Introduction

- Coding and OASIS go hand-in-hand, and their accuracy is critical to your agency’s success! Missing just one step could negatively impact your bottom line and quality outcomes.

- This session will provide details that will help your agency keep errors down, reimbursement up, reduce the risk of an audit, and protect your agency, if audited.

How will home health survive and thrive?
What does it take to succeed?

- Excellent assessment skills
- Interdisciplinary communication
- Supporting documentation
- OASIS and coding accuracy
- Adherence to rules and regulations
- A basic understanding of Medicare PPS

PPS is puzzling!

Some Facts about PPS

- The Balanced Budget Act of 1997 called for a change from the current cost-based reimbursement system to one that paid for services on a reasonable cost basis.
- The Prospective Payment System resulted and became the payment system for home health as of 10/01/2000.
- Home health agencies are now paid a pre-determined base payment for a 60-day episode of care for a “patient episode” versus a “per visit” rate.
- Major revisions to PPS became effective 01/01/2008.
  - Most significant impact on home care since implemented
  - Redefined OASIS items and ICD-9 codes that determine payment based on a case mix adjustment model
Case Mix Adjustment Model

- Recognizes that patients use different amounts of resources
- Predicts patient resource use based on characteristics determined by data collected using the OASIS data set
- Data elements describe three dimensions – Clinical Severity, Functional Status, and Service Utilization
- Classifies patients into case mix groups or home health resource groups (HHRGs)
  - 153 case mix weights
  - Each combination = a different weight and a different payment

Think Payment!

Ca$e Mix and Ca$e Mix Diagno$e$

PPS and Case Mix

- Payment for all Medicare providers paid on a prospective payment system is based on a case mix.
  - Home health agencies
  - Hospitals
  - Nursing homes
- CMS analyzed home care claims data and developed a list of diagnoses that require more intensive resources and contribute to the case mix.
- These are the case mix diagnoses.
22 Case Mix Diagnosis Groups

- Blindness
- Blood disorders
- Cancer & selected benign neoplasms
- Diabetes
- Dysphagia
- Gait Abnormality
- Gastrointestinal disorders
- Heart Disease
- Hypertension
- Neuro 1 (Brain)
- Neuro 2 (Peripheral)
- Neuro 3 (CVA)
- Neuro 4 (MS)
- Ortho 1
- Ortho 2
- Psych 1 (Affective)
- Psych 2 (Degenerative)
- Pulmonary disorders
- Skin 1 (Trauma, burns, post-op complications)
- Skin 2 (Ulcers, abscesses)
- Tracheostomy care
- Urostomy/Cystostomy care

Case Mix Diagnoses = Potential Points

- The 22 case mix diagnosis groups can earn case mix points when coded in:
  - M1020a, Primary diagnosis
  - M1022b-f, Other (Secondary) diagnoses
  - M1024, Payment diagnoses (acute fractures only)
- Case mix diagnoses and groups can be found in Table 3B and may also be identified in the coding manual.
- The number of case mix points earned is based on Table 3 – Case Mix Adjustment Variables and Scores.
- Case mix diagnosis points contribute to the clinical severity dimension when calculating the HHRC.

Case Mix Points

Primary and Secondary Diagnoses
Diagnosis Interactions
Diagnosis/OASIS Interactions
Case Mix Diagnosis Points

- Case mix points are earned for primary and other (secondary) diagnoses.
- Three diagnosis groups yield varying case mix points depending on primary or secondary status:
  - Diabetes
  - Neuro 1 (Brain and paralysis)
  - Skin 1 (Traumatic wounds, burns, and postoperative wound complications)
- Points are counted only once for the same diagnosis group by the Grouper and the Grouper Fairy.

How do we get the points?

