Why Does Documentation Matter?

• CMS Requirements (CoPs)
  – Homebound status
  – Medically reasonable and necessary
  – Intermittent skilled care
• Reimbursement support
• Legal considerations
• Interdisciplinary coordination
• Specific detail for ICD-10 coding

Pre-Claim Review Demonstration

• OIG and MedPAC investigations have found “extensive evidence of fraud and abuse in the Medicare home health program, in particular, in the chosen demonstration states”
• The Medicare improper payment rate for home health services has increased in the past three years:
  – 17.3 percent in 2013
  – 51.4 percent in 2014
  – 59 percent in 2015 (primarily due to “insufficient documentation” errors, especially to support medical necessity of services)
Improper Payments

• This “improper payment rate” is from the CMS Comprehensive Error Rate Testing (CERT) program’s estimation of payments that did not meet Medicare coverage, coding and billing rules
• CMS notes: while all payments made as a result of fraud are considered “improper payments,” not all improper payments constitute fraud

Demonstration Project

• CMS is implementing a 3 year Pre-Claim Review Demonstration project in five states identified as having a high percentage of “improper payments”
• Applies to Home Health agencies providing services to Medicare fee-for-service beneficiaries in these five states
• Goal: reduce current practice of “pay and chase” for inappropriate billing
• Participation in the PCR demonstration project is “voluntary” – but not really!

Demonstration States

• Illinois starting August 1, 2016
  – Episodes of care with “from” date on the certification period on or after August 3
• Florida not earlier than Oct. 1, 2016
• Texas not earlier than Dec. 1, 2016
• Michigan and Massachusetts not earlier than January 1, 2017

Total Length of Stay (LOS)

<table>
<thead>
<tr>
<th>State</th>
<th>Median LOS</th>
<th>Mean LOS</th>
<th>Number of Beneficiaries</th>
<th>Number of Claims</th>
<th>% SSI</th>
<th>% Diabetes</th>
<th>% Vague Therapy</th>
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<td>177.8</td>
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<td>1,1975,008</td>
<td>4.0</td>
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</table>
Pre-Claim Review

- Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment.
- Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

Per CMS...

“The pre-claim review demonstration does not create new documentation requirements, but simply requires currently mandated documentation earlier in the claims payment process. In addition, there are no changes to the home health service benefit for Medicare fee-for-service beneficiaries.”

CMS REGULATIONS

Homebound Status, Skilled Care and Medical Necessity, and Coordination of Care
Medicare Requirements for the Home Health Benefit

• To qualify for the Medicare Home Health benefit, under 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, a Medicare beneficiary must meet all of the following requirements:
  – Be confined to the home at the time of services
  – Be under the care of a physician
  – Receive services under a POC established and periodically reviewed by a physician
  – Be in need of skilled services
  – Have a face-to-face encounter with a medical provider as mandated by the Affordable Care Act

Homebound Definition

• An individual is considered “confined to the home” if the following 2 criteria are met:
  Criteria-One (ONE must be met):
  – Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
  OR
  – Have a condition such that leaving his/her home is medically contraindicated

If the patient does leave home...

• Absences must be infrequent or for periods of relatively short duration, or to get health care treatment, including but not limited to:
  – Attendance at adult day centers to receive medical care
  – Ongoing receipt of outpatient kidney dialysis
  – Receipt of outpatient chemo or radiation therapy
• Absences to attend a religious service
• Occasional trips to the barber, a walk around the block or a drive
• Attendance at a family reunion, funeral, wedding, graduation or other infrequent or unique event

Homebound Definition

• After the patient meets ONE of the Criteria-One conditions, the patient must ALSO meet two additional requirements defined in Criteria Two (BOTH must be met):
  – There must exist a normal inability to leave home
  AND
  – Leaving home must require a considerable and taxing effort
CMS Examples

- Paralyzed due to stroke
- Blind and senile
- Loss of UE use
- Last stages of neurodegenerative disabilities
- Post-op weakness/pain, restrictions
- End-stage ASHD
- Psychiatric illness

CMS says...

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of this reimbursement unless they meet one of the above conditions.

