OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

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In This Issue

Case-mix changes

Take a closer look: Some high therapy cases may earn less case-mix points in 2015

Agencies and clinicians need to take a closer look at the changes CMS is proposing for high-therapy episodes — in some cases, they'd actually lose points and reimbursement instead of gaining as it might seem on first glance.

CMS has some significant changes in store for some case-mix variables in the proposed 2015 PPS rule, removing case-mix points for as many as 200 codes including blindness and low vision,

(*see* ***Therapy***, *p. 9*)

Productivity survey: OASIS-C1

How to prevent productivity declines with new OASIS-C1 vaccination questions

When clinicians have difficulty finding out from patients or caregivers about whether the patient received a pneumococcal vaccination, necessary to fill out M1051 (Pneumococcal vaccine), have them check the common working file (CWF).

Clinicians can ask their agencies' billers for this record, which contains information about Medicare billing for a patient's recent pneumonia vaccination, reminds Ann Rambusch, RN, MSN, HCS-D, Cos-c, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting of Georgetown, Texas.

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

Learn how to avoid crippling CMS survey sanctions

Surveyors are dialing up their scrutiny of agency practices and protocols like never before and penalties can now reach a stratospheric $10,000 per day until deficiencies are addressed. Follow Sharon Litwin as she guides you through the shifting survey process and how to revamp your policies to avoid deficiencies during this can't miss Nov. 5 webinar: *http://www.decisionhealth.com/conferences/A2545*.

OASIS-C1 guidance manual

CMS releases OASIS-C1 guidance manual

All relevant coding guidance is now contained in Chapter 3 of Section C (Patient History and Diagnosis) of the OASIS-C1/ICD-9 Guidance Manual, according to the updated Appendix D document released by CMS on Sept. 11.

Appendix D has historically offered coding-specific guidance, though it was set to be retired with the arrival of ICD-10. Coding experts are not surprised by the lack of detail in the document and agree that the coding guidance found in Chapter 3 provides all necessary instruction.

However, the document indicates it could be expanded at a later date.

The OASIS-C1 conventions, located in Chapter 1, are the same as those for OASIS-C, except some appear in different locations.

For example, general conventions numbers 9 and 10, which deal with understanding tasks and medical restrictions respectively, appear in the OASIS-C1 manual as numbers 3 and 5 in the conventions specific to activities of daily living (ADLs)/instrumental activities of daily living (IADLs) section just below.

To download the guidance manual, go to: *http://tinyurl.com/ldvynwp*. — *Megan Gustafson (mgustafson@decisionhealth.com) and Nicholas Stern (nstern@decisionhealth.com)*

CMS OASIS-C1 webinar

Train on medication, bathing in OASIS-C1 to improve process, outcome measures

Clinicians reading CMS' draft OASIS-C1/ICD-9 guidance manual instructions for M2002 (Medication follow-up) should take care to note that the phrase "without physician involvement" does not signify a shift in guidance for answering this process measure item.

Nurses are still not required to report a clinically significant medication issue that was resolved "with or without physician involvement" before the assessment was completed, CMS clarified in its OASIS-C1 implementation webinar and call held Sept. 3. OASIS-C1/ICD-9 will be implemented starting Jan. 1, 2015.

That same point will be confirmed in a yet-to-be published Q&A. A questioner to CMS asked if the phrase "without physician involvement" in M2002 response-specific instructions changed guidance on the item.

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EDITORIAL

Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice President: Corinne Denlinger
1-301-287-2363
cdenlinger@decisionhealth.com

Senior Content Manager: Marci Heydt
1-301-287-2299
mheydt@decisionhealth.com

Product Manager: Maria Tsigas
1-301-287-2305
mtsigas@decisionhealth.com

Associate Editor: Nicholas Stern
1-301-287-2499
nstern@decisionhealth.com

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But CMS said the phrase was provided only as an example to aid clinicians in the case of, for instance, a family delivering medication that was not in the home at the time of the initial visit.

CMS notes that by not reporting a clinically significant medication issue that was resolved, an agency may miss the positive impact to its process measure adherence rate.

Bathing change makes item easier

Make sure your clinicians also understand guidance for Response 5 "Unable to use the shower or tub…" of OASIS-C1's M1830 (Bathing), which impacts Home Health Compare scores. It has been changed to state that patients need "intermittent or continuous assistance" bathing. In OASIS-C, the item says patients need assistance "throughout the bath."

