OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

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CMS OASIS-C1 Q&As

Follow admitted patients closely to ensure compliance with two-day rule for resumption of care

Agencies must wait to complete resumption of care (ROC) assessments until after they have received physician orders — even if a delay in orders causes the assessment to be late.

CMS' conditions of participation (CoPs) require that clinicians complete ROC assessments within two days of the patient's return home from the inpatient facility or within two days of knowing the patient has returned home, CMS says in its latest OASIS Q&As, released Jan. 22.

(*see* ***OASIS C-1****, p. 9*)

In This Issue

ASAP system

Errors persist in submitting OASIS data to ASAP, CMS reports

CMS is reporting that some agencies are still experiencing issues with rejected OASIS records in the Assessment Submission and Processing (ASAP) system related to inconsistent or missing data in the Certification And Survey Provider Enhanced Reports (CASPER) Provider Auxiliary Facility table with the national database.

The federal Medicare agency has identified inconsistencies between the Branch ID data in the state database and the Branch ID in the national database that are causing some errors, CMS' Quality Improvement and Evaluation System (QIES) Technical Support office (QTSO) reported in a Jan. 23 memo to QTSO state coordinators.

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

Comply with revised face-to-face rules, avoid denials

CMS removed the physician narrative requirement for face-to-face documentation. But documentation still must justify homebound status and the need for skilled care. Get detailed steps for getting the necessary documentation. Sign up for the webinar **Face to face redux: Comply with revised rules** on Feb. 26. Get more details at: *www.decisionhealth.com/conferences/A2571*.

Proposed conditions of participation

Revamped CoPs draw over 100 comments; patient rights changes concern many agencies

Proposed patient rights changes — including a requirement to communicate rights in a way the patient can understand — will be burdensome and expensive, agencies and industry experts contend.

The comment period for the proposed home health conditions of participation (CoPs) ended Jan. 7 and drew more than 100 industry responses. Many expressed concern about patient rights changes, which CMS estimates will have total industry costs of about $144 million a year and take 2.3 million hours to implement.

Two leaders from BJC Health Care, a St. Louis-area health system, told CMS that it applauds CMS' efforts for agencies to more clearly articulate patients' rights. But the leaders expressed concern that the CoPs may create administrative burdens that increase agencies' costs and negatively affect quality patient care.

Although the requirement to properly communicate rights has existed in federal limited English proficiency regulations for years, the addition of this requirement in the CoPs means CMS surveyors now have authority to enforce this, experts explain.

Mary Carr, vice president for regulation at the National Association of Home Care & Hospice (NAHC), believes CMS is underestimating the overall cost for patient rights changes.

"The greatest cost concern is the ongoing costs rather than the initial implementation," adds Bill Dombi, NAHC's vice president for law. But since patient rights have elements that apply to all patients and some that are situation-specific, it's difficult to estimate exactly, he says.

One interpreter service tells DecisionHealth it would charge an agency roughly $1 per minute over the phone and about $50 to translate a one-page document.

The CoPs also require that agencies give patients a copy of the initial plan of care (POC) as well as any revisions to it, NAHC says.

"Providing patients with a copy of the initial POC and at each revision would be burdensome for the agency to track and maintain, particularly for patients that have frequent changes; not to mention the additional cost of [copying] every POC and revision for every patient," NAHC wrote to CMS. "The requirement will be in addition to having to provide a written notice whenever services are to be reduced or terminated and prior to discharge. When multiple written notices are provided to patients they become overwhelming and lose their intended purpose."

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NAHC also is concerned that CMS intends for POCs to be written and communicated verbally in a language patients understand, Dombi says.

An individualized plan of care generally runs two to three pages, and using a service to verbally communicate a plan of care could potentially take 30 minutes per patient, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting in Georgetown, Texas.

Due to the costs it would take for these services, Rambusch says, many smaller agencies aren't providing this information now and won't have resources to in the future.

Patient rights are one of four major categories within the CoP updates. Others are quality assurance and performance improvement, infection prevention and control and revision of patient assessment requirements to reflect patients' physical, mental and psychosocial conditions. CMS has up to three years from the Oct. 9, 2014, publication date to make the proposed CoPs final.