Homebound Status

- May use check boxes with CMS criteria
  - Must use supportive devices to leave home
  - Requires assistance of another person to leave home
  - Requires special transportation to leave home
  - Leaving home is medically contraindicated
  - Has a normal inability to leave home
  - Requires considerable and taxing effort to leave home
- Must add narrative requirements
  - Support check box statements
  - Must include details specific to patient visit
  - Avoid repetitive statements

Homebound Specific Details

- Requires supportive device to leave home
  - Requires assist of one with transfers and uses wheeled walker to ambulate short distances of 10-15 feet
  - Gait unsteady without use of cane, hx of 2 falls in past wk
  - Wife must remind patient to use walker for ambulation
  - PT plan of care includes gait training with crutches as pt currently unsafe with use of device w/o assistance
**Homebound Specific Details**

- **Unable to leave home unassisted**
  - Patient requires supervision to leave home due to mental status, confusion and forgetfulness
  - Requires hands-on assist of 1-2 people to negotiate seven steps in/out of home
  - Patient needs assist of son and use of wheelchair to get to physician appointments
  - POC includes PT for gait training and strengthening as patient must be able to walk 150 ft to ALF dining room and to evacuate building in case of emergency
  - SN called Para-quad and set up handicapped assisted van to transport patient to physician appointment

- **Leaving home medically contraindicated**
  - Pt cannot leave home w/out respiratory barrier due to risk of infection while on chemo
  - Pt at high risk for infection/complications due to long-term steroid treatment for repeated asthma exacerbations, hx of recurrent pneumonia
  - Pt under physician order to keep LLE elevated at all times due to DVT
  - Pt NWB on RLE due to explantation right knee prosthetic joint for infection, w/c bound due to inability to ambulate while maintaining NWB status

- **“Normal inability” to leave home**
  - ALS limits any coordinated movement of UE and LE, and patient unable to tolerate sitting more than a few minutes
  - Patient must stop to rest and catch her breath during dressing activities, takes almost an hour to complete sponge bath and dressing due to severe CHF
  - Requires assistance with meal prep, must stop and rest while eating meal due to dyspnea; SOB while talking, must pause during conversation to catch her breath
  - Patient’s agoraphobia prevents her from leaving her house, suffers panic attacks when she attempts to go outside home

- **Taxing effort to leave home**
  - Requires assist of daughter to go to physician appointments, riding in car causes severe back pain partially relieved by Percocet, on return home patient has to rest in bed due to pain and exhaustion
  - Able to ambulate short distances in home with walker, but requires wheelchair and assist of one to leave home, POC includes PT for gait training with walker and transfer training in/out of wheelchair, safety measures to lock w/c
  - Daughter took pt to doctor appointment yesterday and pt refuses PT visit today since too tired and still in bed
Skilled Care Requirement

• Based on objective clinical evidence regarding patient’s individual need for care
• Care must be provided by professional nurse or therapist to be safe and effective
• Skill can be determined by:
  – Complexity of the care
  – Condition of the patient
  – Accepted standards of practice

Reasonable & Necessary Requirement

• Care must be consistent with nature and severity of patient’s illness/injury and accepted standards of practice
• Consider condition of patient at time services were ordered and reasonable expectation of appropriate treatment for illness/injury during certification period

Patient Condition Considerations

• Structural impairments
• Functional impairments
• Activity limitations
• Performance limitations
• Comorbidities and secondary diagnoses

Failed Medical Necessity Examples

• New medications ordered, but no documentation of teaching on new meds or any side effects or adverse reaction or difficulty taking meds
• Recert for patient with chronic dx and agency has had ample time for teaching, especially if pt/cg has demonstrated understanding and ability to manage care
• Repeated teaching and documentation patient is non-compliant with following instructions
• After repeated instruction, pt/cg will not or is not able to be taught/trained
Reasonable and Necessary Examples

- Type II Diabetes 4 years, recent UTI’s and high blood sugars, no med changes
  - OR DM for 4 years, no changes in condition or tx
- Parkinson’s w/ increase in falls, med changes
  - OR w/falls 1-2 times a wk past 3 months, has had PT and it helped but decline since last HH because he doesn’t do HEP

Reasonable and Necessary Examples

- TKR, 10 days in SNF, now home
  - unable to safely use walker without cues or negotiate steps in/out of home
  - OR incision slightly swollen w/drainage
  - OR safely able to use walker, incision re-epithelialized, no co-morbidities

Reasonable and Necessary Examples

- Alzheimer’s, more confused, now needs reminders for ADL’s, increased difficulty feeding self, recent choking and risk for aspiration
  - OR gradual decline, requires additional care, unable to participate in therapy, caregiver knows how to provide care to dependent patient

Skilled Care Interventions

- Observation and assessment
- Management and evaluation of the care plan
- Skilled teaching
- Medication administration/treatment
- Catheter care
- Wound care
- Psychiatric treatment
- Skilled therapy services
Goals for Skilled Care

Set appropriate goals
• Goals should be objective and measureable
• Goals should be reasonable for condition
• Goals should be functional and meaningful
• Goals should be patient-based and specific
• Goals should be evaluated for progress and continued appropriateness at every visit

Skilled Care Documentation

• CMS says: “it is expected that the home health records for every visit will reflect the need for the skilled medical care provided.”
  – The history and exam pertinent to the day’s visit including response or changes in behavior from prior teaching or skilled services
  – The skilled services provided at the visit
  – The patient/caregiver’s immediate response to the skilled service provided
  – The plan for the next visit based on rationale of prior results and to achieve progress toward goals