Response 5 will include patients who need intermittent help instead of continuous help.

The OASIS-C1 guidance is located in "K- activities of daily living (ADLs)/instrumental activities of daily living (IADLs)."

Other highlights from the webinar

CMS also noted several other changes it made that are associated with the switch to OASIS-C1. These include:

- **CMS will revise its Q&As** to add quarterly Q&As from January 2013 through April 2014, updated OASIS-C1 numbers and incorporated revised guidance and updated weblinks as needed. These can be found here: *https://www.qtso.com/hhatrain.html*.
- **CMS will retire outdated Q&As** and Q&As for deleted M items.
- **Both versions of Q&As for OASIS-C and OASIS-C1** will be available until Dec. 31, after which OASIS-C Q&As will be archived.
- **The CMS OASIS web modules** that include OASIS-C instructions on a variety of topics will be revised to update to OASIS-C1 beginning in early 2015.
- **CMS plans to release the other parts of the OASIS-C1 guidance manual** in the near future, including the Appendix D - "Selection and Assignment of OASIS Diagnosis" that helps clinicians accurately assign diagnoses in the OASIS assessment. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *CMS' outline of OASIS-C1 changes: http://tinyurl.com/ontc9mj.*

More questions? CMS recommends contacting your state OASIS Education Coordinator (OEC) at: http://tinyurl.com/nn3s6qt.

Coding Corner

Back up insulin injection claims with ample documentation to reduce audit risk

Support home health claims that bill solely for insulin injections with detailed documentation and the appropriate secondary codes, or expect denials.

More specifically, document thoroughly why a patient cannot inject his own insulin, why his caregiver cannot be taught to do so, what you've done to find a caregiver who can be taught, and why injectable insulin administered by your agency is the only viable treatment option at every recert or prepare to see your claims denied. And, make sure to back up your documentation with the appropriate codes.

Home health claims that bill solely for insulin injections are one of the main targets for Medicare fraud and abuse suspicion as they are frequently outlier claims with some being reimbursed in excess of $10,000 per episode and receiving 160 skilled nursing visits in a 60-day period, CMS stated in its 2015 proposed PPS rule.

Because of this, as well as an OIG report that indicated many patients receiving skilled nursing visits solely for insulin injections are capable of administering it themselves, CMS said in the rule that it will be keeping a closer eye on these claims and has offered a list of 165 secondary codes that it expects to see on claims to explain why a patient could legitimately require this service.

That list of codes includes physical and mental conditions such as legal blindness (369.4), vascular dementia (290.40) and a contracture of the hand joint (718.44).

While the rule didn't outline the coming of any specific consequences for poorly supported insulin injection claims, denials have been occurring, and will continue to occur over this issue, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

In fact, much of the verbiage CMS used in the rule to describe its concerns mirrors language that's been seen on claims denials, Whitemyer says.

Assess constantly to avoid denials

In order for your agency to get paid for visits to administer insulin to diabetics, it needs to continually look for alternatives to repeated home health visits, such as by finding and teaching a willing caregiver, and then it must repeatedly document why the alternatives aren't feasible and the agency's services are still necessary.

Agencies often initially document the factors that result in the need for the injections but fail to emphasize ongoing reassessment at every certification period, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

But no less than every 60 days your agency needs to recap its efforts to teach the patient, the patient's caregivers, or to find other caregivers or treatment options, Whitemyer says.

For example, if vision deficits make the patient unable to inject insulin, don't just say "poor eyesight." Explain in detail why and how the patient's vision deficit impedes him. If it's an issue of manual dexterity, document what has caused the dexterity deficit and how it gets in the way of injections, she says.

For patients who cannot be taught to inject and have no caregivers who are able or willing to learn, document why they're unable or unwilling and how your agency searched but could not locate any other caregiver, Whitemyer says.

"Daily administration of insulin is a covered service only if there are no other ways to meet patient needs," Adams says.

Tip: Call the physician to ask about alternative forms of treatment for patients on injectable insulin but who have blood sugar readings within the normal limits of 80 to 120, Whitemyer says. Medicare may see this and wonder why oral therapy isn't sufficient for this patient, and why the agency didn't ask about it.

