

Eli's OASIS Alert

Your Guide To Outcomes, Compliance & Reimbursement Success

Volume 10, Number 2

February 2009

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OASIS Alert is always looking for OASIS-related news and trends. Please call us with news, comments or suggestions.

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Training

USE 5 STEPS TO KICK START YOUR OASIS-C PREPARATION

► *Analyze your processes now to avoid last-minute headaches.*

OASIS-C is fast approaching — meaning you must start prepping for the new form now unless you want to wind up scrambling for compliance later.

In November, the **Centers for Medicare & Medicaid Services** issued its latest draft of the OASIS retool, which includes several new process-based items. For instance, the new start of care form under OASIS-C will have 105 M0 items, compared to the current 76, CMS points out.

The form is likely to undergo some tweaks before CMS issues the final version later this year, but agencies can expect the basic structure to stay the same, experts predict.

You can start some of the most time-consuming parts of OASIS-C preparation now, advised Chicago-based regulatory consultant **Rebecca Friedman Zuber** in a December audioconference sponsored by **Eli**, “OASIS-C: What You Need to Know Now About this Major Assessment Overhaul.” She suggests you take these steps:

1. Assess clinical processes and make improvements. The new OASIS-C form asks HHAs to address a wide range of new clinical issues with process-based M0 items — vaccinations, pain, pressure ulcers, diabetes, cardiac issues, depression, falls, and medications.

CMS has been eager to implement assessment items based on processes like they have for nursing homes, experts say. Then they’ll be able to use such measures on Home Health Compare and, possibly, to create a five-star rating system such as the one just launched for nursing homes.

Maybe you already address all these items or maybe you’re currently addressing just a few. Either way, now’s the time to review what you’re doing and improve it, Friedman Zuber

Test Your OASIS Savvy ...

Question: A patient entered our care with Stage II pressure ulcer that has now begun to heal. Can we change the stage of healing to Stage I?

Do you know the answer? Quiz your management and coding staff, as well as your regulatory experts. Once you’ve gotten their answers, turn to page 137 for our expert’s wound coding guidance.

Next step: Tell us about your toughest problems with OASIS so that we can track down answers for you! You can contact the editor at kellyq@eliresearch.com.

advised in the session. (*See related box, p. 11, for questions to ask yourself in the process.*)

Once you have your new and improved clinical processes in place, you’ll have an easier time answering the new M0 items.

Example: CMS will add three new items on risk assessment, care planning, and interventions for pain (M1242, M1244, and M1246). You’ll need to look at what standardized tool you use to assess pain and how the care plan addresses management of it. Remember, “Pain is the new vital sign,” Friedman Zuber said.

CMS may be using the new tool to impact more than just HHAs, Friedman Zuber added. The new M1326 asks, “Are moisture retentive dressings specified on the physician-ordered plan of care?” and M1328 asks, “Since the previous OASIS assessment, were moisture retentive dressings used?”

These questions aim to get docs to consider using evidence-based practice for pressure ulcer treatment. “Plenty of data out there shows that moisture-retentive dressings are the way to

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go for treatment of pressure ulcers,” Friedman Zuber noted. “CMS is clearly using home health as a tool to move physicians in this direction.”

2. Identify screening tools. The new OASIS-C form asks agencies about using four screening tools: for pain (M1242), pressure ulcers (M1300), depression (M1730), and fall risk (M1930). The form also asks about medication review (M2000), Friedman Zuber noted.

If you don't already have standardized screening tools in place for these items, now is the time to acquire them, she advised.

3. Train staff and evaluate their competency. It's too early to educate your staff on the new OASIS-C form, but you should begin training them now on the new underlying assessment tools you adopt, Friedman Zuber urged.

Educate staff, then evaluate their competency with the new tools and add more education if necessary, she said. If you can get that part down pat before OASIS-C hits, your training on the new form itself will be simpler and the resulting data more reliable.

4. Start talking to software and form vendors. OASIS-C will have a wide-ranging impact on your operations, Friedman Zuber warned. The new form will affect your billing software, your clinical documentation system and forms, and your HAVEN or other OASIS reporting software.