Skilled Care Documentation

• Detailed rationale explaining need for skilled service in light of patient’s overall medical condition and situation
• The complexity of the services to be provided
• Any other pertinent characteristics of patient or home environment situation
• Clear picture of treatment provided and “next steps” – avoid vague or subjective descriptions of care provided to patient

Skilled Care Documentation

• Do not be judgmental – avoid documenting statements like “patient non-compliant with low sodium diet.”
• Instead, document “patient ate hot dogs and sauerkraut for dinner last night, stated he didn’t know it was high in sodium. When asked to identify some high sodium foods to avoid, patient was only able to name potato chips and canned soup.”
• Your follow up intervention would be to instruct patient in low sodium diet guidelines and examples of “eat this, not that” to illustrate how to make better food choices. At the next visit, see if patient can recall teaching and name foods to avoid.
Poor Documentation

• “Patient tolerated treatment well”
• “Caregiver instructed on med regimen”
• “Continue with POC”
• “Normal,” “within normal limits,” “no change from prior assessment” or “N/A”

Good Documentation

• “Caregiver doesn’t know how to safely transport patient to physician appointment because patient is unsteady, has poor balance and difficulty walking the 25 feet to the car, and patient has had two falls trying to negotiate down steep front steps to driveway.”

Physician Orders

• All skilled nursing and therapy services must have a physician order that contains:
  – The type of services to be provided
  – The professional who will provide the services
  – The frequency of the services
  – The duration of the services
  – Details needed to provide the appropriate services

  *Per CMS IOM Publication 100-02, Chapter 7, Section 30.2.2*

Therapy Visit Notes

• Must include measurable therapy treatment goals that are related to the patient’s illness or injury or impairment
• Therapy services must be reasonable and necessary appropriate to the patient’s illness or injury or impairment
• Therapy services must be at a level of complexity which requires the skill of a qualified therapist to provide safely and effectively
More CMS Requirements

Medicare beneficiary must meet the following conditions to be eligible for home health services:
- Be under the care of a physician
- Receive services under a Plan of Care established and periodically reviewed by a physician

Under the Care of a Physician

Patient must be under the care of a physician; a “physician” is a:
- Doctor of Medicine;
- Doctor of Osteopathy;
or
- Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).

In addition, the physician must be enrolled as a Medicare provider

Plan of Care

A plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA

The HHA must be acting upon a physician plan of care the meets the requirements of the Medicare Benefit Policy Manual, chapter 7, section 30.2.1 for HHA services to be covered

Content of the Plan of Care

- All pertinent diagnoses
- Patient’s mental status
- Types of services (disciplines), supplies and equipment
- Frequencies of the visits to be made by each discipline
- Prognosis and Rehab potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- Instructions for timely discharge or referral
- Any additional items the HHA or physician choose to add
**Initial Certification POC**

- Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

**Recertification**

- At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode.
- A recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:
  - Patient-elected transfer; or
  - Discharge with goals met and/or no expectation of a return to home health care.
- Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

42 CFR 424.22(b)(1)

**Recertification POC**

- Must be signed and dated by the physician who reviews the plan of care
- Must indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services)
- Must estimate how much longer the skilled services will be required

**CMS FAQ’s**

**Can the recertification visit frequency and duration of visits be on the recertification plan?**

- No, that is merely the ordered frequency.
- It does not indicate how long skilled services are estimated to be needed.
- There should be something that more clearly indicates how much longer skilled services are needed; even if it estimates services for the entire 60- days or longer.
CMS FAQ’s

If a beneficiary is recertified more than once, is a physician estimate of length of service required with each recertification?

• Yes, each recertification requires a physician estimate of the patient’s length of service.

Recertification

• Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.

• However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

Certification for M&E

• If a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential non-skilled care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

• If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

Coordination of Care

• Communication with physician
• Communication between different clinicians visiting patient
• Communication among disciplines
• Communication w/pt, cg, family
### Physician Coordination

- **SOC:** patient status, medication reconciliation, approval of POC (including interventions in M2250)
- ANY changes in patient condition or adverse s/sx, complications
- ALL missed visits by all disciplines
- Progress updates on wounds
- Goals: progress, revisions to POC

### Interdisciplinary Coordination

- RN – LPN/LVN
- Nursing – Therapy
- PT – OT – PTA – COTA
- Home Health Aide (personal care)
- MSW

