

Eli's OASIS Alert

Your Guide To Outcomes, Compliance & Reimbursement Success

Volume 11, Number 5

May 2010

News you can use ...

Clearly Indicate Patients' Pain With This Expert Advice. Just because an item in OASIS C asks about pain doesn't mean your response should note how much pain your patient experiences. Let our experts guide your pain responses. (Page 42)

Note These 2 Differences Between M2250 & M2400. At first glance, M2250 and M2400 seem to ask the same question, but there are some key differences you need to know. (Page 43)

Make 'Backward' Your Motto For POC Tables. For the first time in OASIS history, you have to answer a table of questions in both M2250 and M2400 — and those tables can be quite misleading. Learn this valuable trick. (Page 44)

2 Questions Boost Your Wound Coding Accuracy. Making the wrong assumptions about a patient's wound could determine whether or not it heals — and wasting any treatment time could be fatal. Here's how to avoid that mistake. (Page 44)

CAHPS Deadline Just Around The Corner. If you've been putting CAHPS on the back burner while tackling OASIS C and other concerns, now's the time to move it up before you get burned. Get the scoop. (Page 46)

Remove Any Confusion From Inpatient Procedure Codes. OASIS C has been around awhile, but that doesn't mean you feel any more at ease with the diagnosis code "M" items. Follow this practical advice to get it right every time. (Page 48)

Here's How To Schedule Your ICD-10 Implementation. Any agency banking on rolling implementation for ICD-10 may be in for a rude awakening. This guidance should make scheduling your transition a bit simpler. (Page 49)

Brand-New OASIS C Guidance On Its Way. CMS has some news that will fall on very welcome ears — especially for agencies needing more support for OASIS C. (Page 50)

• **CMS Proposes Home Health COPs, Again**50

• **Your OASIS C Data Is Safe**
From Surveyors50

• **Plan For Gradual ICD-10**
Implementation50

SNEAK PEAK!

Older Personal and Home Care Aides Looking After Elderly....51

CONTENTS

Strategies	42
Education	43
Training	44
Wound Care	44
Patient Satisfaction	46
Diagnosis Coding	48
Reader Question	49
Industry News	50
Sneak Peak.....	51
Continuing Education	52

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

Contact Kelly Quinones Miller, MA
Executive Editor, by email at

kellyq@eliresearch.com.

Mary Compton, PhD, Editorial Director

Melanie Parker, MBA, Assistant
Publisher

Rebecca Johnson, Executive Editor

Your Guide To Outcomes, Compliance & Reimbursement Success

© 2010 OASIS Alert. For Subscription Information, Call (800) 874-9180

*Strategies***CLEARLY INDICATE PATIENTS' PAIN WITH THIS EXPERT ADVICE**

► *Follow this guidance to ensure you correctly assess pain.*

Just because an item in OASIS C asks about pain doesn't mean your response should note how much pain your patient experiences. Sometimes, the point is simply whether you've asked the right questions.

For completing OASIS C, you should consider pain as "the fifth vital sign," notes **Rebecca Friedman Zuber**, a Chicago-based regulatory consultant. A patient's pain levels throughout treatment are as important as their blood pressure or temperature.

Several OASIS C items ask agencies to measure and track patient's pain, but many clinicians have some confusion about how best to use them, according to **Linda Krulish**, president of the **OASIS Certificate and Competency Board (OCCB)**. For instance, many clinicians aren't sure they should ask patients about all types of pain they experience or if the inquiry should focus only on severe, limiting pain. Similarly, should the pain assessment focus on how much pain the patient is in at that moment or on a daily basis?

Crucial: Your clinician should assess for and be concerned about **any and all** pain your patients experience, the **Centers for Medicare & Medicaid Services** states in a clarification posted on the OCCB website. They should then ensure that "all pain is documented in the clinical record and addressed in the plan of care," CMS says.

Consider this guidance for accurately measuring and reporting patients' pain:

Focus on 'Formal' to Answer M1240

While M1240 asks about your pain assessment, it is geared toward how and whether you are assessing pain — not the amount of pain a patient is in, CMS explains.

Test Your Coding Savvy ...

Question: "I've heard that the Oct. 1, 2013 ICD-10 implementation date will vary — that the new code set will phase in depending on provider type. Is this correct? If so, when will home health providers need to start using ICD-10?"