It's never too early to begin communicating with your current vendors — or potential new ones — about the changes.

5. Formulate your OASIS-C training plan. It's unlikely that CMS will make significant changes to the OASIS-C form, but that's always a possibility, Friedman Zuber cautioned. Hold off on training on the new form until later in the year — probably in the early fall.

However, you should get staff involved in the steps you're working on now — assessing clinical processes and adopting new screening tools, Friedman Zuber counseled. This will

help secure staff buy-in and show them how the information they collect will be used.

Note: To order a recording of the OASIS-C session, go to www.audioeducator.com/industry_conference.php?id=1306 or call 1-800-508-2582. ❖

Assessment

PUT DEPRESSION ON YOUR RADAR SCREEN

► *New form forces clinicians to gauge mental health, too.*

While the new OASIS-C will increase the number of physical items you assess, it doesn't stop there.

The new tool will contain three new depression items (M1730, M1734, and M1736) meant to catch the early signs of depression in home health patients, which is “typically underassessed,” explained regulatory consultant **Rebecca Friedman Zuber** in the Eli-sponsored audioconference, “OASIS-C: What You Need to Know Now About this Major Assessment Overhaul.”

Your duty: The **Centers for Medicare & Medicaid Services** will require that you use a standard screening tool for depression, as well as develop an intervention plan — including an assessment scale — that keeps patients from sinking into depression during your care.

Ask Mental Health Experts For Advice

CMS doesn't specify what tool agencies should use to screen for depression — but your patients' primary care physicians aren't your best go-to resource, Friedman Zuber asserted.

Better: Your local mental health center or psychiatric facility can help you distinguish between the most commonly available depression screening tools. Using mental health professionals' advice, you can select the best tool for your patients, she assures **Eli**.

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Team Up Before You Try To Intervene

As with any intervention, your agency must consult with and obtain a physician's order before implementing your depression intervention plan. You can prepare for potential problems by educating everyone about depression.

Get started: Ask mental health professionals to coach your clinicians on how to identify the signs and symptoms of depression, Zuber Friedman recommends. Then, encourage clinicians to educate their patients about what they've learned.

Next step: Urge your clinicians to keep a close eye on patients' mental health by using your chosen depression scale. Determine which place on the scale will raise your agency's depression red flags — and which will kick off your intervention plan. ❖

Clip & Save

MONITOR YOUR OASIS-C PROGRESS WITH THIS HANDY CHECKLIST

► Ask these vital questions to measure your compliance success.

OASIS-C demands that you assess your clinical processes and make improvements — which can be easy if you know what to ask, offers Chicago-based regulatory consultant **Rebecca Friedman Zuber**.

Mark off each item as you accomplish it and use the other items as a guide to what you should work on next.

- Do you use reporting parameters in plans of care?
- Are you assessing the need for vaccinations?
- Are you assessing pain using a standardized tool?
- Are you insuring that pain interventions are in place?

- Are you assessing risk for pressure ulcer development?
- Are you taking appropriate steps to prevent development of pressure ulcers?
- Do you screen patients for depression using a standardized screening tool?
- Does your care plan include interventions for depression and is it implemented?
- Are you assessing patients' drug regimens for adverse effects and reactions?
- Did you address the results of your drug regimen assessment with the physician, including new issues that arise during the course of care?
- Are you providing patient and caregiver education on the high-risk medications the patient is taking?

Bonus: Want a PDF copy of the full list? Send an email to kellyq@eliresearch.com with the Subject line "OASIS-C Checklist" for a PDF copy. ❖

National HH CODING/OASIS Online Discussion Group



**Not on the
list yet?
Join
Today!**

Join home health ICD coding and OASIS experts for an ongoing discussion on how home health agencies can best handle their most pressing diagnosis coding and OASIS dilemmas. Clarify misunderstandings and learn the details about your top OASIS and diagnosis coding questions by networking with your peers.

To register online, go to:

<http://www.elihealthcare.com/groups.htm>.

Then go to "Join by Specialty," click on "Home Health Coding & OASIS," and fill in your details.