Scenario: Insulin-dependent uncontrolled diabetes, hand joint contracture

An 88-year-old woman receives daily insulin injections for her type 2 diabetes that her doctor has stated is uncontrolled. Twenty years ago her hands were badly burned in a cooking accident that led to the amputation of her right hand and a severe joint contracture of her left hand, which make her physically unable to self-inject insulin. She is also a widow and has no children or any family nearby. The agency has been unable to find another caregiver to administer the insulin. She also has hypertension, congestive heart failure (CHF) and COPD, for which she is dependent on oxygen.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix 3	M1024 Case Mix 4
M1020a:	250.02 Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled		
M1022b:	V58.67 Long-term (current) use of insulin		
M1022c:	718.44 Contracture of joint, hand		
M1022d:	906.6 Late effect of burn of wrist and hand		
M1022e:	V49.63 Upper limb amputation status, hand		
M1022f:	428.0 Congestive heart failure, unspecified		

Other diagnoses: *496 (COPD NOS), 401.9 (Essential hypertension, unspecified), V46.2 (Supplemental oxygen)*

Rationale:

- As the diagnosis behind the reason for the home health admission, diabetes is coded primary. Because the doctor diagnosed it as uncontrolled, it can be coded as such.
- While it isn't absolutely necessary to sequence the insulin-use code (V58.67) immediately after the diabetes code, assigning it in that position best reflects the fact that the administration of insulin is driving this home health admission.
- The hand joint contracture (718.44) is an important secondary diagnosis that explains why she can't self-inject insulin and thus it is assigned next. Code 718.44 is one of the codes on CMS' list of secondary diagnoses that indicate a potential inability to self-inject insulin.

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- Because the contracture is a late effect of a burn, the late effect code, 906.6, must directly follow the contracture code, according to coding guidelines.
- The amputation of her other hand is captured next with V49.63 to further justify the need for agency-provided insulin injections.
- As relevant comorbidities, the patient's CHF, COPD and hypertension are coded as well.
- Though she is dependent on oxygen, this cannot be taken to mean her COPD is decompensated. Because there is no further detail, 496 is the only appropriate code to capture the diagnosis in this scenario. — *Megan Gustafson (mgustafson@decisionhealth.com)*

VA patients

Arrange multiple options for physicians' signatures when treating VA patients

When treating patients from the Veterans Administration (VA), make sure you arrange to have a different doctor(s) than the primary attending physician who signs the plan of care ready to approve the plan should the primary doctor not be available through the entire episode of care.

VA physicians tend to move around among VA hospitals frequently and can ship out in the middle of a home health episode, says Cindy Smith, regulatory and compliance coordinator at Home Health Care of East Tennessee and Hospice, Lenoir City, Tenn.

The agency, which has between 5% and 10% of its home health referrals come from two local VA systems as a preferred provider and is seeing that figure grow into a reliable payer source, has developed a policy of listing all VA physicians within the same practice or facility on the plan of care so that if one doctor has to leave, another doctor in the group can take over for the patient, Smith says.

Typically, one of the back-up doctors will be the chief of staff for physicians at the VA who is usually able to coordinate which doctor will be able to follow-up with the patient and sign an ongoing plan of care if needed, she said.

The number of veterans who will need some type of home care has been and will continue to be on the rise, says Bonnie Laiderman, founder and president of St. Louis-based Veterans Home Care. The organization helps veterans or their surviving spouses receive VA pensions that help pay for some home care expenses. Veterans Home Care now has about 1,500 clients, a big increase from none when it started in 2003, she says.

Veterans Home Care subcontracts with about 1,200 agencies across the country — most are private duty agencies but some are home health — to provide services for veterans that help them with their activities of daily living (ADLs), Laiderman said.

Obtaining physician's signature on the plan of care for patients who have the VA as a payer is also a problem for Interim Healthcare of Sunrise, Fla., says Lorraine Teza, senior manager of regulations, standards and policy development for the agency.

The Interim agencies most successful at obtaining such signatures take the time to visit the local VA and identify a point person who has agreed to assist in obtaining doctors' signatures, says Teza. This person's job title will not be the same at each VA, but typically he or she is not a discharge planner.

Instead, she is usually an office manager who keeps the medical staff organized. Agencies should visit the VA's medical department where the doctor's offices are and ask for this person, Teza says.

