OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

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In This Issue

ICD-10 implementation

Agencies brace for productivity declines, increased documentation and coding detail

The results are in: home health agencies nationwide believe the scheduled implementation of ICD-10 — more than payment cuts, Medicare audits or face-to-face changes — will have the biggest impact on home health operations and financials in 2015.

The implementation of ICD-10 on Oct. 1, 2015, will have the greatest regulatory impact for the home health industry, according to 32% of 274 respondents to a question within DecisionHealth's 2015 Trends Survey.

Other changes agencies ranked as having the top impact include payment cuts (31%), face-to-face changes (13%) and proposed conditions of participation (8%).

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

Quality improvement

CMS plans to rate agencies using 5-star quality system on Home Health Compare in 2015

Agencies will need to place even more focus on coordination of care to improve process and outcome measures now that CMS is proposing to score them with a 5-star system that could impact referrals in 2015.

The new system will increase pressure on agencies to improve outcomes on these measures as well as the vaccination items, a goal HomeCare of Holland Home in Grand Rapids, Mich., has been

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

Audits and compliance

Face-to-face developments prompt staffing changes, physician education

Many agencies plan to shift roles internally and educate physicians in order to prepare for the changing face-to-face requirements and to prevent future denials.

Some agencies will send letters to physicians explaining the changes while others will visit offices and educate staff about the continued need to justify homebound status and the need for skilled care, according to 280 respondents to DecisionHealth's 2015 Trends Survey.

One West Virginia agency even plans to provide laminated sample documentation to its referring physicians to illustrate the required information.

The 2015 PPS final rule eliminated the face-to-face narrative requirement for episodes beginning Jan. 1, 2015. But CMS made clear it expects to see documentation verifying why a patient is eligible for home health services.

The documentation, which would justify homebound status and the need for skilled care, would be added to medical records.

As a result of changing face-to-face requirements, one Vermont agency says its intake and quality assurance responsibilities will increase. A Texas agency says the changes may require a clinical employee — instead of clerical one — to oversee face-to-face documentation. And one Montana agency says nursing and rehabilitation employees will have an increased burden to create a summary for the physician that helps support eligibility.

Agencies are continuing to learn more information about what documentation CMS will consider acceptable. The federal Medicare agency held an open-door forum Dec. 16 that discussed face-to-face documentation. It provided examples of discharge summaries and progress notes that would support the need to provide home health services.

Will face-to-face denials continue?

The home health industry remains divided about whether revamped face-to-face documentation requirements will affect the volume of denials from CMS auditors in 2015, the survey shows. There's also no consensus about whether it will be easier or harder to get documentation from physicians.

Nearly 35% of survey respondents say there will be fewer denials in 2015, 32% say there will be more denials and 34% say there will be about the same number.

Meanwhile, about 43% of respondents say it will be easier to get the required information from physicians,

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27% say it will be harder and about 30% say the level of difficulty will remain the same.

Attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman, in Indianapolis, believes getting documentation may be easier. But the real issue is whether the documentation meets auditors' standards, he says.

Overall, Markette doesn't feel the volume of denials this year will change much from 2014.

"They were previously knocking out claims for deficient narrative," he says. The 2015 PPS final rule appears to give them the same leeway to deny claims based upon "deficient physician documentation."

But agencies can help bolster documentation.

The rule lets agencies provide certifying physicians additional homebound/skilled need explanation to sign and incorporate into the medical record, reminds Laura Montalvo, chief clinical officer for SelectData of Anaheim, Calif.

Montalvo remains optimistic that the volume of denials will plummet.

"Under the old rules, agencies did not have the ability to develop or communicate the homebound/skilled need language to the physician," she says. And none of the inpatient/other physician documentation was considered by Medicare administrative contractors (MACs) or recovery audit contractors (RACs) in denial decisions — and now that will change, she says.

Doctors tell all about face-to-face rules

DecisionHealth went to the source —doctors' offices and health care consultants — to find out the best way that agencies can educate physicians about the changing requirements. Here's what they said:

- **Provide visuals.** Don't rely on chats with doctors' offices, suggests Peter Canney, manager of a physician practice in Navasota, Texas.