- Case mix points = the HHRG and are determined by:
  - Certain OASIS data items in the three dimensions
    - Clinical Severity: C1 – C3
    - Functional Status: F1 – F3
    - Service Utilization: S1 – S5
  - Primary versus secondary diagnosis
  - Diagnosis interactions
  - Diagnosis and OASIS interactions
  - Early versus later episode
  - Number of therapy visits
- Based on Table 3...
  - See HHRG worksheet

Let’s take a look at Table 3 (effective 01/01/12)...

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>EQ 1 Early</th>
<th>EQ 2 Early</th>
<th>EQ 3 Later</th>
<th>EQ 4 Later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>13</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Skin 1 (Traumatic wounds, burns, post-operative complications)</td>
<td>10</td>
<td>20</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Skin 1 (Traumatic wounds, burns, post-operative complications)</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
### Primary or Other Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>EQ 1 Early 0-13 T</th>
<th>EQ 2 Early 14+ T</th>
<th>EQ 3 Later 0-13 T</th>
<th>EQ 4 Later 14+ T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness/Low vision</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Blood Disorders</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancer, selected benign neoplasms</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Heart disease or Hypertension</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Neuro 3 (Stroke)</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psych 1 (Affective &amp; other psychoses, depression)</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Psych 2 (Degenerative &amp; organic psychiatric disorders)</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Pulmonary disorders</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Skin 2 (Ulcers &amp; other skin conditions)</td>
<td>6</td>
<td>12</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Urostomy/Cystostomy</td>
<td>6</td>
<td>22</td>
<td>4</td>
<td>22</td>
</tr>
</tbody>
</table>

### Diagnosis to Diagnosis Interactions

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>EQ 1 Early 0-13 T</th>
<th>EQ 2 Early 14+ T</th>
<th>EQ 3 Later 0-13 T</th>
<th>EQ 4 Later 14+ T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysphagia</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Neuro 3 (Stroke)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Neuro 1 (Brain) or Neuro 2 (Peripheral) or Neuro 3 (Stroke) or Neuro 4 (MS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diagnosis and OASIS Interactions

<table>
<thead>
<tr>
<th>Diagnosis and OASIS data item/answer</th>
<th>EQ 1</th>
<th>EQ 2</th>
<th>EQ 3</th>
<th>EQ 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysphagia &amp; M1630 = 3</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gastrointestinal &amp; M1630 = 1 or 2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neuro 1 &amp; M1840 = 2 or more</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Neuro 1 or 2 &amp; M1810 or M1820 = 1, 2, or 3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Neuro 3 &amp; M1820 = 1, 2, or 3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Neuro 3 &amp; M1860 = 4 or more</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neuro 4 or M1830 or M1840 or M1850 = 2 or more or Neuro 4 &amp; M1860 = 4 or more</td>
<td>3</td>
<td>12</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Ortho 1 or gait disorder &amp; M1324 = 1, 2, 3, or 4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ortho 1 or 2 &amp; M1030 = 1 or 2</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pulmonary &amp; M1860 = 1 or more</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Skin 1 or 2 &amp; M1030 = 1 or 2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Case mix points are received if a patient’s primary or secondary diagnosis is a malignant brain neoplasm (Neuro 1) and the patient is unable to get to and from the toilet or bedside commode and transfer on and off safely (M1840 = 2 or more). Either 3, 5, or 8 case mix points are earned, if it is the primary diagnosis. In addition, 3 or 10 points are gained for the diagnosis and OASIS interaction, depending on the episode and the number of therapy visits.

Mr. G had a stroke 6 months ago and is having increased swallowing problems. He choked on food and was taken to the hospital where he was diagnosed with aspiration pneumonia and oral phase dysphagia, a late effect of his CVA. He also has unstable hypertension and a cystostomy that became irritated while he was in the hospital. Nursing will assess his respiratory and cardiac status and provide care to his cystostomy, which he’s unable to do because of his poor vision. He has macular degeneration and is legally blind. Speech therapy will be the primary focus for management of his dysphagia.
Case Mix Points for Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>EQ 1</th>
<th>EQ 2</th>
<th>EQ 3</th>
<th>EQ 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020a: 438.82, Dysphagia, LE of CVA</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>M1022b: 787.21, Dysphagia, oral phase</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M1022c: 401.9, Hypertension, unspecified</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M1022d: 369.4, Legal blindness</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>M1022e: 369.50, Macular degeneration</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M1022f: V55.5, Attention to cystotomy</td>
<td>6</td>
<td>22</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Other: V12.61, History of pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total points:</td>
<td>11/C3</td>
<td>31/C3</td>
<td>7/C3</td>
<td>31/C3</td>
</tr>
</tbody>
</table>