**Do you have an OASIS question, comment or story to share?
Call Kelly Quinones Miller, MA, Editor, at (800) 718-9504.**

*Diagnosis Coding***CLEAR UP CONFUSING DIAGNOSES WITH THESE BASIC CODING STEPS**

► *Decoding this tricky op note can be a whiz with the right tools.*

If you can't distinguish your patients' principal diagnoses from their secondary ones, your coding — and your OASIS efforts — will be the ones to suffer.

Selecting the correct principal and secondary diagnoses is essential for accurate coding. **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of **Selman-Holman & Associates** in Denton, Texas offers the following sample coding scenario to illustrate this point.

Scenario: A patient is admitted to home care three weeks after a myocardial infarction. He has continuing symptoms. The op record states that there was 98 percent obstruction in two vessels and that the patient underwent a coronary artery bypass graft (CABG). The wounds are healing well, and orders are to leave the bypass incision and the leg incision open to air.

The patient also has hypertension (HTN) that is currently well-controlled and gastroesophageal re-flux disease (GERD). His history includes a below-knee amputation (BKA) two years ago due to diabetic peripher-

al angiopathy and a cholecystectomy last year for gall stones.

His diabetes is currently controlled with diet. He will have nursing, physical therapy (PT) for strengthening and gait training, and occupational therapy (OT) for energy conservation techniques and activities of daily living (ADLs). The focus of care is the myocardial infarction, along with aftercare for the CABG.

Code for this patient with the following codes, says Selman-Holman:

- ◆ M0230a: 410.92 (*Acute myocardial infarction; unspecified site; subsequent episode of care*);
- ◆ M0240b: V58.73 (*Aftercare following surgery for circulatory conditions, NEC*);
- ◆ M0240c: 414.00 (*Coronary atherosclerosis; of unspecified type of vessel, native of graft*);
- ◆ M0240d: 250.70 (*Diabetes with peripheral circulatory disorder; type II or unspecified type, not stated as uncontrolled*);
- ◆ M0240e: 443.81 (*Peripheral angiopathy in diseases classified elsewhere*);
- ◆ M0240f: 530.81 (*Esophageal reflux*); and
- ◆ Other pertinent diagnoses: 401.9 (*Essential hypertension; unspecified*), V49.75 (*Lower limb amputation status; below knee*);

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Continuing Education

EXPERT ADVICE IS AT YOUR FINGER TIPS

► *It's never too late to take advantage of OASIS guidance.*

We're in a new year, but that doesn't mean you can't take advantage of these past audioconferences.

Check out these recent home health and OASIS audioconferences to help your agency receive all the reimbursement it is owed — without headaches:

- **“Smart, Easy Ways To Reconcile Medicare Home Health Billing Adjustments.”** Learn easy ways to verify that all of your home health episode payments are correct — and what to do if they're not. **M. Aaron Little, CPA**; operations manager with **BKD**; www.audioeducator.com/industry_conference.php?id=1357.

- **“Survive Your Audits: Therapy Documentation Issues For 2009.”** Here are all the tools you need to assess therapy documentation and prepare for a higher level of review. **Cindy Krafft, MS PT, COS-C**; a 12-year veteran in the home health industry; www.audioeducator.com/industry_conference.php?id=1335.

- **“ICD-9 Changes Hit Home Health Agencies With A Bang.”** Diagnosis coding drives home health reimbursement. Hundreds of new ICD-9 codes took effect last October — is your coding up to snuff? **Judy Adams, RN, BSN, HCS-D**; clinical consultant with **LarsonAllen**; www.audioeducator.com/industry_conference.php?id=1204. ❖

Note: To browse and order Eli home care audioconferences or CDs of past conferences, go to www.audioeducator.com, and select “home health” from the healthcare specialty box or call 800-508-2582.

Rationale: When there are multiple diagnoses that describe the primary reason for care, the assessing clinician can just choose one. In this case, Selman-Holman selected the MI as primary, but the aftercare could have been chosen as the primary diagnosis alternately, she says.