Do you know the answer? Test your knowledge before you turn to page 49 for our expert's answer.

The item wants to know whether your clinician conducted a formal pain assessment within the allowed assessment time — which is five days from the start of care (SOC) or 48 hours from inpatient discharge (ROC) — using a standardized tool.

Definition: "A standardized tool is one that includes a standard response scale (e.g., a scale where patients rate pain from 0-10)," according to Chapter 3 of the *OASIS C Guidance Manual*. However, the tool doesn't have to use the standard number rating system. You could also use a tool like the Wong-Baker scale, which uses faces (from happy to tearful) to demonstrate how a person might be feeling.

CMS doesn't force you to conduct a formal pain assessment, but you should "consider the patient's situation carefully before responding 'no' to this item because the results are crucial to care planning," stresses **Fazzi Associates** in Northampton, Mass.

Final say: For this item, you should select "No" (0) only if you didn't formally assess pain using a standardized tool. If you did use a standardized assessment tool, you would select "2" for a patient in severe pain or "1" for a patient without severe pain.

Stick To Assessment Frame For Severity

If your patients are like most in pain, they have moments when the pain is more

(continued on page 43)

(continued from page 42)

severe than others. For the purposes of M1240, you should only report the severity of pain within the assessment timeframe, CMS clarified. That means you shouldn't take into consideration that the patient was in debilitating pain during the week before the SOC. Instead, ask and report only the five days from SOC and 48 hours from ROC. The item asks for pain levels "at the time of the standardized assessment, per the assessment's scale, and the [Manual's] response-specific instructions," CMS notes.

That doesn't mean you shouldn't note patients' average pain levels. M1242 provides the perfect opportunity to record a patient's daily pain, notes Fazzi.

Think of it this way: M1242 wants to know "to what degree is pain impacting the way you do your activities of daily living," including how often it affects how you sleep, eat, socialize, or perform other regular activity, according to Fazzi's *OASIS C Best Practices* manual.

Using M1242's metric for reporting chronic or acute pain — which goes from "0" for no pain to "4" for pain all the time — allows your patients to elaborate on the results of the standardized assessment, or give a more accurate picture of their pain.

Let POC Drive M2250 Choice

Item M2250, the Plan of Care (POC) Synopsis is designed to show whether your patient's physician-ordered POC incorporates specific best practices, such as whether the patient is at risk for falls or depression. Your responses are based solely on the **presence** of orders, regardless of any assessment.

Potential problem: M2250, Row E, asks whether the POC calls for intervention(s) to monitor or mitigate pain — which can get confusing if your agency assessed the patient for pain and came up empty-handed.

Solution: Your response to this item should be based on the physician's orders — not your agency's assessment. If the physician doesn't include intervention to monitor or miti-

gate pain, you can select "No." If there are no interventions and you found no pain during assessment, you can select "NA" for "no pain identified," CMS says in its clarification.

However, if your patients' physician orders pain management/monitoring interventions, you must select "Yes" — even if your assessment indicated the patient isn't in pain.

Next step: See "Make 'Backward' Your Motto For POC Tables" on the next page for help with the tables in M2250 and M2400. ❖

Education

NOTE THESE 2 DIFFERENCES BETWEEN M2250 & M2400

► **Hint:** One hinges on changes in pain since the last assessment.

At first glance, M2250 and M2400 seem to ask the same question — are there interventions for monitoring and mitigating pain? Yet there are some key differences:

#1. You cannot select "NA" for M2400 unless you've assessed a patient's pain using a standardized tool since the last OASIS assessment, and it revealed no pain.

#2. You must select "Yes" or "No" based not only on whether intervention orders are present, but if there is evidence that they were implemented.

To correctly respond, you'll need to "review the POC and documentation in a systemic, standardized way," says **Fazzi Associates**. That includes referring to any software programs or paper tools started at the SOC that show your work at managing patients' pain.

To simplify your M2400 responses, Fazzi offers these tips:

- You can select "Yes" for ordered interventions that were later determined unnecessary
- You should select "No" for ordered interventions your patients declined to receive
- You can select "Yes" for M2400 despite a "No" answer in M2250 if you received interim orders.

(continued on page 45)

Training

MAKE ‘BACKWARD’ YOUR MOTTO FOR POC TABLES

► *Read right-to-left or risk inaccurate responses, experts warn.*

For the first time in OASIS history, you have to answer a table of questions in both M2250 and M2400 — and those tables can be quite misleading.