Train in case of payer change

If the VA is a payer for the patient, the OASIS need not be filled out, says Smith. Indeed, not filling out an OASIS start of care (SOC) assessment for patients at Home Health Care of East Tennessee and Hospice saves clinicians 30 to 45 minutes, she says.

A comprehensive assessment that collects and documents demographic, diagnosis, nutritional requirements, safety measures, ADLs and other similar data to the OASIS is performed by clinicians on VA patients, Smith says.

A quality manager at the agency reviews clinicians' assessments, documentation and visit notes as they come in and keeps track of changes to the plan of care and addresses any issues at bi-monthly case conference meetings as with Medicare patients.

Having clinicians follow two different processes for VA or Medicare patients can cause confusion among staff as to when a patient needs an OASIS and when not, says Whitemyer.

To avoid this problem, Home Health Care of East Tennessee and Hospice managers train clinicians specifically about the importance of verifying with patients that their insurance has not changed, which has to be done on an at least monthly basis, Smith says. They're also given a special one-hour orientation class on how to complete the non-OASIS comprehensive assessment, in addition to a three-day orientation on the OASIS.

Agencies should also be aware that VA patients can be dual eligible, have Medicare as a secondary payer and switch over to Medicare at some point during treatment, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10 CM-trainer, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

If an agency doesn't catch when those switches to Medicare happened and perform an OASIS, they may have to go back and generate an OASIS, Whitemyer says. This can lead to a late transmission of OASIS data, while the plan of care for the Medicare episode has to be generated and signed, creating issues that may aggrieve physician providers.

The agency could also miss the switch to Medicare entirely and, after 12 months, may not be able to bill the episode at all, says Whitemyer.

Though it doesn't happen often, when a patient at Home Health Care of East Tennessee and Hospice does switch from the VA as a payer to Medicare, the clinician completes a discharge and readmits the patient with a SOC OASIS, Smith says.

Intake nurses at Home Health Care who also coordinate care for patients initially let clinicians know whether the patient has the VA as a payer or Medicare and also help clinicians track patients' payer status through the episode of care, says Smith.

Also, the agency contacts the VA and notifies them that the agency can't readmit the patient under Medicare unless the VA doctor overseeing the care of the patient has a national provider identifier (NPI) within the state and is enrolled in the provider enrollment, chain and ownership system (PECOS), she says.

VA doctors of home health patients who have the VA as the payer don't have to be enrolled in PECOS, Smith says. Such physicians have to have a valid, up-to-date national provider identifier (NPI), but not within Tennessee or a neighboring state as under Medicare, she says.

Focus on VA, surveyor communication

Follow these tips when treating patients with the VA:

- **Send plans of care in batches.** Many Interim agencies that treat VA patients send plans of care on a specific day of the week to the VA point person, such as the doctors' office manager, instead of every day, says Teza. This makes the life of such an office manager easier and thus easier to work with, she says.
- **Watch for doctor moves during the summer.** Consider that staff, including VA doctors needed to sign patients' plans of care, typically move in the middle of the summer, and July is a big changeover month in the VA or in any hospital setting, says Ann Rambusch, RN, MSN, HCS-D, COS-C, president of Rambusch3 Consulting, Georgetown, Texas. Keep in close contact with the VA at this time to ensure your patients doctors are going to be around.
- **Go to your state surveyor with any questions or concerns.** Administrators or managers wishing to treat VA patients in their state should check in with their state surveyors and make sure they have no objections to issues like whether or not VA doctors have to be enrolled in PECOS, as Smith says she has done. — *Nicholas Stern (nstern@decisionhealth.com)*

Productivity survey: Visit weights

Agencies prepare to adjust productivity weights for SOC when ICD-10 goes live

ICD-10 implementation, currently set for Oct. 1, 2015, will require extensive training and could lead agencies to relax productivity standards, at least for a short time.

Teresa Doseck, owner of New Vision Nursing and Home Care in Wapakoneta, Ohio, hasn't started training clinicians yet for ICD-10. She doesn't want it to begin too early and have them forget lessons learned. But she plans on beginning at least two training sessions before implementation and one after.

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She also plans on dropping expected daily nursing visits from five to four at the outset of ICD-10 implementation, and the agency may have to hire another nurse, Doseck says.