### Who Does What?

<table>
<thead>
<tr>
<th>RN, PT, OT, SLP</th>
<th>LPN/LVN, PTA, COTA, HHAide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive assessment</td>
<td></td>
</tr>
<tr>
<td>• Develop Plan of Care interventions and goals</td>
<td></td>
</tr>
<tr>
<td>• Evaluate progress toward goals, determine effectiveness of POC</td>
<td></td>
</tr>
<tr>
<td>• Revise interventions and/or goals with physician input</td>
<td></td>
</tr>
<tr>
<td>• Perform individual treatments / interventions</td>
<td></td>
</tr>
<tr>
<td>• Determine patient response to treatments performed at visit</td>
<td></td>
</tr>
<tr>
<td>• Provide information to RN or therapist about the effectiveness of treatment activities</td>
<td></td>
</tr>
</tbody>
</table>

### Interdisciplinary Coordination

- SOC (within 5 days)
- ROC (within 2 days)
- Prior to recertification
- Prior to discontinuation of a discipline
- Prior to discharge
- Any problems, complications, s/sx of exacerbations or adverse events
**SOC Conference Points**

- Primary diagnosis, focus of care
- Top 5 other diagnoses
- Problem issues
  - Pain, meds, wound care, fall risk
- Patient coping, understanding, motivation
  - Patient’s goals for home care services
- Support / caregiving situation
- Risk for hospitalization, interventions
- Coordination to meet problem issues
- Homebound status and medical necessity

**ROC Conference Points**

- Reason for hospitalization
- Interventions to reduce re-hospitalization risk
  - Changes needed to prevent repeat
- Primary and other diagnoses
- Problem issues
- Support situation and patient coping, etc.
- Revisions to plan of care and goals
  - Focus and responsibilities of each discipline
- Homebound status, medical necessity

**Recertification Conference Points**

- Homebound status
- Evaluate progress toward goals on POC
- Review scores on SOC/ROC OASIS items for outcome measures, evaluate current scores
- Determine if outcome improvement possible and interventions needed to achieve
- Medically necessary skilled care
- Revise goals and plan of care if indicated
- Identify specific responsibilities for each discipline to prepare pt/cg for discharge, evaluate if achievable within this cert period
- Decide if recert or discharge

**Discharge of Discipline Conference Points**

- Goals for discipline achieved
- Identify any unachieved goals, reasons
- Review specific improvement on OASIS items related to outcome measures
- Identify any other changes in plan of care as a result of discipline discharge
  - Plan for PT/INR, dc home health aide, etc.
### Discharge Conference Points

- Review goals on POC, evaluate if achieved
- Review scores on OASIS items, assess if improvement achieved on outcomes
- Identify if teaching done, understanding level:
  - All medications
  - Diabetes and foot care if DM diagnosis
  - Pain management
  - Prevention of falls, pressure ulcers
- Assess patient/caregiver readiness for discharge

### Interdisciplinary Coordination

- Opportunity to support medical necessity, homebound status and skilled need for medically necessary homecare
- Information from all disciplines should agree
- Avoid contradictions between disciplines
- Follow up on problems identified
- Provide supporting education and assessment of effectiveness of interventions

### Face-to-Face

- F2F encounter with physician (or approved designee) must occur either within 90 days prior to HH SOC date or within 30 days after SOC date
- Must be present on certifications for patient with SOC on/after Jan. 1, 2011
  - A certification (vs a recertification) is considered to be any time a new start of care assessment is completed to initiate care
- Physician must complete encounter documentation appropriately
- No F2F documentation? NO PAYMENT!

### F2F Requirement

- The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient’s:
  - Need for the skilled services; and
  - Homebound status
F2F Requirement

• The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain the actual clinical note for the F2F encounter visit that demonstrates that the encounter:
  – Occurred within the required timeframe;
  – Was related to the primary reason the patient requires home health services; and
  – Was performed by an allowed provider type

F2F Requirement

• This information can be found most often in, but is not limited to:
  – Discharge Summary
  – Progress Note
  – Progress Note and Problem List
  – Discharge Summary and Comprehensive Assessment

Palmetto’s “Four Questions” to Ask on F2F

• 1. What is the structural impairment?
• 2. What is the functional impairment?
• 3. What is the activity limitation?
• 4. How do the skills of a nurse or therapist address the specific structural and/or functional impairments and activity limitations cited in steps 1-3?

Palmetto’s F2F Medical Review

• For medical review purposes, CMS requires documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.
Additional Information
• Information from the HHA, such as the patient’s comprehensive assessment, can be incorporated into the certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient.
• Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
• The certifying physician must review and sign off on anything incorporated into the patient’s medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

Additional Information
• The contractor shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination.
• HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission.

