affect the patient's breathing and limit the number of repetitions in range of motion exercises the patient can complete in a day, she says. That could also mean the therapist will order more diaphragm breathing exercises to the plan of care.

Tips to improve care transitions

- **Use smartphones to ease concerns about assistive devices.** That can improve compliance with equipment that is needed to assist with ADLs, Dennis says. For example, a patient that needs a bed rail to safely transfer from her bed may be reluctant to use this equipment in her home because she's imagining what it looked like in the hospital. However, Dennis will show the patient a picture on her phone of the bed rail used at home. This bed rail is just two-feet long and installed at the head of the bed. This often eases patients' concerns about an unwieldy piece of equipment and increases their enthusiasm for using the equipment.

- **Use hospital physical evaluations or conversations with patient caregivers to determine equipment use.** It's helpful for a PT to know, for example, if a patient had progressed from using a walker to a cane while in the hospital for three weeks, Dennis says. Then when developing the plan of care, the PT will have a better sense of the patient's ability to bear weight and improve using the equipment. If that information is not included in the medical records or discharge summary, the therapist should ask the patient or his caregiver about such equipment use. — *Nicholas Stern (nstern@decisionhealth.com)*

Anatomy & Physiology

Look to acute record for increased level of tobacco use detail needed in ICD-10

Prepare your clinicians, coders and intake staff now for the increased level of detail related to tobacco use they'll need to receive from provider sources or capture in documentation to accurately code in ICD-10.

Clinicians will need to document more detail about this risk factor from the patient in order to adhere to the coding guidelines to use additional codes, says Joan Usher, BS, RHIA, COS-C, ACE, AHIMA approved ICD-10 trainer, president and CEO of JLU Health Record Systems, Pembroke, Mass.

For example, agencies will need to make sure intake or liaison staff ask referral sources for smoking information upon admission to home health, Usher says.

Information about the tobacco use of patients 13 or older should be readily available as smoking documentation is a required component of the acute medical record and is captured by the inpatient facility, Usher says.

Remember, hospitals and physician practices that applied for federal funding for meaningful use of electronic medical records (EMR) must comply with this requirement or return the money to the government. This will allow the government to collect and study how smoking affects public health concerns, and with ICD-10 it will be able to drill down to specific codes.

In ICD-9, the level of detail for smoking factors is non-specific in nature and many times is not specific to smoking but rather general conditions. For example, when a person has an occupational exposure to smoke, it is coded to V62.1 (Adverse effects of work environment).

In ICD-10, there is a specific code, Z57.31 (Occupational exposure to environmental tobacco smoke), as well as other codes under Z57.- that are related to specific occupational exposures such as noise, radiation, dust or other contaminants, toxic agents, temperature, vibration and other unspecified risk factors.

Also in ICD-10, we can code whether someone is a current smoker, former smoker or has exposure to smoke. If there is tobacco dependence, we need to know whether it is with cigarettes or chewing tobacco and if the use is uncomplicated, in remission, in withdrawal or with other specific disorders for the tobacco dependence code — F17.2-- (Nicotine dependence).

Use M1036 as documentation trigger

An area where clinicians already capture information about smoking is OASIS C-1's M1036 (Risk factors) Response "1 — Smoking." When clinicians select this option, they need to ask the patient details about his current or historical use of tobacco and document this on the OASIS or the clinical narrative, Usher says.

Also, new in ICD-10 is a chapter note in "Diseases of the Respiratory System" (J00-J99) requiring the coder to use additional code when applicable to identify exposure to or history of tobacco use and dependence for all respiratory conditions. This means that when assigning a respiratory code, three questions need to be asked.

1. Is the person a current smoker?
2. Is the person a former smoker?
3. Was the person exposed to any smoke?

If the answer is yes to any of these questions, more information needs to be collected on the specifics and the additional code needs to be assigned, she says.

Chapter 10 Diseases of the Respiratory System (J00-J99)

Use additional code, where applicable, to identify:

- exposure to environmental tobacco smoke (Z77.22)
- exposure to tobacco smoke in the perinatal period (P96.81)
- history of tobacco use (Z87.891)
- occupational exposure to environmental tobacco smoke (Z57.31)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

The same holds true for many of the code selections in ICD-10. In Diseases of the Circulatory System (I00-I99) there is a similar note that appears under the applicable diagnosis.