CAD is still present after a CABG because those vessels containing the plaque are bypassed and not removed. So the CAD is still an existing condition and is obviously related to the plan of care (POC) for this patient.

The other conditions are co-morbidities as long as they reflect the seriousness of the patient's condition (not to be confused with the severity index), Selman-Holman says. You can list these co-morbidities in any order. The diabetes along with the peripheral angiopathy will obviously impact the care even though at this time the diabetes is controlled.

GERD has the potential to impact the care. For example, if the patient is non-compliant with his medications (including pain medications), his nutrition suffers because of the GERD, or the patient has the potential to confuse the pain of GERD for angina or vice versa, then it will impact the care, Selman-Holman says. That potential should be documented in the record.

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Newsletter Question or Comment?



Do you have a question or comment about home health OASIS issues? You can easily get in touch with the editor, Kelly Quinones Miller, MA, at (919) 718-9504 or kellyq@eliresearch.com.

We want to help solve your toughest OASIS problems, so you should get in touch today!

*Reader Question***HERE'S HOW TO STAGE YOUR PATIENTS' HEALING WOUNDS**

► *Don't 'downstage' your patients' pressure ulcers.*

Question: A patient entered our care with Stage II pressure ulcer that has now begun to heal. Can we change the stage of healing to Stage I?

Answer: You can't "downstage" or "reverse stage" pressure ulcers or other wounds, says the Laguna Beach-based **Wound, Ostomy and Continence Nurses Society (WOCN)**, which the **Centers for Medicare & Medicaid Services** names as a key resources for wound staging along with the **National Pressure Ulcer Advisory Panel**.

"Pressure ulcers heal to progressively more shallow depth," but the original, healthy tissue is replaced with granulation tissue rather than normal tissue — meaning a Stage IV ulcer can never become a Stage III, NPUAP explains.

Strategy: When a Stage IV pressure ulcer is partially healed, you should code it as "healed Stage IV" rather than simply re-staging it, WOCN states.

Caveat: Stage I and II wounds do have the potential to heal, according to the **OASIS Implementation Manual of January 2008**. However, you should follow the same rules as with more serious ulcers. So, rather than downstaging a Stage II to a Stage I as it heals, you should code it as a "healed Stage II."

"All agencies must ensure that their clinicians are educated on all information, guidance and guidelines which are documented as references" by CMS for OASIS, urges **Marianne Rone**, RN, director of clinical services for **Healthcare Provider Solutions** in Nashville, Tenn.

And CMS' reliance on WOCN and NPUAP is unlikely to waver after OASIS-C is finalized, Rone says. "These organizations will provide additional information to assist clinicians in documentation, not necessarily changes," Rone predicts.

Note: You can view WOCN's wound staging advice at www.wocn.org/pdfs/WOCN_Library/Position_Statements/PressureUlcerStaging.pdf and NPUAP's guidance is at www.npuap.org/positn5.htm. ❖

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Other pertinent diagnoses include two conditions that, according to the guidelines, should always be coded, so be sure to add the codes for the HTN and amputation. The cholelithiasis that the patient had in the past is historical information and not pertinent to the POC, so you wouldn't code for that.

Remember: Even though OASIS only has six slots (M0230a-M0240f), the home health agency Conditions of Participation require that you code all pertinent diagnoses on the POC, and the claim form includes nine diagnoses slots plus another for an E code, Selman-Holman notes. ❖

*Case Study***YOU CAN SHUT YOUR AGENCY'S DOORS AT NIGHT**

► *You are not your patients' only resource for care during off hours.*

Your patients may need help in the middle of the night or on the weekend, but you don't have to rush to their bedsides.

You don't have to be at your patients' beck and call, says **Shawn Severson**, director of home health for **St. Mary's/Clearwater Valley Hospital and Clinics** in Cottonwood,

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*Education***MAKE THE CALL TO COLLECT
'DEATH AT HOME' DATA**

► *Your clinicians don't need to collect all data face-to-face.*

When a patient dies or transfers out of your care, your clinicians can collect OASIS data without being in the patient's presence.