Additional Information
• Any information provided to the certifying physician from the HHA and incorporated into the patient’s medical record held by the physician or the acute/post-acute care facility’s medical record could include, but is not limited to:
  – Comprehensive assessment
  – Plan of Care
  – Inpatient discharge summary
  – Multi-disciplinary clinical notes
• Must correspond to the dates of service being billed
• Must not contradict the certifying physician’s and/or the acute/post-acute care facility’s own documentation or medical record entries

Face-to-Face
• If F2F encounter visit has not occurred at SOC:
  – Initiate plan to get patient to physician
  – Address barriers to patient keeping appointment
  – Follow up to verify visit and F2F documentation is obtained by agency before PCR request and/or final billing of episode claim
Medical Review Top Denials

• Lack of Medical Necessity
  – Why did this patient need home care for their medical condition?
• Lack of Skilled Care provided
  – Why did the treatment or education provided require the skills of a professional nurse or therapist?
• Face-to-Face insufficient
• Homebound status not supported

Home Health Resource Group

• OASIS is the basis for payment
  – Payment episode vs. quality episode
• HHRG produced through grouper software
  • Determined by 20 OASIS items
• Three domains
  • Clinical Severity
  • Functional Status
  • Service utilization
• 45 HHRGs; 153 case mix weights
  • C1F1S1 to C3F3S5 for four different equations

REIMBURSEMENT POINTS

Documentation Update

Case Study: Mr. Shelton

• Referral for SN, PT, OT for post-op care following gall bladder surgery
• SOC visit made = Early episode
• Orders for 6 PT and 5 OT visits, total of 11 therapy visits
• Comprehensive assessment with OASIS items completed
Mr. Shelton

Recovering from gall bladder surgery (no full epithelialization yet), other dx: CHF exac during hospitalization, type 2 diabetes (takes insulin), blindness; scores on OASIS data items:

- M1200 = 2
- M1242 = 2
- M1342 = 3
- M1400 = 2
- M1400 = 2
- M1810/1820 = 1
- M1830 = 2
- M1840 = 2
- M1850 = 2
- M1860 = 2
- M2030 = 1

Aftercare for gall bladder surgery, CHF, diabetes and blindness

<table>
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<th>(1)</th>
<th>(2)</th>
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<tbody>
<tr>
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<tr>
<td>M1022(b) CHF exac.</td>
<td>428.0 (3 pts)</td>
</tr>
<tr>
<td>M1022(c) DM II</td>
<td>250.00 (2 pts)</td>
</tr>
<tr>
<td>M1022(d) Blindness</td>
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<tr>
<td>M1022(e) Insulin use</td>
<td>V58.67 (0 pts)</td>
</tr>
<tr>
<td>M1022(f)</td>
<td></td>
</tr>
</tbody>
</table>
**Clinical Severity**

- Diagnoses: 8 pts
- Vision: 1 pt
- Surgical wound status: 4 pts
- Dyspnea: 2 pts

15 clinical points

---

**FUNCTIONAL DIMENSION**

- M1810 or M1820 (Dressing upper or lower body): 1, 2, or 3
- M1830 (Bathing): 2 or more
- M1840 (Toilet transferring): 2 or more
- M1850 (Transferring): 2 or more
- M1860 (Ambulation): 1, 2 or 3
- M1860 (Ambulation): 4 or more

8 functional points

---

**Clinical Severity Level (By points)**

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<th>3</th>
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<td>0 to 2</td>
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<td>C2 (Moderate)</td>
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<tr>
<td>C3 (High)</td>
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<td>6+</td>
<td>17+</td>
<td>15+</td>
</tr>
</tbody>
</table>

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**Clinical Severity Level (By points)**

- C1: 0 to 4
- C2: 5 to 6
- C3: 7 to 14
- C4: 9 to 16
- C5: 8 to 14

---

**Services Utilization Level (Therapy Visits)**

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>20+</td>
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<td>7 to 9</td>
<td>18 to 19</td>
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<tr>
<td>S4</td>
<td>0 to 10</td>
<td>N/A</td>
<td>10 to 13</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>S5</td>
<td>11 to 13</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

**HHRGC = C3F3S5**
Review Identified Problems

• No supporting documentation of any vision deficits to verify blindness
  – Down code blindness dx, M1200 to 0
• Surgical wound is described as “early granulation” with no s/s of infection
  – Down code M1342 to 2

Effect on HHRG

Before Review
• Blindness = 3 pts
• M1200 = 1 pt
• M1342 = 4 pts

Total clinical points
15, a C3

After Review & Down code
• 0 pts
• 0 pts
• 0 pts

Total clinical points
7, now a C2

Review Identified Problems

• Description of bathing ability notes pt needs help in and out of shower, but no mention of any other assistance needed or safety concern getting to and from bathroom or bathing
• Ambulation is independent w/walker
• No description of why pt uses BSC instead of toilet – inconsistent with his ability to get to bathroom for shower
  – Down code M1840 to 1