Refresh tobacco impact on body

Clinicians may need a refresher about how tobacco affects the body and what should be documented to capture this needed information. A good place to begin is with the Centers for Disease Control and Prevention, Usher says.

Here are a few highlights from the CDC website:

- Cigarette smoking causes more than 480,000 deaths each year in the U.S., making it the leading preventable cause of death.
- Smokers are more likely than non-smokers to develop heart disease, stroke and lung cancer.
- Smoking harms nearly every organ of the body and affects a person's overall health, from lower bone density to Type 2 diabetes to adverse immune reactions.

Scenario #1 — Respiratory

A 78-year-old female is admitted for an exacerbation of chronic bronchitis with emphysema. She was a factory worker exposed to smoke at work for 40 years. She is now on supplemental oxygen.

Coding in ICD-9-CM	
Primary and secondary diagnoses	
M1020a: Obstructive chronic bronchitis with acute exacerbation (which includes with emphysema)	491.21
M1022b: Adverse effects of work environment	V62.1

Coding in ICD-10-CM	
Primary and secondary diagnoses	
M1021a: Chronic obstructive pulmonary disease with acute exacerbation (which includes with emphysema)	J44.1
M1021b: Occupational exposure to environmental tobacco smoke	Z57.31

Discussion: Notice in ICD-10 the more detailed code related specifically to environmental exposure to tobacco smoke, while in ICD-9, the code coincides more generically to adverse effects related to the work environment.

Scenario # 2 — Cardiac

A 69-year-old was admitted to the hospital after a NSTEMI myocardial infarction (MI). He then suffered a second NSTEMI MI two days later. He is being admitted to home health three weeks after the onset of the initial MI. He is not a smoker but his wife smokes 1 pack a day.

Coding in ICD-9-CM	
Primary and secondary diagnoses	
M1020a: Acute myocardial infarction, subsequent episode of care	410.72
M1022b:	

Coding in ICD-10-CM	
Primary and secondary diagnoses	
M1021a: Subsequent non-ST elevation (NSTEMI) myocardial infarction	I22.2
M1021b: Non-ST elevation (NSTEMI) myocardial infarction	I21.4
M1021c: Exposure to environmental tobacco smoke	Z77.22

- **Discussion:** Note that for ICD-10, coders have to choose an additional code use, in this case the code coinciding with environmental exposure.

Collection of smoking information will be new for most agencies and staff needs to start now to record this needed information to prepare for the changes, Usher says. The first step is to begin the conversation about smoking with staff and determine what education needs to be provided to what staff.

The types of education needed may be related to the anatomy and physiology of how tobacco affects the body, for example, and what specific documentation needs to be captured to code appropriately. — *Nicholas Stern (nstern@decisionhealth.com)*

Document me

OASIS-C & Outcomes Solutions is providing a new feature to help you more quickly find documentation tips sprinkled in various articles throughout each issue. Just look for the icon for tips to improve your clinicians documentation!

OASIS Tip of the Month

Have clinicians check surgery documentation to see if patients had an ostomy for M1340

Make sure your clinicians understand CMS guidance that an ostomy is not considered a surgical wound for the purposes of answering M1340 (Surgical wound).

Remember, M1340 and its associated item, M1342 (Status of most problematic surgical wound that is observable), are used to calculate the "Improvement in status of surgical wounds" outcome measure on Home Health Compare and also are used to calculate risk adjustment.

In question No. 6 of CMS' January OASIS-C1 Q&As, the questioner asked the federal Medicare agency if a patient with acute cholecystitis who underwent gallbladder decompression with a resulting Jackson-Pratt drain or "JP" drain left sutured in place should be reported as a surgical wound.

CMS responded that a wound with a drain is reported as a surgical wound on M1340 unless it is associated with an ostomy. A surgical wound with a drain remains so after the drain is pulled until re-epithelialization has been present for about 30 days, when it becomes a scar and no longer a reportable surgical wound.