"These time points are not assessments and do not require the clinician to be in the physical presence of the patient," says the **Centers for Medicare & Medicaid Services** in a new clarification posted on the **OASIS Certificate & Competency Board (OCCB)**.

Timesaver: Not only can your clinicians simply call patients or their caregivers to collect the necessary information, you don't have to ensure that the clinician has a history with the patient, the clarification states.

However, your agency might be best served by ensuring that the clinician is familiar with the patient's condition, says **Judy Adams** of **LarsonAllen** in Charlotte, N.C. The clinician should "at least know what the patient was being seen for so that he or she can ask the right questions to get full information from the caregiver or family member," she says.

Goal: Your phone call must get as much pertinent information as possible about the patient's death or transfer as possible, including the what, when, where, and why.

Adams suggests you start with these questions to milk as much data from the patient's family or caregivers as you can:

- ◆ When did the patient go to the hospital?
- ◆ What happened to the patient?
- ◆ Where is the patient now?
- ◆ What did the ER physicians say?

Note: You can read the OCCB's clarification at www.oasiscertificate.org under the "Resources" link. ❖

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Ida. "We stopped around-the-clock call nearly three years ago," she tells **Eli**.

Why: Agencies in rural areas or with a limited number of clinicians simply can't always have someone on call to answer patients' questions or respond to emergencies in the middle of the night. And, the **Centers for Medicare & Medicaid Services** demand only that you have clinicians available during business hours, Severson points out.

However, Severson and her team didn't simply stop offering on-call services to the patients in her area. St. Mary's/Clearwater followed this process to eliminate 24/7 call:

Step 1. Tell physicians what you can — and can't — do.

Physicians who aren't aware of your agency's capabilities and rules can't efficiently prepare their patients to return home.

Better: Make sure all the providers you work with are aware of your agency's stance on around-the-clock care. That way, they can make sure patients know how to get help outside of business hours and you aren't constantly reminding patients of the best way to receive nighttime care.

You don't want the worse-case scenario — patients sitting at home in pain wasting their time trying to contact you when they should be turning to the hospital for help.

Step 2. Adjust your agency's screening practices.

When you know you won't be available to help patients outside of regular business hours, you must make sure to catch potential problems before they blossom out of control, Severson advises.

"We have to be better at screening patients," she says. This includes closely examining patients with IVs and new wounds to ensure no problems will creep up overnight.

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Excellent screening can virtually eliminate your patients' need for care during the night.

Step 3. Check up on hospital admissions and ER visits.

Now that your agency no longer visits patients during the off hours, you must pay close attention to how often your patients visit the emergency room or are admitted to the hospital during the night, Severson notes.

"Each month, I check to see which days of the week our patients are admitted to the hospital or visit the ER," she says. That allows

Severson to adjust the agency's amount of patient phone calls and visits in the hours before they close and after they open.

When the percentage of patients seeking help during the agency's off hours increases outside of normal fluctuation, she re-evaluates and adjusts her clinicians' routine to better meet patients' needs.

The Bottom Line: You can continue providing top-notch service without demanding that your clinicians work throughout the night, Severson asserts. ❖

Reimbursement

DON'T MISS OUT ON THERAPY PAY

► Use this chart to double check your PPS reimbursement.

Even slight inaccuracies could affect your agency's reimbursement for therapy visits (M0826).

Use this chart to quickly spot the "incremental increases in your Medicare PPS reimbursement for each change in therapy visits," says **John Reisinger, CPA**, principal of **Innovative Financial Solutions For Home Health** in Tampa, Fla and publisher of the Home Health Care Resource Planner.

The chart is based on a 'theoretical' core-based statistical area with a wage index of 1.0000 and an NRS Level of 1. It also includes \$14.13 in reimbursement for non-routine medical supplies.