Problem: When you tackle the questions from left-to-right, the first response you hit is “No.” “Our industry doesn’t always read an entire item before selecting a response,” points out **Rhonda Will** with **Fazzi Associates** in Northampton, Va. In this case, without reading the entire item, a clinician could answer “No” when “NA” is more appropriate, she says.

Solution: Rather than start with the question, head to the right side of the table and start with the description of “NA,” Will suggests. Consider these two examples:

Example A (M2250): Your patient entered the episode with a pressure ulcer, but it doesn’t require moist-wound healing.

Plan/Intervention	No	Yes	Not Applicable
Pressure-ulcer treatment based on principles of moist-wound healing OR order for treatment based on moist-wound healing has been requested from physician	0	1	NA Patient has no pressure ulcers with need for moist-wound healing.

Reading strategy: Reading from left-to-right, your clinician may select “0” because the patient has no pressure ulcer that needs moist-wound healing. However, the correct response is “NA.” Answering “0” might indicate that you aren’t basing your treatment on the correct principles or that your physician hasn’t sent an order. By answering “NA,” you show clearly that there is no need for these measures.

Example B (M2400): Your patient exhibited some mild depression symptoms. After a thorough assessment, you determined she did not meet the criteria for depression. The physician agreed and didn’t order an intervention for depression.

Plan/Intervention	No	Yes	Not Applicable
Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	0	1	NA Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment.

Reading strategy: If your clinician starts answering this question on the left, she might answer “0” because no intervention was ordered. However, if she starts on the right, she’ll correctly answer “NA” because the reason there is no intervention is the patient didn’t need one, Will says.

Bottom line: Coach your clinicians to always read the item tables from right-to-left so that they can rule out applicability before they attempt to choose a “Yes” or “No” answer.

Resource: For more OASIS C tips and solutions, access Fazzi Associates’ free 45-minute webinar entitled “OASIS C Best Practices Project” at www.screencast.com/t/ZTY4YWQzNmIt or on Fazzi’s website at www.fazzi.com. ❖

**Do you have an OASIS question, comment or story to share?
Contact Kelly Quinones Miller, Editor, at kellyq@eliresearch.com.**

(continued from page 43)

Resource: For more tips, refer to Fazzi Associates' *OASIS C Best Practices Manual* at www.fazzi.com/oasis/OASIS-C_Best_Practice_Manual.pdf. ❖

Wound Care

2 QUESTIONS BOOST YOUR WOUND CODING ACCURACY

► *Make better use of valuable treatment time with this advice.*

Making the wrong assumptions about a patient's wound could determine whether or not it heals — and wasting any treatment time could be fatal.

Most clinicians would look at a wound on the side of a bed-confined patient's thigh as a pressure wound, but that simple assumption could set the tone for improper — and wasted — treatment, said **Beth Hawkins Bradley** with **Care On Call LLC** in Blythewood, S.C. at the **Eli-sponsored** audioconference, "Making Wound Care Work with OASIS C."

Bradley suggested you ask the following questions to make the correct diagnosis for a patient's wound so that you can provide effective treatment:

Question 1: What caused this wound to begin with?

If a patient's wound is located on a body area that is typically associated with pressure

wounds — such as patients' sides or backs — it's easy to assume that's the cause of the wound.

Better: Rather than jumping to that conclusion, "research the patient's history and ask questions that could bring the wound's origin to light," Bradley recommended. She offered this real-life scenario:

A clinician assessed a wound that was located on a patient's right hip as a pressure ulcer and created a treatment plan for it. During the course of treatment, the wound developed a necrotic center after having been 100-percent granular.

Bradley's approach: Rather than carrying on the pressure-wound treatment, Bradley asked the patient if he had an idea of what caused the wound to start with.

The patient then shared that he didn't know because he never lies on his side. That piece of information led Bradley to investigate the patient's history because "you can't have a pressure ulcer without pressure," she says.

"It turned out that the patient had a five-year history of lymphoma" and the wound was actually caused by the lymphoma rather than by pressure. Knowing that, the agency was able to create a better treatment plan for the patient.

Question 2: What factors are preventing the wound from healing?