Agencies could supply doctors with a flow chart comparing what the process will be like before and after requirement changes. Agencies also could provide offices with a written bullet point description of the new requirements, Canney adds.

Supplying doctors with a checklist of what should be submitted will ensure they supply information "correctly the first time, every time."

- **Education from auditors would help.** It would be valuable to show the video that MAC Palmetto GBA posted on YouTube in November about face-to-face encounters, Canney says. View the video at *http://bit.ly/1t3sGmQ*.

Information from CMS' recent open-door forum, including examples of acceptable documentation, can be viewed at: *http://go.cms.gov/1yEGB8u*.

- **Keep the process as simple as possible.** Limit the number of times you contact doctors' offices seeking face-to-face documentation, Canney advises.

"Keep communications clear and concise," he adds. "Miscommunications create the need for re-working of documentation."

- **Mail doctors education.** A detailed — yet brief — letter agencies send offices could explain how the documentation process should work, suggests David Zetter, founder and lead consultant with Zetter HealthCare in Mechanicsburg, Pa.

The information could outline what Palmetto showed in its video and detail answers to frequently asked questions about face-to-face documentation.

An agency might have more luck getting someone at a doctor's office to read the letter if it is addressed to, for instance, the doctor's personal nurse, Zetter adds. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Anatomy & Physiology

Leverage medical notes to address patients' dependence in ICD-10

Train your clinicians to ask their patients who may have drug dependence issues difficult or sometimes awkward questions about the timing, level and desire for treatment of substance abuse at each visit.

It's important to understand the history of the patient's drug use, abuse or dependence, when considering how the home health agency can best help the patient to achieve his or her desired goals, says Michelle Mantel, MSN, GNP-BC, RN, BCHH-C, COS-C, HCS-D, Atlanta-based quality assurance manager for the Southeast Region at Gentiva Home Health.

For instance, a patient with frequent falls who is dependent on alcohol may have difficulty improving

activities of daily living like ambulation and transfers—measures reported on Home Health Compare, Mantel says. Likewise, if the alcohol dependence is not identified and treated, the patient may see an increased frequency of falls and rehospitalizations.

During a comprehensive assessment, clinicians must be trained to document behavioral details and to ask about nicotine, drug and/or alcohol use, abuse and dependence, she says. For example, they should find out how many alcoholic beverages, cigarettes or doses of an opioid a patient has per day, how long they've maintained that level of use and whether they've been treated before for dependence or abuse, Mantel says.

Done respectfully and non-judgmentally, a thorough interview with the patient about drug use, abuse and dependence will allow the clinician to create a reasonable care plan and realistic goals with the patient and physician. It will also promote enhanced data collection of the information necessary to properly code and capture diagnoses of drug use, abuse and dependence in ICD-10, she says.

On the other hand, a doctor may refer a patient for home health to manage neoplastic-related pain in a patient who is dependent on opioid analgesia. For this patient, the goal is decreased pain, which often includes titration of analgesia for pain relief and the use of multiple drugs on which the patient ultimately becomes dependent.

In ICD-10, the number of separate codes related to alcohol and drug abuse is greatly expanded from ICD-9 to include associated symptoms such as anxiety, delirium, sleep disorders, delusions, psychotic disorders, hallucinations and withdrawal by drug type.

Remember, clinicians should understand the difference between drug use, abuse and dependence, Mantel says. Those distinctions are important for accurate coding because a clinician first and foremost cannot make any assumptions about those diagnoses. Any diagnosis of actual drug use, abuse or dependence would need to be confirmed by the physician prior to use of that diagnosis on a plan of care and home care claim.

Use records to guide conversations

Look to patients' medical records, visit notes and medication lists before undertaking a comprehensive assessment for signs they may be using or abusing drugs or alcohol, says Mantel.

This will serve a couple of different purposes. First, clinicians will be able to check patients' descriptions of drug or alcohol use against their medication lists and use this as information to provide a physician, who may not have diagnosed a drug problem already, when obtaining orders from the doctor, she says. The doctor may then be able to better diagnose and suggest treatment for drugs or alcohol.