Overall, agencies give start-of-care (SOC) visits a weight of 2.10, according to DecisionHealth's 2014 Productivity Survey. The follow-up OASIS visit is weighted 1.58, while the recertification visit is 1.56, according to the survey's 135 respondents. (*See table, p. 8*).

The 2014 SOC figure is slightly lower than last year's weight of 2.19 for SOC visits, survey data show.

Ann Rambusch, president of Rambusch3 Consulting, Georgetown, Texas, speculates this may reflect more pressure being put on clinicians to complete SOCs in the face of decreasing reimbursement from CMS. However, she says agencies should consider that conducting a thorough and accurate SOC should take between two and three hours.

Doseck previously worked as a home health nurse, and she understands how much more time a SOC visit takes to complete, she says.

That's why she gives SOC visits a 2.0 as a routine visit, and even more leeway for nurses new to home health, she says.

Her RNs, who are paid by salary and expected to see five patients per day, are also required to complete their own coding, Doseck says. Discharges, transfers and recertifications are given half the weight, she says.

SOC visits at Greenwood County Home Health in Eureka, Kan., are given a weight of 3.0 as a routine visit, clinical supervisor Ashley Boles says. Recertifications, resumptions of care (ROCs) and discharges are given a weight of 1.5.

Respondents to last year's productivity survey reported nearly similar results to this year's for follow-up and recertification visits; 1.56 for both.

Greenwood County Home Health has not yet decided how to change productivity expectations in light of the switch to ICD-10, Boles says. The agency has begun training coders and in-house staff for ICD-10, including dual coding a couple charts to see how it will work. But training at the agency slowed in April after Congress chose to delay implementation.

Training for clinicians will pick back up in late-winter or early-spring, she says.

Currently, clinicians at Greenwood County Home Health are expected to see about eight patients in routine visits during a typical nine-hour shift, for which they are paid an hourly rate, though that can decrease a bit according to travel time as many patients live in rural areas, she says.

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BENCHMARK of the Week

Average weights for home health visits

As in 2013, start of care, follow-up and recert OASIS visits were given more weight than any other type of home health visit, according to the 135 respondents to DecisionHealth's 2014 Productivity Survey *(see story, p. 6)*. Agencies were asked to mark 1 if they don't add weights to visits. There were 129 respondents to DecisionHealth's 2013 Productivity Survey. Fewer than half of respondents — 55 — responded last year to the telehealth category, which could help account for the significant difference in weight this year.

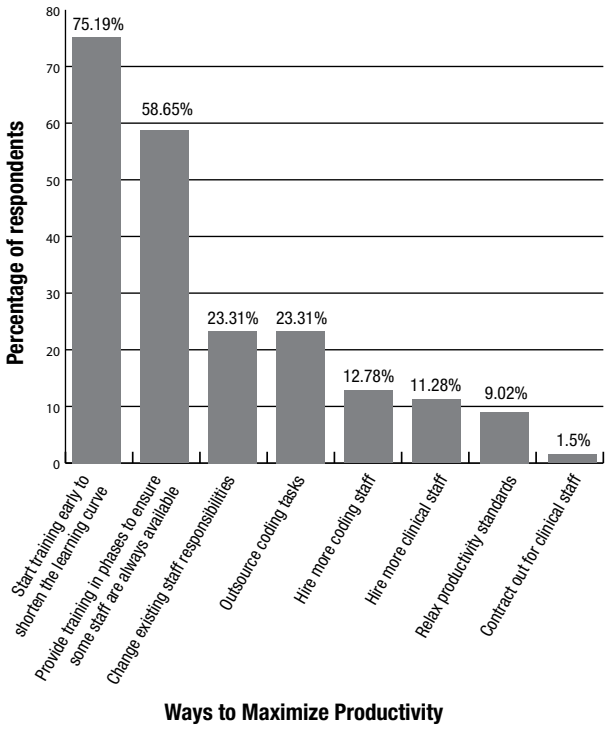
	2014	2013
Start of care	2.10	2.19
Follow-up OASIS	1.58	1.56
Recertification	1.56	1.56
SCIC	1.27	1.29
Discharge	1.28	1.23
Other (e.g.telehealth)	1.15	0.81

Source: DecisionHealth's *2013 and 2014 productivity surveys*

Productivity benchmark

Steps agencies plan to take to minimize productivity losses

About a quarter of agencies plan to change existing staff responsibilities to minimize ICD-10-related clinician and coder productivity losses, according to DecisionHealth's 2014 Productivity Survey. About 9% of respondents plan to relax productivity standards (*see story, p. 6*). Note: Agencies could choose more than one response.