Effect on HHRG

Before Review
• M1840 = 2 pts

Total functional points 8, a F3

After Review & Down code
• 0 pts

Total functional points 6, now a F2
**Review Identified Problems**

- PT made 6 visits as ordered, all the documentation met skilled and medically necessary requirements
- OT made 5 visits as ordered, but the documentation reflected goals met at visit 3 and did not support medical necessity for the last two visits
  - Down code therapy visits to 9

**Effect on HHRG**

<table>
<thead>
<tr>
<th>Before Review</th>
<th>After Review &amp; Down code</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 therapy visits</td>
<td>9 therapy visits</td>
</tr>
</tbody>
</table>

**Service utilization**

- was a S5
- now a S3

**Effect on Reimbursement**

- Original episode was C3F3S5
  - $3435.94
- After review, MAC down coded the episode to C2F2S3
  - $2399.85

*Incomplete/incorrect documentation and OASIS responses cost agency $1,036.09!*

**HHRG and OASIS**

- Assess using appropriate techniques
- Choose accurate OASIS item response(s)
- Provide supporting information for the OASIS response in narrative documentation
- Make sure interventions are included in POC
- Visit note documentation:
  - Support for OASIS responses
  - Implement interventions, note effectiveness
  - Track progress toward goals, revise as needed
Therapy Utilization

<table>
<thead>
<tr>
<th>Therapy thresholds (visits)</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 visits</td>
<td>Diagnoses</td>
</tr>
<tr>
<td>6</td>
<td>Functional limitations</td>
</tr>
<tr>
<td>7-9</td>
<td>Safety concerns/risks</td>
</tr>
<tr>
<td>10</td>
<td>Prior level of ability, recent history</td>
</tr>
<tr>
<td>11-13</td>
<td>Patient’s goals</td>
</tr>
<tr>
<td>14-15</td>
<td>Short/long term goals</td>
</tr>
<tr>
<td>16-17</td>
<td>Goals reasonable/achievable</td>
</tr>
<tr>
<td>18-19</td>
<td>Ability to participate in treatment</td>
</tr>
<tr>
<td>20+</td>
<td></td>
</tr>
</tbody>
</table>

Plan of Care Diagnoses

- Diabetes
- Neurological conditions, Stroke
- Skin conditions, trauma wounds
- Dysphagia
- Psych conditions
- Orthopedic conditions
- Ostomies

Diabetes Documentation

- FBS or RBS at all SN visits or reason unable
  - Patient log of blood sugars, HgbA1C quarterly
- Patient demo of med/insulin administration
- Knowledge of diabetic diet, intake record
- Knowledge of diabetic foot/skin care
- Knowledge of s/sx hypo/hyperglycemia, safety
- Any teaching or instruction to address knowledge deficits identified

DOCUMENTATION TO SUPPORT CASE-MIX POINTS
Neuro Conditions Documentation

- Physical symptoms (tremors, balance, gait, coordination, weakness/paralysis, difficulty swallowing, cognitive deficit)
- Effect of deficits on functional ability
- Medication administration, effectiveness, s.e.
- Knowledge of s/sx to report, safety measures
- Any teaching to address deficits, tx regime
- Response to therapy, compliance w/treatment

Skin/Wound Conditions

- Skin integrity, lesions, wounds, skin tears
  - Etiology, measurements, description
  - Payne-Martin or STAR classification for skin tears
- Skin color, temperature, damp/dryness
- Medication/treatment administration, compliance, response, effectiveness
- Knowledge of s/sx to report, infection control, safety measures, demo of wound care
- Any treatment performed
- Any teaching to address knowledge deficits

Payne-Martin Category 1
Skin Tear - No Tissue Loss

1. **Linear type** - the epidermis and dermis have been pulled apart, as if an incision has been made.
2. **Flap type** - the epidermal flap completely covers the dermis to within 1mm of the wound margin.

   ![Illustration](Jan_Rice,Wound_Foundation_of_Australia)

Payne-Martin Category 2 Skin Tear – Partial Tissue Loss

- **Scant tissue loss** = partial thickness wound in which 25 % or less of the epidermal flap is lost and in which at least 75% or more of the dermis is covered by the flap.
- **Moderate to large tissue loss** = partial thickness wound in which >25% of the epidermal flap is lost and in which >25 % of the dermis is exposed.