Commenters: Changes create burdens

Patient rights changes would significantly increase the paperwork agencies must maintain, distribute and educate patients about, BJC's comments state.

BJC suggested to CMS that the first patient visit require the provider to verbally review the plan of care and patient rights in the patient's preferred language; instruct the patient how to contact the agency with related questions; distribute to the patient written information in the patient's preferred language and format; and have the patient attest that these things were discussed.

For subsequent visits, however, it suggested providers discuss verbally in the patient's preferred language matters regarding the plan of care and distribute to the patient any subsequent changes to the plan of care later.

Tips for translating patient rights

- **Ask about language options.** Winter Park, Fla.-based Optimal Phone Interpreters (OPI), for instance, provides interpretation in more than 200 languages. Recognize, however, that most services an agency requires will be for one of the 20 most commonly spoken languages, says Jackie Snook, the company's chief operating officer.
- **Determine the company's health care knowledge and experience,** as well as whether the company is HIPAA compliant. CyraCom of Tucson, Ariz., says it services more than 2,000 healthcare clients. Its interpreters receive 120 hours of in-person classroom training including medical interpreting training and HIPAA compliance, its website states.
- **Make sure the company will be available at all times.** Many interpreters will be available by phone 24 hours a day, seven days a week, Snook says. But businesses likely won't provide around-the-clock document translation.
- Also, ask about turnaround time for documentation translation. For instance, find out whether it will take a company 24 or 72 hours to translate a one-page document into the languages you need, Snook recommends.
- **Check pricing.** Rates for interpretation services are typically volume-based and vary from 78 cents to $4.99 per minute, Snook says. NAHC members using OPI pay $1.09 per minute. OPI has a $50 monthly minimum.

Meanwhile, OPI's translation of a one-page document costs at least $50; prices vary depending upon the

Proposed CoPs: Discharge process

Commenters ask CMS for details on appropriate transfer, discharge instructions

Several commenters say CMS' proposed criteria for discharging or transferring a patient is too limiting, thus putting agencies at risk for survey citations in the future.

In the proposed conditions of participation (CoPs) CMS said it's acceptable to transfer or discharge a patient who exhibits behavior that is "disruptive, abusive or uncooperative."

The National Association for Home Care & Hospice (NAHC), for instance, says that listing these three behaviors is not sufficient as patients may exhibit other behaviors or have extenuating circumstances that are not clearly defined as disruptive, abusive or uncooperative but still prevent an agency from effectively caring for the patient or might pose a threat to agency staff.

In some situations, the patient might be unable or unwilling to do anything to help himself, says Rebecca Friedman Zuber, president of health care consultancy Rebecca Friedman Zuber Inc. and former head of the Illinois state survey office. There also are times when the patient or family member presents a danger to agency employees, such as drug deals within the home.

Instead, NAHC says CMS should use these three behaviors as examples of when it would be appropriate for an agency to transfer or discharge a patient, but should be allowed to do so for any reason related to cause that affects its ability to provide adequate care and/or threatens the safety of the staff. — *Nicholas Stern (nstern@decisionhealth.com)*

language, Snook says. For subsequent pages, translation to Spanish might cost 20 cents a word, while translation into less common languages ranges in price from 25 to 55 cents per word. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

5-star ratings

Improve Home Health Compare outcomes by training on ability with ADLs at the start of care

Part of the key to improving OASIS outcomes at the start of care (SOC) is having therapists, who are specialists in improving activities of daily living (ADLs), train nurses to understand what a term like 'safely' means when answering an item like M1860 (Ambulation).

That will help your clinicians more accurately gauge your patients' debility for M1860 and other activities of daily living (ADLs) like M1830 (Bathing) and M1850 (Transferring) and to improve outcomes reported on Home Health Compare, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10 trainer, product specialist at DecisionHealth.

Alacare Home Health and Hospice of Birmingham, Ala., has been working for two years to improve its outcomes scores with a focus on better SOC assessments by revamping its training and education processes for clinicians, says Jana Tuck. Tuck, MSN, MBAHCM, COS-C, HCS-D, is vice president of business/clinical intelligence for Alacare.