Detailed information in patients' medical records will also help clinicians frame probing questions of their patients' addiction and thus deflect some of the potential agitation such questions may elicit in their patients, Mantel says.

In practice, many clinicians may be intimidated, embarrassed or afraid of agitating a patient by asking them about their use of drugs or alcohol, she says. Sometimes, patients are not interested in being treated for this type of problem and may want the nurse to focus only on other health problems, like CHF.

So for example, if a patient's hospital admission and discharge notes explain a patient was hospitalized multiple times for falls related to alcohol consumption, the clinician can point out such information as a conversation starter about this behavior, she says.

The clinician can thus say: "I see in your medical records that you had a high blood alcohol level when you went to the hospital; has this happened before?" Or, "I see the doctor listed alcoholism as a co-morbidity. How many years have you been drinking?"

The overarching idea is to remain non-judgmental and respectful, Mantel says. For example, if patients do begin to get agitated by questions related to dependence, tell them you care about them and are only looking out for their well-being. The clinician can then return to the subject at a later time.

Scenario

An 81-year-old woman with cancer of the salivary glands is admitted to home health for treatment of neoplasm-related pain. Her medication list includes morphine 60 mg liquid solution by mouth twice daily, and her doctor also indicates her opioid dependence has caused a sleeping disorder. The clinician also discovers the patient had a high blood-alcohol level when recently admitted to the hospital, and confirmed a diagnosis of alcohol dependence with the physician.

Coding in ICD-9			
Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a: Neoplasm-related pain	338.3		
M1022b: Salivary gland cancer	142.9		
M1022c: Drug-induced sleep disorders	292.85		
M1022d: Adverse Effect therapeutic use of opiates	E935.2		
M1022e: Opioid type dependence	304.01		
M1022f: Alchohol dependence	303.91		

Coding in ICD-10 (OASIS-C1 numbers for this category are M1021 for OASIS-C's M1020 and M1023 for OASIS-C's M1022, in column 1 and M1025 for M1024 in column 3)			
Primary and Secondary Diagnoses		M1025 Case Mix	
		3	4
M1021a: Neoplasm-related pain	G89.3		
M1023b: Salivary gland cancer	C08.9		
M1023b: Opioid dependence with opiod-induced sleep disorder	F11.282		
M1023d: Alchohol dependence	F10.20		

Discussion: Here we see the increased level of detail in ICD-10 related to specific drug-dependence. Moreover, the opioid dependence and its associated sleep disorder are contained in one code in ICD-10.

Note how the clinician used the information in the medical record to confirm a diagnosis of alcoholism/alcohol dependence with the patient's physician when obtaining orders for the plan of care. — *Nicholas Stern (nstern@decisionhealth.com)*

Patient education

Split treatment goals into smaller, discrete actions to encourage success

Improve your patient satisfaction scores on Home Health Compare by creating action plans for patients that identify their overall goal for home health treatment — such as being able to go to the beauty parlor or to lose weight — and break that goal down into weekly steps that can be measured and tracked.

This was among the lessons learned by the Visiting Nurse Association of Somerset Hills in Basking Ridge, N.J. It spent about a year two years ago training staff on patient education best practices, among other chronic care management strategies, and having them gain certification in chronic care management from the Sutter Center for Integrated Care, based in Sacramento, Calif., president and CEO Ann Painter says.

Action plans that clinicians used as part of the revamped patient education strategy have helped the agency maintain its "patient would recommend your agency" patient satisfaction measure on Home Health Compare at 83%, well above the New Jersey average of 77% for this measure, Painter says.

For instance, if the overall goal of a patient with COPD is to walk from his house to the mailbox without having to stop from getting winded, a weekly goal at the beginning of treatment would be to get out of his chair, Painter says.

Clinicians at the VNA of Somerset Hills would document in writing what happened during the first attempt to get out of the chair in the agency's electronic health records (EHR) system, she says.

Nurses also write in the agency's EHR system what they and their patients have agreed upon in terms of patients' goals and what exercises or dietary changes, for example, patients will undertake, Painter says.

A clinician can then use this documentation to demonstrate to a patient his progress in reaching his goal through the episode of care, and as a means to supply positive feedback to the patient to continue to encourage him.