Note: If the status code, V44.50, is assigned – not a case mix diagnosis and no supply points will be earned.

Now, let's look at Mrs. M...

Mrs. M was admitted for nursing due to worsening of her emphysema and has dyspnea with moderate exertion when performing her ADLs and walking less than 20 feet using her walker. She also has atrial fibrillation, which required a change in medication while she was in the hospital. She said she’s “feeling down” about being hospitalized again, but denies being depressed. She’s on an antidepressant and a history of depression is documented in the H&P. She also said she’s incontinent at night because she can’t get to the bathroom in time.

- Functional score = F2
- No therapy = S1
- 1st Medicare episode of care = Equation 1, low therapy

Per assessing clinician...

<table>
<thead>
<tr>
<th>Data Items</th>
<th>Diagnoses and OASIS Items</th>
<th>Case Mix Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020</td>
<td>492.8, Emphysema</td>
<td>1</td>
</tr>
<tr>
<td>M1022</td>
<td>427.31, Atrial fibrillation (427.31)</td>
<td>0</td>
</tr>
<tr>
<td>M1400</td>
<td>Dyspnea = 2&quot; (walking &lt; 20 feet)</td>
<td>2</td>
</tr>
<tr>
<td>M1860</td>
<td>Emphysema + Ambulation = 1 or &gt;</td>
<td>1</td>
</tr>
</tbody>
</table>

Clinical Points (ICD-9-CM and OASIS): 4

HHRG: C1F2S1
After review...

<table>
<thead>
<tr>
<th>Data Items</th>
<th>Diagnoses and OASIS Items</th>
<th>Case Mix Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020</td>
<td>Emphysema (492.8)</td>
<td>1</td>
</tr>
<tr>
<td>M1022</td>
<td>Atrial fibrillation (427.31)</td>
<td>0</td>
</tr>
<tr>
<td>M1022</td>
<td>Depression NOS (311)</td>
<td>3</td>
</tr>
<tr>
<td>M1400</td>
<td>Dyspnea = 2 (walking &lt; 20 feet)</td>
<td>2</td>
</tr>
<tr>
<td>M1860</td>
<td>Emphysema + Ambulation = 1 or &gt;</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Clinical Points (ICD-9-CM and OASIS)</td>
<td>7</td>
</tr>
<tr>
<td>HHRC</td>
<td>C2F2S1</td>
<td></td>
</tr>
</tbody>
</table>

What if Mrs. M also has a pressure ulcer?

Non–Routine Supplies (NRS)

- Diagnoses
  - Skin conditions such as abscesses, cellulitis, gangrene, chronic ulcers, trauma wounds, burns, post-op complications, and care of tracheostomy, cystostomy, and urostomy

- OASIS data elements
  - Pressure ulcers, stasis ulcers, surgical wounds, ostomy for bowel elimination, therapy at home (IV, parenteral, or enteral), urinary catheter, and bowel incontinence

See NRS worksheet
More about NRS...

- Placement of diagnoses as primary or secondary may affect NRS points.

- Diagnoses must support OASIS data items related to NRS – for example, if a pressure ulcer is identified in M1308 or M1322, it should be coded in M1020, M1022, or as an additional diagnosis.

- NRS points are cumulative and payment is in addition to the HHRG payment, which could add hundreds of dollars to the episode payment!

Clinicians must...