The agency, with 700 nurses and multiple branches spread across Alabama, saw improvements in M1830 scores to 77% in October 2014 from 63% in January 2012, an increase in M1850 scores to 63% in October 2014 from 49% in January 2012 and M1830 improvement to 77% in October 2014 from 63% in January 2012, she says.

For example, when answering M1860, a patient may be able to walk across his living room with a walker and thus a nurse watching him do so may choose Response 2, "Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces."

But it could be he was also so weak and shaky that for him to walk safely he might need to use a wheelchair until his strength returns, Tuck says. In that case, a clinician might choose Response 3, "Able to walk only with the supervision or assistance of another person at all times."

Outcome improvement in this case would be hampered by a clinician who chose Response 2 at the SOC.

It will also be important to boost your ADL scores on Home Health Compare in light of CMS' plans to implement a new 5-star rating system for agencies to make quality measures more transparent and easily accessible to the public, Tuck says.

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 the rating will be adjusted based on differences in agencies, CMS proposes.

In a December Open Door Forum, CMS said that while 5-star ratings are expected to appear this year on Home Health Compare, they probably will show up no sooner than this summer. Before the ratings appear to the public, agencies will also have a change to see their rating based on a preview report from CMS.

Also, CMS will continue the dialogue with stakeholders as it finalizes the 5-star system.

Understand therapy terms to train ADLs

Having nurses understand how to better capture a patient's true functional level by training on terms therapists use to assess patients will help nurses demonstrate a patient's improvement through the episode, Whitemyer says.

For example, terms used often in therapy that clinicians might not be as familiar with include a 'contact guard assist,' — essentially touching patients when transferring them — and 'end of range gait,' — basically the distance a patient can walk before stopping, for example, to take a breath, Whitemyer says.

Also, while training clinicians on this topic, be sure they understand the importance of a patient's cognitive functioning, represented in items like M1710 (When confused) and M1720 (When anxious), and its impact on a patient's outcomes, Tuck says. Typically, patients with confusion and anxiety can take longer to show outcome improvement, she says.

Offer achievement/pay ladder

Another way to prepare to become a 5-star agency is to tie better outcomes achievement to clinician incentive plans for improved performance. It will also help you achieve better buy-in from nurses and improved retention rates.

Alacare implemented an incentive plan two years ago to allow clinicians who've independently managed patients on their own for a year to test for and attain a title of Case Manager 1 at the agency that includes OASIS performance, Tuck says. The agency uses Santa Barbara, Calif.-based data vendor Strategic Healthcare Programs to track individual clinician performance.

Clinicians who pass the test, which also includes a review of Medicare regulations, earn a percentage raise in salary, she says. The agency also has a Case Manager 2 title that can be earned after two years of experience, and nurses who earn it also see a bump in salary.

This incentive, combined with several other process improvements like providing a mentor or preceptor who answers clinicians' questions about the OASIS, CMS guidelines or other aspects of the home health industry, served to reduce the agency's turnover rate to 29% from an all-time high of over 40%, Tuck says.

Poll clinicians to improve retention

Here are more tips to increase employee retention and gain clinician buy-in for improving OASIS outcomes:

- **Call clinicians and ask them if there's something the agency can do to improve their job satisfaction.** This has worked to change some clinicians' minds on whether to stay, Tuck says. Sometimes, clinicians in a busy agency don't believe anyone cares whether they come or go.
- **Poll clinicians anonymously to learn their likes and dislikes.** Alacare used the SurveyMonkey polling service to ask clinicians what they thought about orientation training that involved having them travel from sometimes disparate parts of Alabama to Birmingham for a day or two of training, Tuck says. Clinicians responded that they preferred to have regional training that made travel to and from orientation possible within the same day. Alacare made this change, which further improved the agency's retention rate, she says.
- **Allow 'elite' clinicians to head up QAPI efforts.** One strategy Whitemyer suggests to some agencies is to track a percentage of each clinician's outcomes performance and then announce a winner for the best several nurses each quarter. This will give them a sense of accomplishment and satisfaction for being among the top performers, Whitemyer says.

Then, put the nurse with the best outcomes on your agency's quality assurance and improvement (QAPI) team and have the nurse pick two or three outcomes to focus on for agency improvement over the upcoming quarter, she says. This works to give such nurses a sense of control and satisfaction.