Most home health patients have chronic illnesses, and many have a history of rehospitalizations and can get easily discouraged from realizing improvements in health such as increased mobility or weight loss, says Mary Narayan, home health clinical nurse specialist with Narayan Associates, Vienna, Va.

Narayan has reviewed many studies of patient education best practices and recently contributed to the patient engagement and education chapter of the 19th edition of the Visiting Nurse Associations of America's Clinical Procedure Manual.

One of the keys to improving patient confidence and self-efficacy, she's seen, is to create micro-goals to be completed each week that are specific, measurable, achievable and realistic.

For example, a patient with CHF whose overall goal is to improve his diet could begin his first week of home health with a micro-goal of accurately reading food labels and determining salt intake, she says. Clinicians can provide the patient with an example of how to accurately read food nutrition labels as a model to follow.

Don't just tell the patient he needs to read the label, but show him how to do so. In this case, patients need only to focus on the number of servings and the amount of sodium to know whether they're reducing or increasing salt intake.

The next short-term goal could then be to reduce sodium intake by 30% for the week, Narayan says.

Make sure patients create own goals

Have clinicians follow these tips to improve their patient education efforts:

- **Make sure your patients create or choose their own goals for treatment.** Before the VNA of Somerset Hills decided to change its patient education policy, clinicians, particularly those who had not been exposed to the latest in patient engagement techniques, would often just tell a patient what his goals should be, Painter says.

But experience has shown that a patient becomes more inspired to adhere to treatment goals if he sets them, even if those goals do not seem like they would obviously improve a patient's condition.

For example, a patient with COPD might simply want to be able to bathe himself without a caregiver's help, Painter says. Some patients might be embarrassed about being bathed by a relative, but they might need help because COPD causes them to get quickly short of breath when using a towel.

A quick solution for the clinician could then be to have the patient use a terry cloth robe that will dry off the patient without the effort of drying off using a conventional towel, Painter says.

The clinician can then point to the success of reaching the goal of being more independent in bathing to encourage other facets of the treatment plan. For example, the patient can be encouraged to improve his diet to include more calories — COPD patients often need to boost calorie intake, as they expend significant energy breathing.

- **Incentivize adherence to care plan by reinforcing successes.** For example, if a patient with COPD wants to stop smoking, and in one week manages to smoke less in a day 50% of the time in one week, congratulate her at the end of that week, Narayan says. Then, set the next week's goal to reduce smoking 60% of the time. "You should always be encouraging them and helping them take the next step," she says. — *Nicholas Stern (nstern@decisionhealth.com)*

OASIS Tip of the Month

Have clinicians review OASIS conventions to increase M1850 accuracy

Ensuring your clinicians understand when to use Response 1 in M1850 (Transferring) and when it is appropriate to use Response 2 may impact not only your agency's HHRG score but also your agency's ability to demonstrate improvement in patient outcomes in transferring from bed to chair.

Response 1 in M1850 states that a patient is "Able to transfer with minimal human assistance or with use of an assistive device." Response 2 indicates that the patient is "Able to bear weight and pivot during the transfer process but unable to transfer self."

Knowing how to interpret and respond to M1850 can mean the difference between choosing Response 1 and thus earning zero functional case-mix points or choosing Response 2 and earning three points in 2015, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting, Georgetown, Texas.

Responding correctly to this item about the patient's transferring ability at the start of care (SOC) will also make it easier to correctly identify improvement in transferring at discharge, the outcome of which is reported on Home Health Compare, Rambusch says.

Remember, CMS is tracking OASIS data and plans on adjusting case-mix weights in the future, it said in the 2015 PPS final rule. If agencies don't maintain accurate responses, they could be underestimating the patient's debility that could in turn impact payment in the future.

CMS' Chapter 3 Guidance for M1850 defines "minimal human assistance" as including any combination of verbal cueing, environmental set-up and/or actual hands-on assistance that contributes less than 25% of the total effort required to perform the transfer.

But understanding the definition of minimal human assistance is not all you need to know to select Response 1, Rambusch says.