- Determine correct diagnoses and sequencing
- Understand the underlying etiology of ulcers
- Correctly stage pressure ulcers
- Accurately describe the healing status of pressure ulcers, stasis ulcers, and surgical wounds
- Have supporting and consistent documentation!

> Resource: www.wocn.org

Coding and OASIS fit together!
What does CMS say?

- Appropriate coding practices will ensure the integrity of the home health diagnoses assigned to the OASIS.
- Avoid the practice of allowing the case mix status of a diagnosis to influence the diagnosis selection process.
- Staff members are expected to report any indication of fraudulent coding directly to the administrator of the HHA.
- Each patient’s overall medical condition and care needs must be comprehensively assessed before the HHA selects and assigns the OASIS diagnoses.

(OASIS-C Guidance Manual)

First step…

**Comprehensive Assessment!**

- Is NOT the OASIS assessment, but INCLUDES the OASIS assessment!
- Establishes the blueprint for the plan of care and the baseline from which outcomes of home health services will be determined
- Must assess many aspects of the patient’s situation rather than only his/her “disease”
- Required for all home health patients under the Medicare Condition of Participation §484.55
About the Assessment

- It is **not** a series of checkboxes alone!
  - Patients do **not** fall neatly into specific categories or choices.
  - It requires explanation and expansion on what the patient can and cannot do within the assessment areas.
  - It should provide a clear reflection of each individual patient.
- Just as we are uniquely different individuals, so are each of our patients!
- There needs to be a history and summary of key facts which must support the necessity of **skilled** home health services and the diagnoses selected.

Next...

*Determine the relevant diagnoses and procedures.*

The Coding Challenge

- Home health coding has unique challenges, since agencies frequently receive little or no information about the patient's medical condition.
- Agencies need to look to many sources for clues and necessary information to code each patient's health status accurately and completely.
Sources of Information

- Inpatient facility documentation
  - Admission note/History & Physical
  - Consultations
  - Operative note
  - Laboratory reports
  - Discharge summary
- Physician office medical record
- Intake/Referral form
- Admission process
  - Nursing/Therapy evaluations
  - Standardized assessments for high risk areas, such as falls, skin breakdown, pain, and depression
  - Medication profile

Assessment Documentation

- A brief history of the patient’s health status.
- Detailed description of findings that support the diagnoses selected and the services to be provided.
- A review of the associated diagnosis for all medications.
- Hints in the medication review and OASIS item responses may indicate additional diagnoses and should be further evaluated but, alone, cannot establish a diagnosis.

Then...

- Following the assessment, documentation must confirm communication/collaboration with the MD to:
  - Clarify/confirm diagnoses
  - Determine if manifestations, such as neuropathy and PVD, are due to diabetes or are co-morbidities in addition to diabetes
  - Confirm the specific type of wound – e.g., whether ulcers are pressure, arterial, stasis, diabetic, or chronic
  - Verify any wound complications – e.g., infection, dehiscence, non-healing
  - Reconcile medication issues
  - Discuss POC for his/her review and agreement
  - Receive continuing orders for patient’s POC

**DOCUMENT all communication with the physician!**
Diagnosis Coding

- Diagnosis coding is a key component in the plan of care and plays a critical role in determining episode payment as well as patient outcomes.
  - The main purpose of diagnosis codes is to provide an updated, accurate picture of the patient’s health status that requires referral to home care, the need for skilled services or recertification.
  - Diagnosis code selection should be determined based on the “seriousness” of the diagnoses as they relate to the care plan and not on payment considerations.
- Coding must be in compliance with official sources!

Official Sources

- Coding Guidelines and Conventions
- OASIS–C Guidance Manual
  - Chapter 3 – Data Items
  - Appendix D – Diagnoses
- Coding Clinic
  - Published quarterly by the American Hospital Association
  - Approved publication by CMS
- Medicare Benefit and Claims Processing Manuals
- Other CMS Guidance
  - PPS Final Rules
  - CMS Q&As – January, April, July, and October
  - www.qtsco.com/hhadminload.html
  - www.oasisanswers.com
Per CMS...