Even if you've accurately diagnosed a wound, you may still find that healing comes to

(continued on page 46)

Eli's OASIS Alert — Your Guide to Outcomes, Compliance & Reimbursement Success
PO Box 90324 Washington DC 20090-0324
(800) 874-9180 FAX (847) 954-2609

Kelly Quinones Miller, MA, Executive Editor
kellyq@eliresearch.com.

Mary Compton, PhD, Editorial Director

Melanie Parker, MBA, Assistant Publisher
(919) 281-0474 x363

Rebecca Johnson, Executive Editor (888) 234-5896

Eli's OASIS Alert (USPS 022-013) (ISSN 1549-6775, for print and ISSN 1947-8763, for online), is published monthly by Eli Research, 2222 Sedwick Rd, Durham, NC 27713. Annual Subscription price is \$297.

Periodicals postage is paid at Durham, NC 27705 and at additional entry offices. POSTMASTER: Send address changes to Eli's OASIS Alert, P O Box 413006, Naples, FL 34101-3006.

To order a subscription, call **(800) 874-9180** between 8:30 am and 5:00 pm EST. Or send a check or money order for \$297 to: Eli's OASIS Alert, Eli Healthcare, P.O. Box 933723, Atlanta GA 31193-3229. © World Copyright 2010, Eli's OASIS Alert — Your Guide to Outcomes, Compliance & Reimbursement Success. WARNING: Unauthorized photocopying or e-mail forwarding is punishable by up to \$100,000 per violation under federal law. We'll share 50% of any proceeds if you report violations to Samantha Saldukas, sam@medville.com, (239) 790-3083.

(continued from page 45)

a standstill at some point during the treatment plan. Assumption comes into play here as well: “Many clinicians assume everything’s going to plan without regularly checking the parameters,” she states.

For instance, you may be correctly checking and dressing a patient’s wound, but if she doesn’t stay hydrated or understand why it’s so important that she alter her body’s position, her wound won’t be able to heal, Bradley points out.

Your job: “You have to be a private investigator and stop being afraid of snooping around a little,” she encourages. Make sure you find out whether your patient is following the guidance you’ve given her when you’re not around, that she knows how her nutrition affects wound care and why she should care, and that you know all the variables that might affect the wound’s healing.

Bottom line: Your agency’s reputation and your patient’s health care costs hinge on your ability to effectively treat wounds. Asking these two questions should get you started on the right track, Bradley says.

Resource: Order a copy of “Making Wound Care Work with OASIS C” by going to www.audioeducator.com/conference-Wound-Care-Work-with-OASIS-C-210110 or calling (866) 458-2965.

Patient Satisfaction

CAHPS DEADLINE JUST AROUND THE CORNER

► **Apply for exemption by June or face payment hit.**

If you’ve been putting CAHPS on the back burner while tackling OASIS C and other concerns, now’s the time to move it up before you get burned.

Starting in 2012, the **Centers for Medicare & Medicaid Services** will reduce home health agencies’ prospective payment system payments by 2 percent if they don’t report patient satisfaction survey data under the new

Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.

The patient satisfaction survey data will be publicly reported on Home Health Compare starting in spring 2011, noted CMS’s **Elizabeth Goldstein** at the **National Association for Home Care & Hospice’s** March on Washington annual meeting. Then the data will get updated quarterly.

Background: HHAs that participate in the CAHPS program must contract with a third party vendor to conduct patient satisfaction surveys that include 34 core required questions and nine optional ones. Agencies may also add their own unique questions to the tool, CMS explained in last year’s PPS rate update notice. Agencies must strive to obtain 300 survey completions per year.

Although 2012 sounds far away, “you need to start data collection now,” Goldstein emphasized at the meeting.

Under the CAHPS requirements, agencies must conduct a “dry run” of survey data collection in July, August, or September of this year, Goldstein said in an April 12 session. Then ongoing data collection begins in October.

“The dry run period is really valuable,” Goldstein said. Agencies can use it to iron out any kinks in the survey process with their new vendor. “If you mess up, it’s OK to mess up in the dry run period,” she reassured attendees.

Tip: There is no requirement of how much data an agency must report during the dry run, Goldstein added.

CMS has 41 vendors currently approved for CAHPS data collection, Goldstein reported.

(continued on page 48)

Newsletter Question or Comment?



If you have a question or comment about home health OASIS issues, please contact the editor, Kelly Quinones Miller, MA at kellyq@eliresearch.com.