In this or similar scenarios, clinicians must have in their documentation a copy of the patient's operative report, because there they would be able to find out if, for example, a cholecystectomy had been performed or not, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting, Georgetown, Texas.

If one had been performed, then the clinician would answer "0 – No," because it was associated with an ostomy.

Another area that can be confusing for clinicians is determining whether the use of a peripherally inserted central catheter (PICC) line can be considered as a surgical wound for M1340, Rambusch says. CMS has said (*CMS' Q&As, 1/14*) a PICC line catheter that was used

as a central catheter to a central site such as an internal jugular vein is considered a surgical wound.

In other situations, PICC lines, whether they are tunneled or non-tunneled, are not considered surgical wounds but lesions if they were inserted peripherally.

In practice, documentation in the patient's record can say a PICC catheter was used, even though once the PICC catheter is inserted centrally, it's considered a central catheter and thus a surgical wound, she says.

Quality or clinical managers training clinicians on this and other wound items should make sure they are using the latest integumentary guidance — from February 2014 — from the Wound, Ostomy and Continence Nurses (WOCN) Society (wocn.org).

In particular, the glossary has valuable definitions related to wound anatomy and physiology that can be used to quiz nurses on their knowledge. (*See insert for quiz.*)

Assess primary or secondary intention

Even if a clinician assessing a surgical wound when answering M1342 finds all the wound edges seem to be stuck together except for a one or two centimeter area of separation, the CMS Guidance Manual has instructed that the separation indicates the wound is healing by secondary intention.

Deciding between primary and secondary intention for the wound is the first criteria nurses must use when answering this item.

Surgical wounds healing by primary intention do not granulate, and thus, the only appropriate responses to M1342 when a nurse has this type of wound are "0 — Newly epithelialized" or "3 — Not healing." By contrast, clinicians treating wounds that heal by secondary intention can choose among any of the four possible responses to M1342.

Remember, a Response 2 — "Early/partial granulation for M1342" is worth up to 14 case-mix points in late episodes, while choosing Response 3 — "Not healing" is worth up to 11 case-mix points in late episodes, according to the 2015 PPS final rule. Non-routine supply points for responses 2 or 3 also lead to a payment of $51.91.

M1342 is also used to calculate risk adjustment for the potentially avoidable events measure Discharged to the community needing wound care or medication assistance.

Nurses should remember that Response 3 — "Not healing," is the only response for M1342 that requires the patient met just one of its five criteria, Rambusch says. These include that 25% or more of the wound bed has avascular tissue or signs or symptoms of infection. Choosing any of the other responses means that all of the criteria associated with those responses must be met.

Clinicians should take care to document what they see happening with the surgical wound to choose the accurate response for M1342. For example: "Thirty percent of the wound bed is granulation tissue, minimal avascular tissue, no signs or symptoms of infection" for Response 2 — "Early/partial granulation."

IMPACT Act

CMS hosts forum on mandated, unified post-acute care provider assessment

Agencies will soon have to submit quality data to CMS in a standardized fashion with other post-acute care providers as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

During a Feb. 25 open door forum, CMS provided an overview of standardized data to be collected — starting no later than Jan. 1, 2019 — concerning quality measures and standardized assessment domains required under the act. The data will be publicly reported starting no later than two years after application of the act begins, the act says.

Data categories to be covered in all post-acute care settings are: Functional status; cognitive function and mental status; special services, treatments and interventions; medical conditions and co-morbidities; impairments; and other categories.

Rehospitalization during the first 30 days of home health is also being considered, as is the total estimated Medicare spending per beneficiary. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *For more on the IMPACT Act, visit: http://tinyurl.com/l92ypwx and http://tinyurl.com/oshwbcq.*

ICD-10 prep

CMS announces results of its first-ever ICD-10 end-to-end testing week

About 81% of claims received during CMS' first-ever ICD-10 end-to-end testing week were found acceptable by Medicare contractors, CMS announced Feb. 25.

During the Jan. 26 through Feb. 3 end-to-end testing week, more than 660 businesses including providers, clearinghouses and billing agencies

submitted ICD-10 claims and had them processed through billing systems.