- Only the assessing clinician can determine the primary and secondary diagnoses and assign the symptom control rating based on the actual assessment findings.
- Coders are allowed to assign the actual ICD-9-CM codes and review the record for consistency, but not allowed to change the sequencing of diagnoses, even if only to follow the guidelines, unless the assessing clinician is notified and agrees.

> Documentation of communication is imperative!

Selecting and Sequencing Diagnoses

- Following the comprehensive assessment, determine the diagnosis that is chief reason for home care.
- The primary diagnosis represents the most “serious” condition requiring the most intensive skilled services.
  - Ensure that the POC and visit notes clearly address this diagnosis as the focus of care.
- Identify “other” diagnoses (co-morbidities) that may impact healing or recovery or will require:
  - Monitoring
  - Evaluation
  - Active treatment

More guidance...

- Assign V codes that further define care, such as aftercare, attention to, or admission for therapy.
- Sequence the diagnoses according to their “seriousness” related to the care plan.
- Ensure that coding guidelines, OASIS requirements, and the 2013 PPS instructions for M1024 are followed:
  - Etiology/manifestation rules
  - Coding only “active” diagnoses
  - Only acute fractures qualify to earn case mix points in M1024, when paired with the appropriate V code (V54.1 and V54.2).
- Onset and exacerbation dates are not mandated by CMS.
- Coding procedures in M1012 is not required.

> REMEMBER: Coding co-morbidities helps to portray the complexity of the patient’s condition and to support the services provided, and may impact reimbursement!
Let’s look at Mr. Z...

Mr. Z was referred for PT and OT following an acute CVA with hemiplegia of the dominant side. The referral states he also has HTN, CHF, diabetes, and depression.

His blood pressure was elevated in the hospital and he was placed on Enalapril 10 mg. po daily.

He is 68 years old and has always been very active in community activities and maintaining the exterior of his house and 2 acre yard.

The intake staff asked about the need for nursing. The MD declined saying Mr. Z’s blood pressure is now under control, and he only needs therapy.

The PT assessment determines...

- Mr. Z’s blood pressure was 170/85, and he said he was instructed about his new medication in the hospital and understood what it was for and how to take it.
- He has dyspnea with moderate exertion and 1+ edema of his lower extremities.
- He has had diabetes for years, but he has never taken any medication for it...just watches what he eats.
- He had a positive screening for depression using the PHQ-2 scale at M1730 and is on an antidepressant.

More findings...

- Functional assessment:
  - M1800 Grooming: 2, requires assistance
  - M1810/M1820 Dressing: 2, requires assistance
  - M1830 Bathing: 5, unable to get into shower/tub and requires assistance with bath
  - M1840 Toilet transferring: 2, uses BSC
  - M1850 Transferring: 2, unable to transfer self
  - M1860 Ambulation: 3, requires supervision or assistance at all times
- This is his first Medicare episode of care, and 10 PT and 6 OT visits are ordered (Equation 2).
Mr. Z: Coded Correctly

<table>
<thead>
<tr>
<th>M Item</th>
<th>ICD-9-CM Code and Diagnosis</th>
<th>Case Mix Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020</td>
<td>V57.89 Admission for multiple therapy</td>
<td>0</td>
</tr>
<tr>
<td>M1022</td>
<td>438.21 LE CVA hemiplegia, dominant side</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>with M1810/1820 dressing: score of 2</td>
<td>3</td>
</tr>
<tr>
<td>M1022</td>
<td>250.00 Diabetes w/o complications</td>
<td>13</td>
</tr>
<tr>
<td>M1022</td>
<td>401.9 Hypertension</td>
<td>0</td>
</tr>
<tr>
<td>M1022</td>
<td>428.0 CHF</td>
<td>6</td>
</tr>
<tr>
<td>M1022</td>
<td>311 Depression</td>
<td>6</td>
</tr>
</tbody>
</table>