   ![Illustration](Jan_Rice,Wound_Foundation_of_Australia)
Category 3 Skin Tear – Full Tissue Loss

- Epidermal flap is missing

STAR Skin Tear Classification

- Category 1a: skin tear where edges can be realigned to the normal anatomical position (without undue stretching) and skin or flap color is not pale, dusky or darkened
- Category 1b: skin tear where edges can be realigned to the normal anatomical position (without undue stretching) and skin or flap color is pale, dusky or darkened

STAR Skin Tear Classification

- Category 2a: skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap color is not pale, dusky or darkened
- Category 2b: skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap color is pale, dusky or darkened

Dysphagia

- Physical symptoms (swallowing difficulties, pain, appetite, presence of G-tube)
- Any complicating symptoms (pain, aspiration, stricture/obstruction, perforation)
- Knowledge of diet, use of supplements or enteral nutrition, compliance, tolerance
- Knowledge of s/sx to report
- Any teaching to address deficits identified
Psych Conditions

- Behavior, mental status, confusion, paranoia, delusions, sleep disturbances
- Physical symptoms, pain, appetite changes
- Med administration, effectiveness, s.e.
- Pt/cg knowledge of s/sx to report
- Ability of caregiver to cope with patient behavior and manage care safely
- Any teaching to address deficits identified

Orthopedic Conditions

- Pain, impact on functional ability, use of analgesics, effectiveness of meds and non-pharmacological measures for pain
- Mobility, ROM, balance, falls
- Use of device(s), compliance, safety
- Home environment, need for changes
- Therapy treatment provided and response

Ostomies

- Type of ostomy: any bowel ostomy, urostomy or cystostomy, tracheostomy
  - OASIS items marked appropriately
  - ICD-10-CM code assigned on POC
- Circumstances related to ostomy

Support OASIS responses

- OASIS items used to determine PPS episode payment require supporting documentation in the clinical record
- Supporting information doesn’t have to be documented every visit, but should be documented more than just in the OASIS item, including interventions on POC, actions by clinician, documentation of patient response to interventions
**Infusion Therapy**

- Catheter insertion site appearance
- Procedure for med administration, flushes
- Dressing change procedure
- Teaching procedure to pt/cg, return demo
- Teaching infection control, s/sx to report
- Ability of pt/cg to perform
- S/sx med side effects or adverse effects

**Enteral Therapy**

- Feeding tube insertion site appearance
- Prep/administration of feeding, meds, flushes
- Care of tube site, dressing change, skin care
- Teaching procedure, infection control, s/sx to report to patient/caregiver
- Ability of pt/cg to perform, return demo
- Patient tolerance of feedings, nutrition and hydration status, weight (if able) or upper arm circumference

**Vision no longer case-mix points**

- Any confirmed physical conditions or deficits
- Functional impact of vision deficits
- Environmental adaptations or devices used
- Assistance needed for activities due to vision
- Safety precautions or instruction related to vision deficits
- Use of teaching tools with large print, pictures, recorded audio reminders

**Pain**

- Pain should be assessed and documented every visit by every discipline
  - Location, site of pain
  - Description of pain quality, sensation
  - Intensity: 0-10 scale, severity description
  - Timing: when pain occurs, is better/worse
  - Causes, precipitating factors
  - Changes in typical behavior or vital signs
Pain

• Non-verbal s/sx of pain
  – Pain noises or expressions
  – Rubbing, bracing, restlessness
• Impact on activity, mental status, lifestyle
• Relief measures, use, frequency, effectiveness
• Teaching on pain management
• Pt/cg ability to follow pain mgt guidelines
• Follow up on any interventions for pain

Barriers to Pain Assessment

• Cognitive impairment
  – Poor memory
  – Depression
  – Sensory impairment
• Inaccurate reporting of pain by patient
  – Cultural bias
  – Fear of disease progression
  – Jeopardizing patient’s independence

Wounds

• Comprehensive skin assessment
  – Time points
  – Observe all body surfaces
    • Bony Prominences
    • Peri area
• Documentation format

Wound Identification

• Sources of information
  – Referral information, H&P
  – History from patient, family, caregiver
• Investigate and verify if necessary
  – Physician confirmation – *document it!*
• Provide accurate documentation
• Medical record must be consistent
Types of Wounds

• Pressure ulcers
• Venous stasis ulcers
• Arterial ulcers
• Diabetic ulcers
• Surgical wounds
• Other: trauma, burns, cellulitis

Wound Identification Resource

WOCN Clinical Fact Sheet for Quick Assessment of Leg Ulcers
  – Venous Insufficiency
  – Arterial Insufficiency
  – Peripheral Neuropathy
Available at www.wocn.org

WOCN Guidance for OASIS-C2

• Definitions used in OASIS items
  – Types of wounds
  – Criteria for determining healing status
• Pressure ulcer stages I-IV, unstageable, suspected deep tissue injury
• Glossary of terms

Wound Documentation

• Location
• Size, shape, measurements
• Wound bed appearance
• Drainage
• Odor
• Surrounding tissue
• Pain
Wound Documentation