End-to-end testing processes claims through all Medicare system edits to produce and return an accurate electronic remittance advice. CMS previously has held front-end testing weeks, but that type of testing simply provides agencies with electronic acknowledgments that claims submitted were received.

Of 14,929 test claims received during end-to-end testing, 12,149 were accepted, CMS says.

Most claims errors were unrelated to ICD-9 or ICD-10.

About 3% of claims were rejected due to invalid submission of an ICD-9 diagnosis or procedure code, and about 3% were rejected due to invalid submission of ICD-10 diagnosis or procedure code.

Meanwhile, about 13% were rejected for non-ICD-10 related errors, such as incorrect national provider identifier (NPI), dates of service outside the range valid for testing and invalid HCPCS codes.

Testing identified an issue involving home health claims with dates that spanned ICD-10's Oct. 1 implementation date not being processed correctly. The claims contained ICD-10 codes but were returned to the submitter.

Less than 10 claims were affected. CMS says the issue will be resolved prior its testing week next month.
— *Josh Poltilove (jpoltilove@decisionhealth.com)*

Medicare CoPs

Avoid scrutiny by developing ready-made, faxable forms for missed visits

Avoid undue CMS surveyor scrutiny by using a standardized form to notify physicians of a missed visit.

Notifying physicians of missed visit frequency is one of the conditions of participation (CoPs) that remains a challenge for agencies, says Judy Adams, AHIMA approved ICD-10 trainer, president of Adams Home Care Consulting in Asheville, N.C.

Surveyors and Medicare administrative contractors look at any regular listing of missed visits and may question the quality of the care provided and whether services were needed as often as ordered, Adams says.

When a missed visit occurs, the first step any agency should take is to try to reschedule the visit within the week it was scheduled to avoid the missed visit altogether, Adams says. If that is impossible, the agency should have a form ready to fax or email the physician.

Beacon Home Health Agency, of Missouri City, Texas, uses a clickable feature on its electronic health record (EHR) system — the agency uses Kinnser Software of Austin, Texas — to track, generate and send out missed visit forms via fax to its patients' physicians when any missed visit happens, says Lora Mayes, administrator.

The form has several set options to click on as the reason for the missed visit, including outpatient

procedure, cancellation of care, doctor's or clinic appointment, family caregiver able to assist, no answer to locked door or other, in which the clinician can fill in a different reason, Mayes says. If clinicians fail to complete the form, it will automatically notify them with an alert that remains until the form is completed.

The agency also requires clinicians to fill in a separate comment box describing how the ordered care was provided in the absence of the visit and any other salient details about why the visit was missed, such as the patient no longer wanting as many aide visits, she says.

If an agency doesn't have such an electronic system, it should still prepare a standardized fax form for missed visits and keep it on hand to send to doctors, Adams says. It should include a space to fill in the patient's name, the date of the missed visit, the type of visit missed such as occupational or speech therapy or aide visit and the reason the visit was missed.

Track quantity, reasons for missed visits

Managers should track the number and reasons for missed visits to look for patterns and to make certain the plan of care contains the appropriate number of visits, Adams says.

If there's a regular pattern of missing one of three visits ordered per week, it may be an appropriate time to discuss with the physician changing the frequency for the patient to twice a week, she says.

If the patient refused a large number of therapy visits, for instance, the agency should evaluate the appropriateness of the plan of care and discuss with the patient what he or she wants from the services and potentially change the plan of care, Adams says.

Clinicians at Beacon Home Health often notify supervisors in their EHR system about missed visits that may necessitate a changed plan of care, Mayes says. Case managers will then discuss with the clinician about whether a change in the plan of care is needed. Ultimately, the clinician must decide this to stay in compliance with Medicare's one-clinician rule that requires only one clinician to complete OASIS assessments.

Take steps to avoid missed visits

Having standardized forms in place to notify physicians about missed visits is key to maintaining compliance with CoPs. But agencies should make every attempt to avoid missing visits in the first place.