Source: DecisionHealth's *2014 Productivity Survey*

Train to maintain OASIS productivity

Your agency should look to train its clinicians on the changes in OASIS-C1/ICD-9 before it goes into effect Jan. 1, 2015, in order to prevent productivity declines and maintain quality outcomes and proper risk adjustment.

Greenwood County Home Health has already had clinicians listen to several webinars including CMS' OASIS-C1 webinar in September, and it plans on training on more key, parts anticipated to take up more of clinicians time such as the wound items, Boles says.

Currently, Greenwood County Home Health is not yet anticipating lengthening the amount of time clinicians are expected to spend on SOC and other OASIS visits, Boles says.

That's because she doesn't expect many of the changes she's seen in OASIS-C1 will necessarily take more time, though there could be a bit of a learning curve at the beginning as clinicians may have to check Ch. 3 of the OASIS-C1 guidance manual on specific items, particularly the wound items.

However, the agency will wait to see if it may have to adjust productivity standards to account for the switch to an updated OASIS assessment, Boles says.

Doseck also doesn't plan on shifting productivity standards in light of the switch to OASIS-C1. She has printed out the new OASIS-C1 forms and given them to clinicians to look over, but she is not yet sure they'll even need special education to prepare for OASIS-C1.

But beware, agencies that don't train for OASIS-C1 do so at their peril, Rambusch says. From a compliance standpoint, agencies are supposed to complete OASIS assessments correctly and follow its rules.

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If people are not following the rules, the odds are they are either underestimating or overestimating how well or sick the patient is, she says. Particularly for agencies overestimating the sickness of patients, CMS can wind up denying payment. Incorrect answers can also negatively impact risk adjustment and quality outcomes, Rambusch says. — *Nicholas Stern (nstern@decisionhealth.com)*

Therapy

(*continued from p. 1*)

gastrointestinal disorders and psych 1 and 2 as well as pulmonary diagnosis groups and OASIS items M1200 (Vision) and M2030 (Injectable drug use). In general, case-mix points will be reduced for clinical diagnoses and OASIS items, while high therapy episodes with 14 or more visits would earn the most points.

Part of the key to understanding how your agency might be impacted by such case-mix declines in a given situation is to look at how the points for clinical as well as functional items will change, says Ann Rambusch, RN, MSN, HCS-D, COS-C, AHIMA approved ICD-10 trainer, president of Rambusch3 Consulting, Georgetown, Texas.

The following is a scenario that shows how a high-therapy case could result in the loss of about $170.

Scenario: Mr. Benjamin was admitted for his first home health episode for management of hemiplegia as a late effect of a cardiovascular accident (CVA) six days ago. He also has congestive heart failure (CHF) and diabetes. Fourteen therapy visits are planned.

Remember, in its proposed 2015 PPS rule, CMS made significant changes to point values associated with the four-equation model. This scenario fits into equation two (early episode, 14+ therapy visits).

In 2014, a clinician would mark the following:

- Late effects of the CVA = two case-mix points
- Diabetes as a secondary diagnosis = five case-mix points
- CHF = six case-mix points
- CVA + M1810 (Current ability to dress upper body)/M1820 (Current ability to dress lower body) is > 0 = three case-mix points

- In 2015, according to the proposed PPS rule, a clinician would mark the following:
- Late effects of the CVA, hemiplegia = 10 case-mix points
- Diabetes as secondary diagnosis = zero case-mix points
- CHF = zero case-mix points
- CVA + M1810/M1820 is > 0 = four case-mix points

This table shows the number of clinical and case-mix points that this patient would receive in 2014 and 2015.