The guidance further states that clinicians should use Response 1 "if the patient transfers either with minimal human assistance (but not device)," or with the use of a device (but no human assistance), she notes. If the patient requires both minimal human assistance and an assistive device to transfer safely, clinicians need to select Response 2.

Take the example of a man who has just had a knee replacement and is otherwise healthy.

The home health nurse visits him the third day after his operation. To get into a sitting position in bed and transfer to a chair at the bedside, the patient needs the assistance of his wife, who assists him to rise to a sitting position by supporting him and gently pulling him into a sitting position.

She then brings him a walker and puts it beside the bed so he can easily reach it. She provides verbal cues and stands by for assistance as her husband uses the walker to rise and transfer from his bed to his chair.

At first glance, Response 1 may appear to be the right choice. But key to answering this question correctly with Response 2 depends on the clinician's understanding of the term "minimum assistance," Rambusch says. (*See also CMS Q&As No. 151.4, 06/14.*)

Documentation in the record should support the M1850 response selected by the clinician and should detail what assistance or devices are needed to accomplish the transfer.

In an early episode, high therapy case that also assumes the patient requires intermittent assistance for M1850, this could amount to a difference of $27.18, which adds up to $2,718 over 100 different episodes, she says.

Getting assistance right for bathing

Answering M1830 (Bathing) correctly and accurately the first time also requires clinicians recall that human assistance, as defined by CMS in the *OASIS-C1/ICD-9 Guidance Manual*, Ch. 1, is not limited to physical contact and "includes both verbal cues and supervision," Rambusch says.

According to the final rule, clinicians who score patients with a "2" or higher on M1830 will earn six case-mix points in early episodes, compared to three points currently.

But if the clinician doesn't interpret the OASIS guidance correctly, she may answer 0 — "Able to bathe self in shower or tub independently, including getting in and out of tub/shower," which earns no case-mix points.

And clinicians who answer the bathing item incorrectly and mark the patient as more independent than he actually is will find that even though he may have actually improved in his ability to bathe himself independently through the episode, they'll be unable to reflect that improvement in the publicly reported measure at discharge. — *Nicholas Stern (nstern@decisionhealth.com)*

OASIS-C1 implementation

Prepare for new items, submission process when OASIS-C1 takes effect

Agencies will receive extensive, ongoing training this year for OASIS-C1/ICD-9, which took effect Jan. 1.

But a couple of hour-long in-service trainings covering the changes in the OASIS-C1/ICD-9 assessment form — including for new measures such as M1046 (Influenza vaccine received) and M1309 (Worsening in pressure ulcer status) — helped FIRST At Home clinicians become mostly prepared, believes Janet Kondziela, director of nursing for FIRST At Home in Atlantis, Fla.

The agency recently sent one of its case managers to an OASIS-C1 training seminar at the Home Care Association of Florida, and the agency uses materials gathered there to conduct scenario-based training.

The agency also has trained on changes to M2250 (Plan of care synopsis), including "d — depression intervention(s)," which now includes the phrase "and/or physician notified the patient screened positive for depression," to allow agencies to receive credit when they attempt to notify the physician but don't get through.

Knowledge of the changes is tested by having clinicians complete a discharge OASIS in OASIS-C1/ICD-9 and OASIS-C about once a week, she says.

Clinicians at Northern Rose Home Health, in Libertyville, Ill., also were well-prepared for OASIS-C1/ICD-9, Administrator Kate Semmerling says.

Clinicians there have discussed changes to the assessment form in every second or third weekly clinical team meeting.

Both agencies plan on reviewing ongoing mistakes or other issues that arise with OASIS-C1/ICD-9 following its implementation.

In addition to training to receiving ongoing training, agencies should remember to check with their vendors for any issues that arise with the new OASIS submission process, dubbed the Assessment Submission and Processing (ASAP) system. The process took effect Jan. 1. — *Nicholas Stern (nstern@decisionhealth.com)*

Productivity

(*continued from p. 1*)

Part of the reason agencies are concerned about ICD-10 is that estimates circulating in the health care industry suggest ICD-10 could cause providers a decrease in productivity of 30% to 50%.

ICD-10's impact is also particularly significant when you consider that about 56% of trends survey respondents believe they will see revenue decline in 2015.