	Episode #	Range of Therapy Visits	PPS Payment	Change
C1F1S1	1 or 2	0-5	\$1,337.97	
C1F1S2	1 or 2	6	1,946.85	\$608.87
C1F1S3	1 or 2	7-9	2,422.13	475.28
C1F1S4	1 or 2	10	2,909.46	487.33
C1F1S5	1 or 2	11-13	3,309.77	400.31
C1F1S1	1 or 2	14-15	3,676.00	366.23
C1F1S2	1 or 2	16-17	4,029.74	353.74
C1F1S3	1 or 2	18-19	4,341.22	311.48
C1F1S1	Any	20+	5,806.38	1465.16
C1F1S1	3+	0-5	\$1,500.64	
C1F1S2	3+	6	2,295.36	\$794.72
C1F1S3	3+	7-9	2,755.20	459.84
C1F1S4	3+	10	3,257.74	502.55
C1F1S5	3+	11-12	3,654.65	396.90
C1F1S1	3+	14-15	3,996.80	342.15
C1F1S2	3+	16-17	4,260.11	263.31
C1F1S3	3+	18-19	4,615.21	355.10
C1F1S1	Any	20+	5,806.38	1,191.16

Industry Notes

CMS GIVES PROVIDERS AN EXTRA 2 YEARS TO IMPLEMENT ICD-10

► *New coding system target date is 2013, according to final rule.*

If you were concerned about the proposed ICD-10 implementation date of Oct. 1, 2011, take heart.

The **Centers for Medicare & Medicaid Services** has extended that date by two years, according to a recently published **Department of Health and Human Services** final rule.

You'll have to ensure compliance with ICD-10 by the effective date of Oct. 1, 2013, according to a Jan. 15 HHS press release. The new edition of the ICD manual will expand the code set from 17,000 codes, which ICD-9-CM currently has, to more than 155,000 codes, which ICD-10 includes.

"HHS received more than 3,000 comments on the ICD-10 proposed rule, and support for transition to the ICD-10-CM and ICD-10-PCS is strong throughout the health-care industry," says **Kerry Weems**, acting CMS administrator, in the release.

Home care provider groups, including the **National Association for Home Care & Hospice**, urged CMS in their comments to delay the implementation date. The rule is at www.federalregister.gov/OFRUpload/OFRData/2009-00743_PI.pdf.

• **CMS soon may rework its HCPCS coding for negative pressure wound therapy (NPWT) devices.** CMS and the **Agency for Healthcare Research and Quality** are reviewing the items. CMS is calling for "relevant studies and information for use in consideration of coding changes," it says in a message to providers. "CMS will use this review in its assessment of whether existing HCPCS codes adequately represent the technology and comparative benefits of NPWT devices."

"We are particularly interested in those well-conducted clinical trials that describe the comparative benefits of these devices," the agency adds. Submissions must be received on or before Feb. 6.

More information is online at www.ahrq.gov/clinic/ta/npwtrequest.htm.

• **You know how irritating it is** when you can't bill for a patient who transferred from another home health agency, because that HHA hasn't submitted the final claim for her? Don't do that same thing to outpatient therapy providers, urges regional home health intermediary **National Government Services** in its January bulletin for providers.

"It is important that home health agencies discharge their patients in a timely manner," NGS says. "Patients treated under a home health plan of care should be discharged from the HHA when they are no longer homebound" and can receive outpatient rehabilitation services.

Don't hold up the Part B therapy provider, NGS exhorts. "If the HHA does not file their claim in a timely manner, the rehabilitation agency is not able to bill Medicare for the services they provide." ❖

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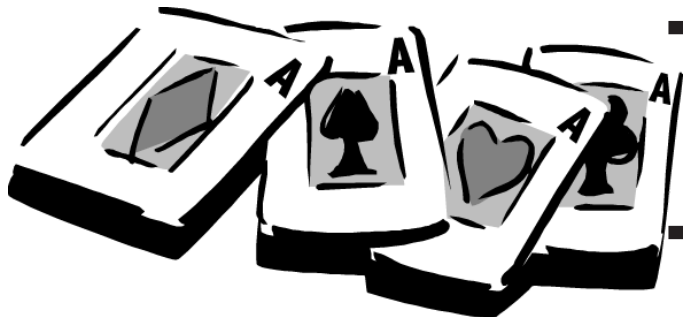
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