Here are a few tips agencies should keep in mind to do this:

- **Ask patients ahead of time about doctor visits.** Conflicting commitments, such as a doctor's visit coinciding with a home health visit, is a common reason for missed visits and should really be worked around in the home health setting, Adams says. Ask patients about upcoming doctor's appointments at each visit.
- **Find out if patients do not want visits on certain days of the week.** For example, patients may have a family member visiting on a Friday and not want any interruptions, Adams says.
- **Leave a note on the patient's door.** If a nurse visits a patient only to find the patient doesn't answer the door, make sure the nurse leaves a note to call the agency office as soon as possible and reschedule, says Cheryl Peltekis, president of Penta Care Consulting in Newtown, Pa.

— Nicholas Stern (nstern@decisionhealth.com)

Submission

(*continued from p. 1*)

If the HIPPS code from the OASIS assessment differs, Medicare will use the OASIS-calculated HIPPS code for payment. And if no corresponding OASIS assessment is found, the claim will process normally for now, CMS says in a Jan. 30 MLN article.

However, later in the article CMS states that in the future it plans to use this claims matching process to enforce the condition of payment and will deny claims when a corresponding assessment is past due in the Quality Information Evaluation System (QIES) but is not found in that system.

CMS says it plans to notify agencies as soon as possible after it determines an implementation date for the enforcement part of the claims matching process.

These changes are based in part on recommendations made by the HHS Office of Inspector General (OIG) in 2012 for CMS to come up with a better enforcement mechanism for tracking timely OASIS submissions.

Before this change, the transmission of assessment data and the submission of claims were entirely separate processes, CMS says. The Fiscal Intermediary Shared System (FISS), which processes all original Medicare home health claims, did not have access to the quality data repository.

FISS could not check the submitted HIPPS code against the associated OASIS assessment. This situation

created a payment vulnerability for the Medicare program, CMS says.

HIPPS codes differences occur for a variety of reasons; a common one involves differences created when agencies use different electronic medical records (EMR) systems for clinical and billing purposes, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10 trainer and product specialist at DecisionHealth.

What agencies can expect

You won't need to make any changes to your billing systems, CMS says. Claims will be suspended temporarily to allow for the file exchange between FISS and QIES. The claims will be suspended with FISS reason code "37071" in status locations SMFRX0-SMFRX4. This will happen during the 14-day payment floor period and should not delay payments to agencies.

If the matching process changes the HIPPS code used for payment, special coding on the remittance advice will notify the agency, CMS says. Claim Adjustment Reason Code 186 (Level of care change adjustment) and Remittance Advice Remark Code N69 (PPS code changed by claims processing system) will identify the recoded claims, CMS says.

These are the same codes used to identify claims recoded due to changes in therapy services. The electronic remittance advice also will return to the agency the HIPPS code used for payment.

Also, CMS says the FISS will display a new field in a Direct Data Entry (DDE) that will contain the OASIS-calculated HIPPS code. The field will be named "Return-HIPPS1." When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice, CMS says.

It's also possible that an OASIS-calculated HIPPS code may be re-coded further by Medicare systems, CMS says. The OASIS-calculated HIPPS code will be sent to the home health PPS Pricer program, which may change the code based on changes in therapy services or whether the claim is for an early or later episode.

In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field, CMS says.

Agencies will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE.

Achieve timely OASIS submission

Whitemyer offers these tips for timely OASIS submission:

- **Aim to submit OASIS within a week.** That gives your agency leeway to also correct any rejections or errors. A claim submitted on the 28th day, for example, will leave little room for correction.
- **Incorporate OASIS submission into quarterly quality improvement meetings/training.** If your agency is correctly submitting about 80% of OASIS assessments on a timely basis because of communication problems among employees, for instance, you have a big problem and may need a nearly full work day, about six hours, of time to re-learn your agency's work flow plan for submitting claims and OASIS data. If you're at 95%, you may just need a quick review of the work process as it currently exists.
- **Check your Certification And Survey Provider Enhanced Reports (CASPER).** These reports provide agencies with information about timely submission of claims. Use them as material during your agency's quarterly meetings to highlight your effectiveness in timely submission. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *Official instructions issued to your Medicare administrative contractor regarding this change are available at http://go.cms.gov/18NFXxw. Recommendations from OIG are at: http://1.usa.gov/1KcHpac.*

Denials

(*continued from p. 1*)

same file, says Martha Garcia, owner and CEO of With Open Arms Home Health Care LLC in McAllen, Texas.