In anticipation of the transition to the new code set and greater documentation specificity required, 74% of agencies surveyed said they plan to spend more on ICD-10 training this year.

Remember, even if ICD-10 is not implemented this year, training in terms of asking physicians for more documentation and having clinicians record more detailed documentation is a good policy to increase coding and payment accuracy, advises Joan Usher, BS, RHIA, COS-C, ACE, president and CEO of JLU Health Record Systems, Pembroke, Mass., and an AHIMA-approved ICD-10-CM trainer.

Many agencies postponed ICD-10 training until late 2014 or early 2015 in the wake of Congress' delay of ICD-10 last year, Usher says.

Recent statements from some Congressmen suggest they are interested in holding fast to the current deadline. House Energy and Commerce Committee Chairman Fred Upton (R-Mich.) and House Rules Committee Chairman Pete Sessions (R-Texas) issued a statement Dec. 10 that the Energy and Commerce Committee has been working with CMS to ensure the implementation date will be followed.

In the meantime, the National Physicians' Council for Healthcare Policy, the Medical Society of the State of New York, the Texas Medical Association and other medical groups are requesting another delay until 2017, according to a report by Healthcare-informatics.com.

Agencies still cautious and waiting to see what Congress will do in 2015 will really start to believe ICD-10 is coming if legislators pass the "doc fix" at about the end of March with no mention of an ICD-10 delay, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA-approved ICD-10 trainer, president of Rambusch3 Consulting in Georgetown, Texas.

"At that point … 50% of us will function in full panic mode for the remainder of the year," she says. Remember: Congress snuck the latest ICD-10 delay into the "doc fix" bill in 2014.

Agencies prepare for ICD-10 transition

Agencies need to start immediately preparing for the switch to ICD-10 by planning out what needs to be done.

By early spring, agencies should complete a gap analysis, check vendor readiness and purchase ICD-10 coding resources, Usher says.

Agencies should begin dual coding, assess productivity and educate intake, coding and performance improvement staff by late spring or early summer. By July through September, agencies should continue dual coding, increase coding productivity and establish competency for ICD-10.

The increased level of specificity regarding, for instance, the more specific site location of pressure ulcers in the coding set will allow for more accurate coding and payment than currently available in ICD-9.

Home health agency FIRST At Home, in Atlantis, Fla., has been training coders and clinicians for ICD-10 for more than a year.

Janet Kondziela, its director of nursing, earned her HCS-D certification this summer in preparation for ICD-10. The agency's coders and clinicians also have been meeting for the past year at quarterly quality assurance meetings to review the need for more detailed documentation on areas such as precise pressure ulcer location and cardiac issues for treating patients coming out of open-heart surgery.

Part of this training involves reminding clinicians, particularly at intake, that they'll need to consistently ask for and make certain they receive doctors' notes coming from referrals, Kondziela says.

Her agency's electronic medical records (EMR) vendor, Kinnser, also has a feature that allows her to type in a basic description of the code she's searching for and returning a list of possible codes in ICD-10. That feature has been helpful in her agency's coding training as the agency uses common coding scenarios from the types of patients it typically sees.

Kondziela's agency isn't alone in gearing up and getting ready for ICD-10 to take place.

Northern Rose Home Health, in Libertyville, Ill., sent its primary coder to an ICD-10 training seminar and purchased an ICD-10 training book. The agency reviewed the book, chapter by chapter, at least every other week during weekly hour-long in-service training sessions with coders and clinicians. The agency has mostly used scenarios and practice questions to quiz staff, Administrator, RN, BSN, Kate Semmerling says.

Going forward, Semmerling plans to keep herself and others at the agency on their toes by dual coding every fifth or sixth chart in ICD-9 and ICD-10.

After each visit, clinicians complete documentation and consult with a nursing supervisor to ensure coding is as accurate as possible, she says.

Prepare for productivity hit in ICD-10

To deal with productivity declines expected from ICD-10, many agencies will turn to outsourcing coding, Rambusch says.

Indeed, according to a fall 2014 DecisionHealth productivity survey, close to one third of 248 respondents were worried about reduced coder productivity. About 14.5% of respondents said they either planned to outsource coding for the first several weeks or months after ICD-10 implementation or would do so for the long term.