- **Instill the competitive spirit among your clinicians.** Nurses respond with a desire to improve outcomes when they see evidence that they're not doing as well as the competition in their towns or cities, Whitemyer says. Posting Home Health Compare outcomes scores for your agency and a competitor agency can work to inspire improved performance, she says. The 5-star rating system, then, provides another chance to best competitors with outcomes scores. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *Send CMS comments about the 5-star system to hhc_star_rating_helpdesk@cms.hhs.gov.*

Coding Corner

Coding basics: Get specific to accurately code GI conditions in ICD-10

By Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O

You need just one code to capture co-occurring gastroesophageal reflux (GERD) and esophagitis in ICD-10: K21.0 (Gastroesophageal reflux with esophagitis). By contrast, in ICD-9 you need two codes — 530.81 for the GERD and 530.11 for the esophagitis.

While the coding of many conditions will be simplified by the presence of combination codes, the coding of gastrointestinal (GI) conditions in ICD-10 will also require greater attention to detail and an enhanced knowledge of anatomy and physiology.

This is because many of the codes that capture gastrointestinal disorders in ICD-10 are combination codes that not only include the diagnosis, but also the symptoms that may manifest from the condition. Because of this, you'll need to know more detail about these diagnoses than is currently required to code them accurately.

ICD-10 codes for GI conditions are found in Chapter 11 (Diseases of the Digestive System) and range from K00.- (Disorders of tooth development and eruption) to K95.- (Complications of bariatric procedures).

How to code Barrett's esophagus

Enhancing your knowledge of the pathology of the disease process for GI conditions will aid you in

identifying what level of detail you'll need to know to code these diseases in ICD-10. For example, consider the diagnosis of Barrett's esophagus.

Since patients with this condition often develop dysplasia within the esophagus, if the medical record indicates both esophageal dysplasia and Barrett's esophagus, you will assign a code from the K22.71- category to indicate Barrett's esophagus with dysplasia. The sixth character will specify the level of dysplasia, such as K22.711 (Barrett's esophagus with high grade dysplasia).

In the current system, this condition is captured with 530.85 (Barrett's esophagus), and dysplasia is not included in the code choice. There is no unique ICD-9 code for dysplasia associated with Barrett's esophagus.

Diverticular disease of the intestine is another example of a GI condition for which ICD-10 offers more specific code choices than are currently available. This disease is coded to category K57.- (Diverticular disease of intestine). Codes within this category are not only specific to diverticular disease of the small and large intestine, but also include specific codes for the presence of bleeding and perforation and/or an abscess.

To accurately assign these ICD-10 codes, you'll need to know specifics about the patient's condition and any associated complications. Should a patient have a diagnosis of diverticulitis of the large intestine, for example, you'll need to first identify if the patient had a resulting abscess and/or perforation.

Imagine a patient with diverticulitis with an abscess or perforation. You'll start with the K57.2- category, but you'll need more information to choose the appropriate fifth character which indicates whether bleeding is present (K57.21) or not (K57.20).

Remember that coding any gastrointestinal condition in ICD-10 will require a closer examination of the clinical record in order to ensure any associated symptoms are coded using the correct combination code when this is an option.

Documentation ties it all together

Make sure that the home health clinical record supports coding a more specific diagnosis, in addition to obtaining more specific physician documentation. If the clinical record does not address the specifics of a combination code under consideration, more clear documentation from the assessing clinician will be necessary.

For example, if the physician records provided indicate that the patient has esophageal reflux and reflux esophagitis, clinicians should indicate the esophagitis as well as the reflux in the admission and plan of care.

Obtaining history and physical documents, physician progress notes, and other medical records pertinent to the patient upon admission is critical. Start stressing the importance of obtaining these documents to the staff members responsible for the admission process and begin implementing processes within the agency to secure these records at that time.

Lack of support for diagnoses in the clinical record, as well as unclear or unavailable physician confirmation of a diagnosis, result in a less specific and, ultimately, poorly supported claim.

Coding guidelines require the assignment of the most specific code. It is always in the best interest of the agency to obtain detailed information and reflect this in the plan of care and clinical record. When documentation is not present to support assigned codes, the claim and your agency's reimbursement may be at risk.