In 2014:	Proposed 2015:
Case-mix points from diagnoses = 13	Case-mix points from diagnoses = 10
CVA + M1820 = 3	CVA + M1820 = 4
The C score (C3) = 16	The C score (C3) = 14
M1810/M1820 = 4	M 1810/M1820 = 0
M1830 (Bathing) = 3	M1830 (Bathing) = 3
M1840 (Toilet transferring) = 3	M1840 (Toilet transferring) = 3
M1850 (Transferring) = 0	M1850 (Transferring) = 0
M1860 (Ambulation/locomotion) = 0	M1860 (Ambulation/locomotion) = 0
The F score (F3) = 10	The F score (F2) = 6
The S score (Therapy) = S1 (14 visits)	The S score (Therapy) = S1 (14 visits)
C3F3S1 (1.6263)	C3F2S1 (1.5386)
Payment = $4,666.29	Payment = $4,496.96
	Difference = -$169.33

Discussion: Notice that both CHF and diabetes earn zero case-mix points under the proposed PPS rule changes in the early episode, high-therapy equation.

Now, let's look at the clinical and functional scores using the scenario above.

In this case, M1810 and M1820 earn no case-mix points in a high-therapy case under the proposed changes, while they currently earn four points, contributing significantly to the payment loss of $169.33.

Pay attention to functional items

With such potential losses in case-mix points, clinicians need to make sure they understand how to answer sometimes difficult functional items like M1850 (Transferring) and M1860 (Ambulation/locomotion) so they don't lose case-mix points they should be earning, advises Rambusch. And remember, answering these items correctly can impact Home Health Compare scores as well as risk adjustment.

Also don't forget, for example, that choosing an accurate response to M1850 requires a correct understanding of the term "minimal human assistance."

Often times, clinicians mark Response 1 - "Able to transfer with minimal human assistance…" when they should be choosing Response 2 - "Able to bear weight and pivot but unable to transfer self," Rambusch says.

And while case-mix points would not change in the above scenario depending on whether clinicians choose either of these options, an agency's risk adjustment and Home Health Compare score on the "Improvement in bed transferring" outcome measure could.

Minimal human assistance means the individual assisting the patient contributes less than 25% of the total effort required to perform the transfer, according to CMS' draft OASIS-C1 guidance manual. If the patient requires both minimal human assistance and an assistive device to transfer safely, clinicians should select Response 2.

Clinicians can have problems answering M1860, Rambusch says. That's because they might not know that if a patient needs both an assistive device and human assistance at all times, Response 5 - "Chairfast, unable to ambulate and is unable to wheel self" is appropriate, even if the patient is not using a wheelchair (Q&A, 6/14, Q155.3.1).

If, using the scenario above, the clinician answered Response 5, the agency would earn eight case-mix points for a total of 14 functional points and thus earn $289.35 more. — *Nicholas Stern (nstern@decisionhealth.com)*

Vaccination

(*continued from p. 1*)

If clinicians know where to look for this information, it could help reduce any productivity losses that may result as OASIS-C1 goes into effect on Jan. 1, 2015.

Also, answering this question correctly impacts agencies' process measure scores on Home Health Compare.

This OASIS question was among those that agencies fear will take more time in OASIS-C1, according to respondents to DecisionHealth's 2014 Productivity Survey. Other questions include those related to wounds and functional items.

About one quarter of 135 respondents said they expect an OASIS-C1 start-of-care (SOC) assessment initially will take 10 to 19 minutes longer to complete, 20% said it would take 20 to 29 minutes longer and 10% said it would take 30 to 44 minutes longer.

Check hospital's immunization records

Clinicians can request that the hospital or doctor's office staff fax immunization info to the home health agency or obtain the information by phone if the doctor's office prefers, says Michelle Mantel, quality assurance manager for the Southeast Region at Gentiva Home Health, West Palm Beach, Fla.

The pneumococcal vaccination is at times more difficult to collect, because it was usually only given once. Or, for more immune-compromised patients, it was given at five-year intervals, Mantel says. Thus, it is difficult for patients and caregivers to remember if it was ever given or received.

But more and more, physicians, hospitals and other providers including the Veterans Administration use software that prompts providers to enter immunization data when they see the patient at each visit and a running tally of all immunizations is captured in patients' medical records, she says. Those records typically can be obtained by home health clinicians.

The good news: Some of the changes in wording to the flu and pneumonia vaccination questions will make the items easier for clinicians to understand and answer.

For M1051, the item now asks if the patient has ever received the pneumonia vaccine instead of if the patient received the vaccine from your agency during this episode of care. — *Nicholas Stern (nstern@decisionhealth.com).*

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