**Do you have an OASIS question, comment or story to share?
Contact Kelly Quinones Miller, Editor, at kellyq@eliresearch.com.**

“This list will go up over time,” she predicted. But you must “look at the vendor list as soon as possible” so that you have enough time to select one in time to do the dry run,” urged **Lori Teichman** in CMS’ April 14 Open Door Forum for home care providers.

CMS began allowing CAHPS data collection in October 2009 and the first data has begun coming in, Goldstein noted.

Note: HHAs that serve less than 60 survey-eligible patients annually are exempt from the CAHPS requirement. However, they must fill out an exemption application or lose the 2 percent off their 2012 reimbursement rates.

The applications are due by June 16, Goldstein stressed. “I encourage you to get it done as soon as possible,” she told agencies. CMS has begun receiving applications already, she reported.

CAHPS Data To Hit Home Health Compare Next Spring

While CAHPS data will be reported on Home Health Compare, not every question will be listed because that would be too overwhelming for consumers, Goldstein explained.

Instead, the site will report three composite measures on care of patients, communication between providers and patients, and specific care issues. It also will display two global ratings on the agency — an overall score and a measure on patient willingness to recommend the HHA to family and friends.

CMS and its contractor are working on a risk adjustment model for the patient survey data now, Goldstein said.

For example: Patients with more education tend to be “pickier” and give agencies lower scores, Goldstein pointed out. The risk adjustment model will take such demographic information into account.

CMS and its contractor are also conducting a “mode experiment” to see whether data differs based on how it’s collected — by mail or phone. In other CAHPS settings like hospitals, phone responses tend to be more pos-

itive than mail ones, Goldstein noted. If that’s the case in home care, the risk adjustment model will take the mode into account.

Clarification: Your CAHPS survey data will still be displayed on Home Health Compare, even if you don’t reach the 300-survey goal, Goldstein pointed out in response to a question from an attendee.

As long as you survey all of your eligible patients, you won’t be held at fault if you don’t reach the 300 mark, Goldstein said in response to another question. As long as you are following the CAHPS protocols, you’ll be fine, she assured.

Tip: Your patients may have difficulty filling out the surveys, but you aren’t allowed to help them with it at all, Goldstein emphasized. That means you can’t even read the questions for them.

Unlike in some other CAHPS settings, CMS will allow a proxy to fill out the survey for the patient, she added. That means family or friends can complete the survey.

Keep in mind: If you want to opt out of the survey and take the 2-percent hit, CMS will allow it. “Agencies may still choose not to participate in the survey if they believe that the costs of participating will exceed the 2-percent reduction of the full annual payment update they would otherwise receive,” CMS stated in the 2009 PPS final rule.

CAHPS simply isn’t for everyone, notes Chicago-based regulatory consultant **Rebecca Friedman Zuber**. “It will make sense for some agencies not to do it ... because the financial hit will be less than the cost,” she observes.

However, you shouldn’t write it off forever. CMS may just make CAHPS mandatory after a test run, experts forecast, and you’ll have to scramble to catch up on the requirement. Also, because the CAHPS data will be publicly reported on Home Health Compare, you won’t look the same as your other competitors who do have data displayed, which “does not make good business sense,” warns consultant **Betty Gordon** with **Simione Consultants** in Westborough, Mass.

(continued from page 47)

Lacking that CAHPS data “will make the non-participant agencies look like they don’t care, and that will be bad in a competitive market,” Friedman Zuber stresses.

Do this: Carefully weigh the potential costs of having to catch up to the industry with the cost of implementing the survey. Now that you know pretty much what CMS is planning, the time to revisit all your options is now, industry experts urge.

More information and resources on CAHPS, including the exemption application and the list of vendors, is at www.homehealthcahps.org. ❖

Diagnosis Coding

REMOVE ANY CONFUSION FROM INPATIENT PROCEDURE CODES

► *Look no further for clarity on what the 14-day rule actually measures.*

OASIS C has been around awhile, but that doesn’t mean you feel any more at ease with the diagnosis code “M” items. Settle comfortably into completing M1012 (*Inpatient procedure*) with this expert advice:

Report All Plan-of-Care-Related Procedures

While inpatient surgical procedures have long been reported on the 485 (*Home Health Certification and Plan of Care*), the difference with M1012 is that you now need to report key inpatient procedures related to the plan of care on the OASIS, says consultant **Rhonda Will** with **Fazzi Associates** in Northampton, Mass. This includes not just surgical procedures, but medical and diagnostic procedures as well.