Scenario: Gastroesophageal reflux

A patient is admitted to home health following an exacerbation of gastroesophageal reflux disease with significant reflux that has affected her appetite and caused a weight loss of 35 pounds. Her H&P notes "significant reflux esophagitis."

Code the scenario in ICD-9:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Esophageal reflux	530.81		
M1022: Reflux esophagitis	530.11		

Rationale: This condition requires two codes in ICD-9 to indicate both the reflux and the esophagitis.

Code the scenario in ICD-10:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Gastroesophageal reflux with esophagitis	K21.0		

Rationale: The availability of a combination code in ICD-10 enables both conditions to be captured in one single code.

Scenario: Barrett's esophagus

A patient is admitted to home health for teaching regarding newly diagnosed Barrett's esophagus with low-grade dysplasia.

Code the scenario in ICD-9:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Barrett's esophagus	530.85		

Rationale: There's no way to indicate that the patient also has low-grade dysplasia along with Barrett's esophagus in ICD-9. Thus, only the Barrett's esophagus is coded.

Code the scenario in ICD-10:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Barrett's esophagus with low grade dysplasia	K22.710		

Rationale: There are three separate codes for Barrett's esophagus with dysplasia in ICD-10, depending on the grade of the dysplasia. In this case, K22.710 is the appropriate code choice.

About the author*: Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, is an AHIMA-Approved ICD-10-CM Trainer and the Product Specialist for DecisionHealth in Gaithersburg, Md. She continues to provide quality oversight for Transitions Health and Wellness Solutions, an outsourced coding and QA firm, in Harlingen, Texas. She can be reached at bwhitemyer@decisionhealth.com.*

HHCAHPS news

New CMS HHCAHPS newsletter to be posted every quarter on survey website

CMS has begun publishing its Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey newsletter for agencies and vendors. The newsletter will be posted on the HHCAPHS website — *https://homehealthcahps.org/Home.aspx* — and updated quarterly every calendar year. — *Nicholas Stern (nstern@decisionhealth.com)*

OASIS-C1/ICD-10 form

CMS sends OASIS-C1/ICD-10 version to OMB

CMS has submitted its request to the Office of Management and Budget (OMB) to modify the OASIS to accommodate ICD-10 codes when ICD-10 is expected to take effect, Oct. 1, or thereafter. CMS says it does not estimate these changes will result in any additional burden to agencies. — *Nicholas Stern (nstern@decisionhealth.com)*

Related link: *Find CMS' OASIS-C1/ICD-10 that it sent to the OMB here: http://tinyurl.com/nulr3s2.*

Staffing policies

Implement quarterly compliance checks to ensure nursing licenses are active

Establish a consistent process to ensure clinicians' nursing licenses are valid and up-to-date or you could wind up hiring a person who has fraudulently obtained a license.

As the FBI reported Dec. 9, 2014, a Dallas woman pleaded guilty to fraud and faces 15 years in federal prison for stealing a nurse's identification numbers and obtaining employment as a registered nurse at eight different hospice companies.

The Dallas woman also faces a $250,000 fine and restitution. From 2009 to 2012, about $2.3 million in hospice claims were billed to Medicare and Medicaid for services performed by the woman. The FBI did not report what consequences, if any, applied to the agencies involved in hiring her.

Generally, agencies that have nurses practicing without a valid or up-to-date license risk surveyor scrutiny and investigation, denial of payment from CMS for all or a portion of services rendered by out-of-compliance nurses, False Claims Act fines and even charges of fraud from the FBI and Office of the Inspector General, says attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman.

Markette says he's seen a case where nurses' licenses at a home health agency in Indiana inadvertently lapsed as the state licensing system moved online. Another had employed a social worker for a year after the employee's license had been revoked by the state's attorney general for misconduct.

In the former case, the nurses got cited and had to submit a plan of correction, which alone can cost thousands. In the latter case, the agency fired the employee, carried out an investigation and discovered that little if any billing had been submitted for services provided by the social worker over that period.

Begin investigations immediately

Make sure your agency begins an investigation into any licensing problems immediately after learning about them, Markette warns.

That's due in part to the federal False Claims Act, which requires an agency, for example, to return any money taken from CMS to be returned within 60 days or be considered a false claim. The False Claims Act can allow the government to pursue damages that generally double the amount received from Medicare, as well as attorney's fees, Markette says.