Clinical Severity Points (ICD-9-CM and OASIS) = 31 points = C3
Functional Status Points (OASIS) = 12 points = F3
Service Utilization Points (OASIS) = 16 therapy = S2
Clinical, Functional & Service Utilization Score = C3F3S2
Case weight for the episode = 2.4603
Reimbursement for C3F3S2 = $5,261.40

Justification for Coding Co-morbidities

• Under Standards of good practice, we would expect the therapist to take the BP and ask about blood sugars on each visit to evaluate the effect of the increased exercise on the HTN and diabetes, as well as monitoring the impact of the depression on the patient’s motivation to participate in the rehabilitative therapy program.

Coder only codes therapy diagnoses...

<table>
<thead>
<tr>
<th>M Item</th>
<th>ICD-9-CM Code and Diagnosis</th>
<th>Case Mix Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020</td>
<td>V57.89 Admission for multiple therapy</td>
<td>0</td>
</tr>
<tr>
<td>M1022</td>
<td>438.21 LE CVA hemiplegia, dominant side</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>with M1810/1820 dressing: score of 2</td>
<td>3</td>
</tr>
</tbody>
</table>

Clinical Severity Points (ICD-9-CM and OASIS) = 5 points = C1
Functional Status Points (OASIS) = 12 points = F3
Service Utilization Points (OASIS) = 16 therapy = S2
Clinical, Functional & Service Utilization Score = C1F3S2
Case weight for the episode = 2.0252
Reimbursement for C1F3S2 = $4,330.93
Difference between C3 and C1 = $930.47

See HHRG Rates
Understanding OASIS–C

Ignoring ≠ Innocence

OASIS is Key!

Understanding the OASIS is critical ~

IT’S LIKE ROCKET SCIENCE!

Knowledge and precision are the keys to success!
Painting the Picture

Every answer to an OASIS question is a brush stroke painting the picture of the patient!

Why OASIS Is So Challenging

- Multiple uses of the tool:
  - Data collection
  - Quality measurement
  - Reimbursement
- Guidance not always clear...is sometimes confusing
- Requires significant depth of knowledge
- Political climate related to Medicare, CMS, and provision of home health care
- Pressure to "get it right" for:
  - Staying compliant with rules and regulations
  - Best possible reimbursement for care provided

$$$ OASIS Data Items that Impact Payment

- M0110 (Episode timing)
- M1020 (Primary diagnosis)
- M1022 (Secondary diagnoses)
- M1024 (Payment diagnoses)
- M1030 (Therapy at home)
- M1200 (Vision)
- M1242 (Pain)
- M1308 (Number pressure ulcers)
- M1324 (Most problematic stage)
- M1334 (Stasis ulcer status)
- M1342 (Surgical wound status)
- M1400 (Dyspnea)
- M1620 (Bowel incontinence)
- M1630 (Bowel ostomy)
- M2030 (Injectable drug use)
- M1810 or M1820 (Dressing)
- M1830 (Bathing)
- M1840 (Toileting)
- M1850 (Transferring)
- M1860 (Ambulation)
- M2200 (Therapy need)
OASIS, Coding, MD orders and Documentation... keys to the POC!

The Plan of Care

Documentation is the key to successful medical reviews.

Plan of Care Requirements

- Medicare Condition of Participation §484.18(a) Standard: Plan of Care
  "If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan."

- Documentation must support the physician's collaboration and agreement with the POC.
- Diagnoses coded and OASIS responses form the blueprint for the POC.
- The POC should be patient-specific based on the comprehensive assessment and codes assigned.
Supporting Documentation

- Diagnoses assigned to the OASIS and POC must be included in physician documentation or confirmation must be documented in the medical record.
- The medical record must clearly show how the diagnoses affect each another, support the skilled services provided, and impact the POC.
- Appropriate OASIS data items must support the diagnoses coded.
- The POC must have interventions related to each of the top six diagnoses (at a minimum).