Key: All of the procedures you report in M1012 must be relevant to the care you plan to furnish your patient.

Don’t list a procedure from the hospital that doesn’t have an impact on the care you will

be providing, agrees consultant **Lynda Laff** with **Laff Associates** in Hilton Head Island, S.C.

The clinician should pick and choose the procedure codes that are relevant to the plan of care from the list of procedures the hospital provides, Will says.

Example: Your patient went into the hospital for congestive heart failure and had a routine colonoscopy while there. Don’t list the colonoscopy procedure code (45.23) in M1012 unless something is found that will have an impact on the care you offer, Laff says.

Best bet: If you have identified a procedure at M1012, make sure you are addressing the diagnosis related to the procedure code in your plan of care, Laff says.

Know How The 14-Day Rule Works

When reporting inpatient procedures, the patient’s inpatient discharge must have occurred sometime in the 14 days prior to the patient’s start or resumption of home care. However, the procedures you report in M1012 can take place at any time during that stay.

So your patient could have had a procedure three weeks ago, but if the discharge from inpatient care was within the last 14 days, that procedure counts — provided it’s relevant to the care you furnish, says consultant **Karen Vance** with **BKD** in Springfield, Mo.

Look Here For The Inpatient Information You Need

The procedures should be coded in the hospital, but you’ll have to learn where to look for them, Will says. And you’ll also need to learn the language of the procedures. Familiarize yourself with Volume 3 of your ICD-9 coding book, especially if you’re not used to looking up procedure codes.

This inpatient procedure information can only be as good as what your intake staff gathers, Will says. Talk to your intake staff about the importance of gathering this information. If you

(continued on page 49)

**Do you have an OASIS question, comment or story to share?
Contact Kelly Quinones Miller, Editor, at kellyq@eliresearch.com.**

*Reader Question***HERE'S HOW TO SCHEDULE YOUR ICD-10 IMPLEMENTATION**

► *Don't depend on a soft-start; get ready for this set-in-stone date.*

Question: *I've heard that the Oct. 1, 2013 ICD-10 implementation date will vary — that the new code set will phase in depending on provider type. Is this correct? If so, when will home health providers need to start using ICD-10?*

Answer: No matter where you work (home health agency, hospital, etc.), the Oct. 1, 2013 ICD-10 deadline applies to you — and your M0 coding hinges on compliance.

“I must stress quite strongly that Oct. 1, 2013 will be the date that everyone will begin to use ICD-10,” said **Pat Brooks, RHIA**, senior technical advisor with CMS, during a March 23 **Centers for Medicare & Medicaid Services** Open Door Forum call. “There will be no grace period,” Brooks said. “In other words, we will not be slipping the date beyond Oct. 1, 2013 for ICD-10 codes, and this will be a compulsory implementation of this system.”

CMS will not accept ICD-9 codes for any dates of service on or after Oct. 1, 2013, but will continue to process claims for services prior to that date “for a period of time,” Brooks said.

Sue Bowman, RHIA, CCS, director of coding policy and compliance with the **American Health Information Management Association (AHIMA)**, also aimed to dispel several other ICD-10 myths during the call:

- **Books will exist:** “One myth is that there won't be any hard copy ICD-10 code books,” Bowman said, “but that's not true. ICD-10-CM code books are actually already available from some publishers, and are of a normal, manageable size,” she said.

- **Documentation won't be overhauled:** Another myth is that insurers will require unnecessarily detailed medical record documentation. But, Bowman noted, “much of the detail contained in ICD-10-CM is already in the medical record documentation, but it's just not being utilized because it's not needed for ICD-9 coding.”

- **ICD-10 won't be user-unfriendly:** One of the bigger myths regarding ICD-10 is that the increased number of codes will make ICD-10 impossible to use. Not so, Bowman said. “Just as the size of a dictionary doesn't make the dictionary more difficult to use, a higher number of codes doesn't necessarily increase the complexity of the coding,” Bowman said. In fact, she noted, greater specificity and clinical accuracy should actually make ICD-10 easier to use. ❖

(continued from page 48)

have liaisons in the hospital, make sure they know to communicate this information.