Remember, most of the time, your own employees will be the ones to report false claims to the government and potentially earn a significant portion of money the government can receive through a civil claim, he says.

Also, if a nurse in charge of compliance related to licensure at your agency discovers another nurse who is knowingly practicing without a license, she is typically obligated to report it to the state nursing board as part of nursing professional standards, Markette says.

The agency should document its internal investigation and store the information in its compliance files to present to surveyors if they have questions, he says. The investigation should include who was spoken to, conclusions reached and what steps the agency took to fix the problem.

And remember, the more changes you make to a claim, the more likely it is that you'll pop up on an auditor's radar, Markette says.

Use state websites to verify licenses

At Vanderbilt Home Care Services in Nashville, Tenn., the hospital-based home health agency takes several steps to ensure that every nurse or any employee that requires credentials to provide services has up-to-date credentials, director of staff development Julia Triplett says.

During the interview process, a nurse applicant is asked to bring in a physical copy of his or her license, Triplett says. Human resources at the agency then verify that the license is valid through Tennessee's Department of Health license verification website.

The agency uses Vanderbilt's Credentials Application Tracking System (CATS) to send email reminders to staff every 90, 60 and 30 days before a credential is set to expire and has human resources staff follow up to ensure that employees maintain compliance, Triplett says.

Aside from nursing licenses, the system also checks driver's license validity, insurance and CPR compliance, she says.

A hiring manager typically follows up with an employee who is failing to renew any valid licenses or certifications. An employee who does not renew any license or certification, such as CPR, cannot work and is placed on unpaid leave until the documents are renewed, she says.

Consistently track licenses

- **Put someone in charge of overseeing licenses.** Quality or clinical managers can oversee compliance in terms of nursing licenses and other matters like driver's licenses, CPR certifications and various types of insurance, and make it a part of their quality assessment and performance improvement process, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10 trainer and product specialist at DecisionHealth. This should involve formal, quarterly audits on employee files.
- **Have clerical staff review compliance on a monthly basis.** Making sure a clerical staff member maintains at least monthly checks on licenses and certifications and maintains a database in a spreadsheet, for example, is also good practice for catching any potential expiration issues in a timely manner, Whitemyer says.
- **Double-check your compliance process.** If you've begun to make more frequent license compliance checks, double-check after a few months to make sure it has been an effective change, Markette says. — *Nicholas Stern (nstern@decisionhealth.com)*

OASIS C-1

(*continued from p. 1*)

Agencies should document the details of the efforts to obtain orders and complete the ROC as soon as orders are received, CMS states in response to question No. 2 of the nine most recent OASIS questions.

Following this step is important because surveyors look for any instances when the ROC was not completed within 48 hours, and agencies' scores on the timely initiation of care measure reported on Home Health Compare will suffer for not doing so, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting, Georgetown, Texas.

To try to speed up the time it takes to receive orders from a physician, your agency should track when a patient went into the hospital, Rambusch says. Make sure you have intake staff call the hospital every day until the patient is discharged and otherwise track what happens to the patient every day.

Rambusch also advises to try to call patients in the hospital and ask when they'll get out. That will not only help the agency comply with the CoP, it could serve to boost patient satisfaction with the agency's care, Rambusch says.

If you miss the deadline, keep documentation of why the orders were late clear and simple, she says. For example, describe that the agency made multiple attempts to reach a physician and didn't obtain the orders until whichever date.

Also, be diplomatic and explain to doctors asking about the 48-hour timeframe that it is a Medicare requirement and that not complying can hurt not just your agency's Home Health Compare scores, but the physician's as well.

Confirm "hoarding" diagnosis

Be sure clinicians confirm a diagnosis of a hoarding disorder with a physician when answering M1740 (Cognitive, behavioral, and psychiatric symptoms). Also, note any associated, disruptive behaviors that result in concern for a patient's and/or caregiver's safety or wellbeing.

CMS had this guidance for a questioner who asked if hoarding would be considered disruptive behavior that triggered a "Yes" response to any of the seven response options in M1740, the federal Medicare agency says in No. 7 of the Q&As.