Are you managing your coding and OASIS processes?

- Are your processes compliant with the rules and regulations?
- Are clinicians who complete OASIS assessments and assign diagnosis coding competent?
  - How do you know?
- Does your staff have the tools and education that they need to get it right?
- Is your revenue being impacted by your processes?
- Are audits being done on a regular basis?

More questions to ask...

- Do you foster and embrace an environment of compliance/accountability in your agency?
- Do you share results among your staff?
- Are you at risk for claim denial and fraud and abuse allegations?
- Are you measuring and managing the right things?
- Are you complying with CMS expectations?
CMS Expectations for OASIS

- Medicare Home Health Care Conditions of Participation §484.20(b) Standard:
  - Accuracy of encoded OASIS data stipulates that the encoded OASIS data must accurately reflect the patient’s status at the time the information is collected.
- Once the qualified skilled professional completes the assessment, the HHA should develop a means to ensure that the OASIS data input into the computer and transmitted to the State agency (or CMS contractor) exactly reflect the data collected by the skilled professional.
  
  (OASIS-C Guidance Manual: Appendix B)

More expectations...

- There should be congruency between documentation of findings from the comprehensive assessment and the plan of care.
- Since OASIS data may be used to determine incentive payments under a quality–based purchasing program, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete.
- Agencies will develop internal systems for monitoring data accuracy. These may include clinical record audits, data entry audits, and other activities.
  
  (The OASIS-C Guidance Manual)

And more expectations...

- Minimizing data errors that could affect accuracy of clinical data or outcome analyses is a necessary condition.
- This function is the responsibility of the agency.
- Internal staff development and training must focus on data accuracy not only at the start-up of OASIS data collection, but on a continuing basis.
- CMS recommends that data quality audits be conducted in agencies on a routine basis.
  
  (OASIS-C Guidance Manual, Appendix B)
Data Quality Audits

- Clinical Record Audit – 5 SOC and 5 DC per month
  - Verify accuracy of OASIS patient status items compared to other related patient documentation.
  - Review for systematic bias – positive or negative.
- Data Entry Audits – 5 records per month
  - Clerical and/or clinical staff entry of data
  - May enter each record x 2 or compare hard copy
- Clinical Visit Audits – 3 to 4 per quarter
  - Supervisor or peer in home parallel OASIS responses

(OASIS-C Guidance Manual, Appendix B)

Coding Audits

- Conduct coding audits at least twice a year.
  - More frequently if you outsource the coding
- Be sure your staff is coding to describe the patient’s condition – Not Coding for Payment!
- Be sure the medical record supports the diagnoses.
  - Is the primary diagnosis really the one that is the focus of care in the POC and notes?
  - Are the diagnoses listed in order of their seriousness to the patient’s condition and the POC?
  - Has the MD confirmed the diagnoses?
  - Are there too many symptom codes or vague diagnoses?
  - Are at least the top six diagnoses addressed in the POC?

Audit is NOT a dirty word!

- Auditing is a formal process of evaluating:
  - Processes
  - Patient outcomes
  - Systems and/or
  - The organization
- The goal is to provide reasonable assurance that an organization’s processes and systems are working as they are supposed to.
Audits are like washing clothes!

› You need to do audits regularly.
› Doing them helps ensure processes are clean!

View Audits as Opportunities

› To increase coding and OASIS competency and efficiency
  • Focus on each clinician’s needs.
  • Ensure that coding and OASIS training is ongoing!
› To increase billing competency and efficiency – especially pre-billing audit process
› To increase staff understanding of Medicare rules/regulations
› To improve clinical record documentation

More opportunities...

› To integrate the pre-billing audit with clinical record review for medical necessity and congruence with the plan of care.
› To review/address high risk or vulnerable areas
› To enhance the agency’s existing compliance plan and increase awareness of the plan

Learn from your mistakes!