At FIRST At Home, productivity will definitely be impacted, though the agency plans on keeping coding in-house and will rely on continued training and experience to get back up to speed in the months following implementation, Kondziela says.

Kondziela has many codes in ICD-9 memorized. But she expects that with ICD-10, she'll likely drop productivity by about 50% — at least at first. The higher level of detail for the coding of fractures and cardiac conditions will be among the challenges that will likely slow her agency down, she says.

"But in home care, you really get used to change," she says. "It happens all the time. You just roll with it."

Much more of a concern from her perspective is the readiness of smaller physicians' offices, particularly primary care doctors who Kondziela believes may be having a tough time preparing for the code set switch.

Further, she worries CMS will not be ready for the shift to ICD-10 and may cause unnecessary delays or denials in payment.

According to the productivity survey, claims delays and denials was respondents' top category of concern related to ICD-10's implementation. — *Nicholas Stern (nstern@decisionhealth.com)*

Ratings

(*continued from p. 1*)

working hard to achieve over recent years, says Carolyn Flietstra, vice president of home and community services.

The agency's efforts have paid off as evidenced by its 99% score on Home Health Compare for timely initiation of care — well above the state average of 87%.

An agency's score through the 5-star system — 5 being the best — would be based in part on 10 of the 27 process and outcome quality measures currently reported on Home Health Compare, CMS says in a Dec. 11 press release. An agency's quality measures will be compared to national averages, and their rating will be adjusted based on differences in agencies, CMS proposes.

For patients and families, the star system will simplify the process of initially choosing the right agency, Flietstra says.

CMS is proposing the new rating system as part of an effort outlined in the Affordable Care Act to make quality measures more transparent and easily accessible to the public, CMS says.

And the number of stars your agency receives could determine your chances of participating in an accountable care organization (ACO). In its latest ACO proposals CMS has said that agencies with three or more stars would be eligible to participate.

Does your agency have star quality?

CMS has proposed that the list of measures that will determine your star rating are a combination of the following process and outcome scores.

- **Process measures include:** Timely initiation of care, drug education on all medications provided to patient/caregiver, influenza immunization received for current flu season and pneumococcal vaccine ever received.
- **Outcome measures include:** Improvement in ambulation, improvement in bed transferring, improvement in bathing, improvement in pain interfering with activity, improvement in dyspnea and acute care hospitalization.

In Flietstra's view, the measures CMS has chosen to include in the system, such as the claims-based measure acute care hospitalization, as well as the measures related to activities of daily living, such as improvement in ambulation and bed transferring, are quite valid and apply to many patients that come to home health.

Agencies that earn 4.5 to 5 stars are 5-star agencies, 3.5 to 4.49 earn 4-stars, 2.5 to 3.49 are 3-stars, 1.5 to 2.49 are 2-star agencies and those that earn 1 to 1.49 are 1-star agencies.

All certified agencies would be eligible to receive a star rating, but they must report quality data for six of the 10 measures used in the calculation, the federal Medicare agency says.

Remember, agencies currently must have at least 20 complete quality episodes for data on a measure to be reported on Home Health Compare.

CMS seeks input on 5-star ratings

The Visiting Nurse Associations of America (VNAA) supports the new system and will work with CMS to "… ensure that providers are engaged in the development of the new system, including identifying appropriate measures and ensuring a testing and review period prior to full implementation," says Tracey Moorhead, president and CEO of the VNAA.

Agencies and stakeholders will be able to provide feedback on the proposal's star-rating methodology, including the measures proposed for inclusion, CMS says. The federal Medicare agency solicited feedback in a Dec. 17 open door forum and will post a Frequently Asked Questions document on the CMS website for agencies' reference.

You'lbe able to send additional comments about the star ratings to *HHC_Star_Ratings_Helpdesk@cms.hhs.gov.*

The ratings methodology will be finalized based on the feedback and additional technical analysis. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *CMS plans to post the open door forum transcript at: http://tinyurl.com/owgzl6h.*

CMS press release: http://tinyurl.com/qh3zu8x.

FAQs: http://tinyurl.com/nyrvjo9.