In such a case, CMS says, the clinician may determine the hoarding behaviors meet the intent of Response 2 — "Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions," and/or Response 5 — "Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)." Mark the former when the patient can't stop the unsafe behavior, for example, and the latter when the behavior is disruptive or socially inappropriate.

Clinicians will want to discuss with the physician what was found in the patient's home, how the patient is living and what dangers to his safety exist, as well as the possibility of bringing in social services or a psychiatric nurse to address the hoarding disorder, Rambusch says.

Getting this item correct is important as it used to calculate risk adjustment for the potentially avoidable event measure "Discharged to the community with behavioral problems."

Also, patients with such psychiatric problems can take longer to teach and develop a positive outcome for other illnesses, Rambusch says.

Distinguish caregiver types in M2102

As long as your agency has a different provider identification number for Medicare Skilled Home Health and Medicaid In-Home care, CMS considers Medicaid caregivers non-agency caregivers for the purpose of answering M2102 (Types and sources of assistance). (*See related tool.*)

Guidance for the item states that "caregiver" refers to non-agency caregivers and excludes care by agency staff, the federal Medicare agency answered in question No. 9 of the Q&As. The questioner asked CMS if services provided by the Medicaid-side staff would be excluded for M2102.

Remember, getting this item correct is important for agencies as it is used to calculate risk adjustment related to potentially avoidable events "Discharged to the community needing wound care or medication assistance," "Discharged to the community needing toileting assistance" and "Discharged to the community with behavioral problems." — *Nicholas Stern (nstern@decisionhealth.com)*

ASAP

(*continued from p. 1*)

Don't forget that the process by which agencies submitting OASIS data to CMS changed Jan. 1 so that they will now submit OASIS data through ASAP directly to CMS, instead of through their state agencies.

Here are two examples causing OASIS records to be rejected, according to the QTSO:

- **Error -4700** — This rejection is related to "Invalid Branch: If the assessment was performed by the home office of an agency with branches or by the home office of a subunit with branches, then M0016 must contain P." It is occurring because the ASAP system identifies at least one open branch on the certification in effect for the effective date of the OASIS record in the national database; however, the agency believes it does not have any open branches. The ASAP system expects a 'P' or valid Branch ID value to be submitted, but agencies are submitting an 'N,' indicating no branches.
- **Error -4710** — This rejection is related to "Invalid Branch: M0016 must contain a standard branch ID, N, or P." In this case, some agencies are submitting a branch ID ending in '002.' '002' indicates that this is the ID of the agency's second branch. But in the national database, there is only one branch for the agency and that Branch ID ends in '001.'

In the state database for that same agency, there are two branches identified; one for the first branch — the one that ends in '001' — and one for the second branch — in which the Branch ID ends in '002.' The state agency may need to update the branch information in ASPEN and upload the kit so it will be available in the national database. After the upload is successful, the state needs to notify the provider that it can submit the assessments with the Branch ID '002' and will no longer receive fatal error -4710.

Some agencies see errors

Renata Cambria, RN, MSN, COS-C, HCS-D, senior director of compliance and education at Prime Home Health Services in Brooklyn, N.Y., says she's been having a very difficult time submitting OASIS data.

Cambria says she's having trouble, for example, submitting data for files where patients have two-word names, like hyphenated names.

At Porter Hills Home Care in Grand Rapids, Mich., coding supervisor Laura Sucaldito says she's seen claims with error codes CMS says it is working on, as well as a different one — 3060 — related to state ID information, she says.

She's substantially reduced submissions because of the problems since Jan. 1 — about eight went through, nine were rejected and 16 came back with a test failed message related to the 3060 error, she says.

The issue has added to her workload, including more time spent tracking the outcome of OASIS submissions, Sucaldito says.

Contact CMS with questions

If your agency receives either of these errors, CMS asks you contact your OASIS Automation Coordinator or OASIS Education Coordinator for assistance. If you have questions about updating the branch information in the ASPEN software, contact *help@qtso.com* or call 1-888-477-7876.

For a copy of the QTSO memo, which was obtained by the National Association for Home Care & Hospice, go to: *https://www.nahc.org/assets/1/7/Branch_ID_Memo.pdf*. — *Nicholas Stern (nstern@decisionhealth.com)*