Unfortunately, it is highly unlikely that home care coders will get the actual codes from the hospital, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of **Selman-Holman & Associates** and **CoDR – Coding Done Right** in Denton, Texas. The coding is done after the patient's discharge from the hospital in most cases, and by the time the hospital coder gets around to it, it's often

too late to do the home care coder any good, she says. So becoming familiar with Volume 3 of your ICD-9 manual is even more important.

CMS Wants You To Complete M1012

In adding M1012 to the OASIS assessment, the **Centers for Medicare & Medicaid Services** wants a more comprehensive picture of your patient's condition prior to the start of home care.

(continued on page 40)

(continued from page 49)

When your patient has a surgical procedure, it can have an impact on his health, Will says. Plus, diagnostic procedures such as an MRI (88.9x) or ultrasonography (88.7x) can validate a diagnosis, she says. For example, diagnostic tests might confirm that a cancer patient has a tumor, or show the bulging disk causing another patient's back pain.

It remains to be seen how this information will be used, Will notes. CMS wants to gather the information now, but perhaps it is trying to see what data it can use in assessing risk adjustment in the future, she says. ❖

Industry News

BRAND-NEW OASIS C GUIDANCE ON ITS WAY

► *Be on the lookout for new training opportunities, too.*

The Centers for Medicare & Medicaid Services has some news that will fall on very welcome ears — especially for agencies needing more OASIS C support.

The agency is issuing a new manual about the OASIS C process measures any day, according to CMS' Pat Sevast in the April 14 Open Door Forum for home care providers.

"This manual will provide an explanation and description of the process measure report that will be available in September from CASPER about the different process measures from OASIS C," Sevast said in the call.

And, better late than never, you will get more help from CMS on OASIS C training. CMS is developing two one-hour "Web broadcast training sessions," Sevast reported.

They will be available in late spring or early summer. CMS also may develop more Web-based training modules, she added.

• **The home health conditions of participation are back on the table once again.** The home health COPs were last proposed in March 1997, noted CMS's Pat Sevast at the National

(continued on page 50)

National HH CODING/OASIS Online Discussion Group



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

Think Out of the Box
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: www.elihealthcare.com/groups.htm.
Then go to "Join by Specialty," click on "Home Health Coding & OASIS," and fill in your details.

Great News, Subscribers!

We're pleased to announce a brand-new resource now available to you as part of your subscription to *OASIS Alert* — Eli's Home Care Connection.



This savvy new online tool gives you keyword-searchable access to your latest issues as well as free special reports, interactive tools, forums, and more. And best of all — it's free with your subscription.

Log on to www.elihomecareconnection.com today to start taking advantage of this cutting-edge new tool.

If you have questions about this or any other part of your subscription, please give us a call at 1-800-874-9180.



Your Inside connection to the Latest Home Care News & Information

Log on today for breaking news & expert insight!

**Do you have an OASIS question, comment or story to share?
Contact Kelly Quinones Miller, Editor, at kellyq@eliresearch.com.**

(continued from page 50)

Association for Home Care & Hospice's March on Washington meeting in Washington, D.C.

The COPs have been revised again and again since that time and are now on track for fall publication, Sevast told attendees at an April 12 session.

However, be aware that changes enacted in the health care reform package could take priority over the COPs finally coming out. "Anything can bump them," she said.

- **Don't worry that surveyors will be using your OASIS C data** to target survey activities any time soon. Surveyors won't get new survey instructions based on OASIS C until outcome-based quality improvement (OBQI) reports based on OASIS C are available, noted Sevast.

Right now OBQI reports are suspended during the transition to OASIS C. Process measure-based reports will be available in September and outcome-based reports will be available again in May 2011, reported CMS' **Robin Dowell** at the NAHC meeting.

Surveyors will pull your most recent OASIS B-1-based reports for surveys, Pat Sevast explained. The last B-1 reports came out April 15.

- **When you're working out your plan to transition to ICD-10** diagnosis coding, don't expect to do it in one leap.

"It's not practical to cut over to the new coding system all at once," advises technology consulting firm **CSC** based in Falls Church, Va. "Health care organizations can expect an extended transition period during which they will have to support both ICD-9 and ICD-10 coding systems," CSC says in a new report, "ICD-10 Implementation: Objects on the Horizon Are Closer Than You Think."

ICD-10's 2013 implementation date may sound far away, but health care providers should be starting their ICD-10 migration strategy now, CSC urges in the report. ❖

SNEAK PEAK

Need more home care advice and strategies? Check out our free online newswire at <http://homecarenews.inhealthcare.com>. This resource delivers fresh, relevant information on a variety of home care topics.