Create winners…celebrate your staff’s success!
Auditing and Monitoring

- Can save/find money for the agency and prevent future financial problems
- Can provide opportunities to improve care and patient outcomes
- Should be the basis for education of staff, reviewers, and educators, improving staff satisfaction
- Should be focused on basic management and quality of care issues
- Should NOT be a burden – keep it simple (KISS)!

Simple (KISS) Audit

- Make the audit simple and quick.
  - Perform a small number at a time (e.g., 5/month).
  - Limit the number of indicators.
  - Once compliance is achieved for an indicator, move on to another one.
- Make the audit part of the QA and compliance process.
- Use data to provide agency leadership with information as to steps to take next (plan of action):
  - Staff education
  - Corrections to clinical record
  - Claim adjustments

Use Regulations to Guide You

- Medicare Benefit Policy Manual
- OASIS-C Guidance Manual
  - Chapter 1: Introduction
  - Chapter 3: Item-specific Guidance
  - Appendix B: OASIS Data Accuracy
  - Appendix D: Selection and Assignment of OASIS Diagnosis
- ICD-9-CM Official Guidelines for Coding and Reporting
- Medicare Home Health Care Condition of Participation §484.20(b) Standard: Accuracy of Encoded Data
Key Questions

- Were coding guidelines and CMS guidance followed?
- Does documentation and the POC support the primary diagnosis selection?
- Are secondary diagnoses coded in M1022 addressed in the POC?
- Is there any evidence of “upcoding” or “downcoding”?
- Are the elements within the record consistent with each other – comprehensive assessment, OASIS, coding, POC, and other documentation?
- If compliance is below the threshold(s) set, what is the correction plan?

Corrections to OASIS

- The comprehensive assessment, including the OASIS, can only be completed by one person.
- It is a legal document and when signed by a clinician, the signature is an attestation that all contained in the document is truthful and accurate.
- If an error is discovered upon review by a supervisor or other auditing staff and it can be validated that it is a true error and not just a discrepancy (a difference between two data items without knowledge of which data item is correct), that error should be corrected following the agency’s correction policy and established professional medical record documentation standards.

Correction Process

- Must follow agency and CMS policy.
- Should be agreed to by the clinician responsible for the assessment and concurrence documented.
- Should be documented by the person making the change, if not the assessing clinician.
- Process must follow established medical record documentation standards for late entries or changes to the record.
- Documentation of changes should be found in the record (transparency).
Avoiding Red Flags

If it’s important enough to code, it’s important enough to address in the POC!

If the agency is getting case mix points and payment for a code or an OASIS response, then CMS expects you will do something about it!

Doing something means documenting what you found, including it in the POC, and implementing interventions based on the POC.

How can you avoid denials?

- Do not believe the mythology that care is covered because that’s the way we’ve always done it, or that’s what the doctor ordered, or that’s what the patient needs!
  - Keep up-to-date with current rules and regulations.
  - Follow all the rules.
  - Train staff on the rules.
- Think…are the services being provided reasonable and necessary for the patient?
- DOCUMENT to support physician involvement in the POC, medical necessity, and compliance!

Keep Your Eye on Compliance

- Congruency and consistency within the record is key to maintaining a compliant record:
  - Diagnosis codes
  - OASIS responses
  - Physician orders and POC development
  - Clinical notes as part of comprehensive assessment
  - Visit notes by skilled clinicians that support ongoing skill and medical necessity
- The challenge for agencies is to get their documentation right for the right reason… the patient!
The key to improved patient care and outcomes is an accurate OASIS assessment and comprehensive POC based on the patient’s needs, problems, and condition.
- Focus on the patient
- Be compliant with the rules and guidelines
- DOCUMENT, DOCUMENT, DOCUMENT!

Agencies that are up-to-date and compliant with OASIS, coding, and documentation stand to benefit in two areas:
- Outcomes
- Income

The secret to a good outcomes and good income is a great front line who follows the rules.

When the patient wins... the agency wins!

This is your opportunity to...
ask questions about anything we have or have not discussed!
Thank you for attending!

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