This process improvement strategy to avoid denials when receiving ADRs began in September 2013 when Garcia's agency received, for the first time in about a decade of operation, a large batch of ADRs — about 31 worth roughly $75,000, Garcia says.

It helped her eventually receive full payment for 13 claims, she says. Eight ADRs ultimately resulted in denials. The remaining claims resulted in partial denials and are on appeal at the administrative law judge (ALJ) level.

The ADRs were all related to medical necessity, homebound status or other face-to-face requirements, she says.

An episodic outline, which should be no longer than a page to a page and a half, can help easily guide a reviewer through an audit by laying out essential details they'll need to see to allow payment to be complete, says Brandi Whitemyer, AHIMA approved ICD-10 trainer and product specialist at DecisionHealth.

The outline's details should include why the patient was homebound, why he was admitted to home health, what information supports medical necessity, how the patient progressed through the episode, how the patient met his goals by the end of the episode or why he was recertified, Whitemyer says.

If an auditor calls, your ADR point person — such as a quality or clinical manager or administrator — will quickly and easily be able to access the essential details of the patient, says Garcia, who has consulted with Whitemyer to better respond to the ADRs and to improve her agency's processes so that future ADRs can be avoided.

Plus, if a staff member in charge of handling ADRs at your agency leaves during the lengthy appeals wait at the ALJ level, for instance, you'll still be able to use the summary to recall the patient's episode of care, she says.

Know where each ADR is at any time

As a result of the flurry of ADRs her agency received, Garcia decided to also implement a system for keeping close track of the elemental details of each ADR and its ongoing timeline.

She put the medical records for each ADR into a unique, sealed manila envelope, Garcia says. On the outside of the envelope, she wrote the patient's name, the date the first letter from the auditor was received, the name of the auditor and the timelines for each step of determinations and appeals.

This step is important because it helps those responsible to easily monitor timelines that are vital in responding to ADRs; for example, agencies have 30 days to respond to an ADR in order to keep full payment for the episode, Whitemyer says.

Retrain on documentation

As Garcia's agency went through its quality assurance review of the records related to ADRs, it found gaps in documentation it needed its nurses to improve and began re-training them in weekly, hour-long in-service sessions, Garcia says.

For example, the agency trained its nurses to never enter into their documentation that a patient was homebound due to taxing effort, but to elaborate on why the patient is having a taxing effort, she says. The nurse should write that the patient, for instance, is blind or cognitively impaired or morbidly obese, short of breath and is at risk for leaving the house.

With medical necessity, nurses have to document that skilled care is needed because, say, a patient requires complex wound care or is taking 20 medications and is unable to define the purpose of each or verbalize when each medication should be taken, she says.

For some cases involved with the ADRs, a few 80- to 90-year-old patients had had varicose vein surgery and had compression stockings on their legs from the ankle to the hip for a week or so, Garcia says. They couldn't bend their leg or knee during that first week, yet the way some nurses were answering functional OASIS items seemed to show the patients could walk up and down the stairs and go to the bathroom independently.

Training focused on how to answer OASIS items like M1840 (Toilet transferring) according to the OASIS guidance manual so that the nurse assesses the patient's ability more than 50% of the time period under consideration, which is the whole 24-hour day of the assessment, Whitemyer says.

Improve your responses to ADRs

- **Make sure just one person is responsible for handling ADRs.** If you have multiple team members responsible for organizing your agency's response to an ADR, you'll be more likely to miss something like an impending timeline, Whitemyer says.
- **Delegate authority while you focus on ADRs.** Garcia spent a month focusing on the initial responses to the large batch of ADRs she received starting in 2013, she says. During that time, she split her other administrative responsibilities among her director of nursing, administrator and a field nurse. This helped her to review and collect needed information in a more calm and thorough manner, she says.
- **Look for low-hanging fruit first.** When trying to avoid ADRs, make sure your agency is not missing elemental details in the claim like physicians' signatures on the plan of care or doctors' signatures without a date, Whitemyer says. This is exactly the type of more easily identifiable information an auditor will look for first when reviewing a claim, she says.

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