Act now: Here's a sneak peak at what you'll find and how you can put it to good use:

Direct Care

OLDER PERSONAL AND HOME CARE AIDES LOOKING AFTER ELDERLY

► *Labor market faces an aging workforce in short supply.*

The U.S. will have 1.2 million direct-care female workers who are 55 years and older by 2018, comprising 30 percent of the country's direct-care workforce. This increase — rising from 22 percent in just 10 years — is among the projections made by technical assistance provider **PHI** on employment demographics for direct-care workers.

Meanwhile, there is a projected 46 percent increase in demand for personal and home care aides by 2018; a 35 percent increase is expected for all direct-care workers, according to the study. In contrast, an alarmingly low growth rate of the female population aged 25-54 will decline from 14 percent in 1998 to 2 percent by 2018.

Nursing home assistants, home health aides, and personal and home care aides comprise direct-care workers.

The research figures reveal one thing of concern about the home care sector's future: tight labor resources + aging workforce = dilemma. "Older women are increasingly providing frontline services and supports for frail elders and people with disabilities to live independently and with dignity," noted PHI president **Steven Dawson**.

(continued on page 52)

(continued from page 51)

The U.S.'s entire workforce continues to grow dramatically from 3.2 million to 4.3 million workers, not to mention that these workers are also aging. Because of this, older women are expected to be more prevalent in the direct-care workforce, said PHI in a news release. A shortage in human resources further threatens the sector with a widening gap between people over 65 and women aged 24 to 44.

Despite these projections, wage — not age — might force the workers to look for better job opportunities elsewhere. For instance, the normal median hourly wage for personal and home care aides was \$9.22 in 2008, but these workers got a mere \$7.31 as a real median hourly wage, reports PHI.

Dawson urged national and state lawmakers to “work together to ensure that direct-care jobs, which are primarily funded through public dollars, are quality jobs that attract a stable, compassionate workforce.” He added that these workers play an important role in supporting elders to live independently and to continue to have meaning in their lives through healthy relationships and activities.

Females make up 90 percent of the whole direct-care workforce. While only 18 percent were aged 55 years and over in the overall female workforce, 22 percent of direct-care workers were that age in 2008. Among this

percentage, 28.1 percent are personal and home care aides.

Dorie Seavey, PhD, director of policy research at PHI, led the study by analyzing data from the **U.S. Census Bureau**, Current Population Survey (CPS), 2009, Annual Social and Economic (ASEC) Supplement, and applying the information to the **Bureau of Labor Statistics** Employment Projections Program.

Check out graphical representations of the study's results at the Chart Gallery of the PHI at phinational.org/policy/chart-gallery. ❖

Continuing Education

TAKE THE STING OUT OF OASIS' PROCEDURE CODES

► *Clear up your Appendix D confusion, too.*

OASIS C offered many new items, but procedure codes might be the trickiest — and getting them right is crucial.

There's new guidance for completing key M0 items. Learn how to approach these items in “Diagnosis Coding and OASIS C,” an audioconference presented on Wed., May 26 at 1 p.m. by **Tricia A. Twombly** with **Foundation Management Services** in Denton, Texas.

Register for the session at www.audioeducator.com/conference-Diagnosis-Coding-and-OASIS-C-260510. ❖

Order or Renew Your Subscription!

- Yes! Enter my:
 - one-year subscription (12 issues) to *OASIS Alert* for just \$297.
 - Extend! I already subscribe. Extend my subscription for one year for just \$297.

Subscription Version Options: (check one)

- Print Online* Both* (Add online to print subscription FREE)

Name _____

Title _____

Company _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

E-mail _____

To help us serve you better, please provide all requested information

PAYMENT OPTIONS

- Charge my: MasterCard VISA
 AMEX Discover

Card # _____

Exp. Date: ____/____/____

Signature: _____

- Check enclosed
(Make payable to *Eli Healthcare*)

- Bill me (please add \$15 processing fee for all billed orders)

OASIS Alert
Eli Healthcare
P.O. Box 933723,
Atlanta, GA, 31193-3229
Call: (800) 874-9180
Fax: (800) 508-2592

**Do you have an OASIS question, comment or story to share?
Contact Kelly Quinones Miller, Editor, at kellyq@eliresearch.com.**