- Number wounds consistently
- Describe wound every visit
- Measure at least weekly
- Take pictures if possible and permitted
- Document detailed wound care performed (avoid “wound care per order”)
- Document all communication with physician on wound progress or lack of progress

Dyspnea

- Describe activities that cause shortness of breath or dyspnea
- Include physical symptoms: increased respiratory rate or heart rate, O2 sat
- Describe what patient does to cope with dyspnea (rest, use O2, use inhaler, avoid activities or take longer to complete tasks)
<table>
<thead>
<tr>
<th>Urinary/Bowel Incontinence</th>
<th>Ostomies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Observed or reported by patient or caregiver</td>
<td>• Location and type of ostomy</td>
</tr>
<tr>
<td>• Evidence seen by clinician or HH Aide</td>
<td>• Stoma, surrounding skin condition</td>
</tr>
<tr>
<td>• Diagnoses with potential incontinence issues</td>
<td>• Complications (hernia, necrosis, etc.)</td>
</tr>
<tr>
<td>• Episodes of diarrhea</td>
<td>• Type of appliance used, frequency of changes, any concerns with use/effectiveness</td>
</tr>
<tr>
<td>• Measures used to deal with incontinence (use of depends, frequent cleansing, topical skin barrier, assist needed for toileting hygiene)</td>
<td>• Ability of pt/cg to empty and change, teaching done if needed</td>
</tr>
<tr>
<td>• Complications related to incontinence</td>
<td>• Appliance vendor, supplies ordered</td>
</tr>
<tr>
<td>• Teaching of pt/cg and response to education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADL’s</th>
<th>Dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• M1810/1820: Dressing upper and lower body</td>
<td>• Clothing adaptation due to pt ability/deficit</td>
</tr>
<tr>
<td>• M1830: Bathing</td>
<td>• Types of fasteners used or unable to use</td>
</tr>
<tr>
<td>• M1840: Toileting</td>
<td>• Assistance needed from another person</td>
</tr>
<tr>
<td>• M1850: Transferring</td>
<td>• Devices used for dressing aids</td>
</tr>
<tr>
<td>• M1860: Ambulation/locomotion</td>
<td>• Frequency of clothing changes</td>
</tr>
<tr>
<td></td>
<td>• OT plan of care interventions to address deficits, progress toward goals</td>
</tr>
</tbody>
</table>
Upper Body Dressing

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper body clothing.
- 3 - Patient depends entirely upon another person to dress the upper body.

Lower Body Dressing

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

Bathing

- Detailed explanation of deficits related to bathing and impact on performance:
  - ROM, balance, pain, safety
- Devices used or needed
- Assistance needed from another person
- PT and/or OT plan of care interventions to address deficits, progress toward goals

(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair):

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.
Toilet Transferring

- Describe home environment and impact on performance of toilet transfer
- Detailed explanation of deficits related to toilet transfer and impact on ability to get from anywhere in home to bathroom toilet or BSC:
  - ROM, balance, pain, safety
- Devices used or needed
- Assistance needed from another person
- PT and/or OT plan of care interventions to address deficits, progress toward goals

Transferring

- Describe environmental factors related to transfer (sleeps in recliner, no bedroom chair)
- Detailed explanation of deficits related to bed-chair transfer and impact on performance:
  - ROM, balance, weakness, pain, safety
- Devices used or needed
- Assistance needed from another person
- PT and/or OT plan of care interventions to address deficits, progress toward goals
Ambulation / Locomotion

- Describe environmental factors affecting ambulation/locomotion (flooring, stairs, hazards identified in home)
- Explanation of deficits affecting performance:
  - Physical: ROM, balance, weakness, vision, pain, safety
  - Mental: forgetfulness, confusion, need for supervision
- Devices used or needed
- Assistance needed from another person
- PT and/or OT plan of care interventions to address, progress toward goals

IADL’s

- M1870: Feeding/eating
- M1880: Light meal prep
- M1890: Telephone use
- M1900: Prior for Household tasks

Feeding / Meal prep

- Impact of deficits on performance, safety:
  - Physical: vision, pain, dyspnea, joint stiffness and manual dexterity, use of ambulatory devices
  - Mental: cognitive, forgetfulness, poor judgment
- Use of adaptive devices or environmental modifications
- Assistance needed from another person
- OT plan of care interventions to address deficits, progress toward goals
### Telephone Use

- Impact of deficits on performance:
  - Physical: vision, joint stiffness, manual dexterity
  - Mental: cognitive, forgetfulness, poor judgment
- Use of adaptive devices, special phone or features, environmental modifications
- Assistance needed from another person
- OT plan of care interventions to address deficits, progress toward goals
- Instances of patient unable to use phone effectively (observed or reported)

### Oral Medication Administration

- Impact of deficits on performance:
  - Physical: vision, manual dexterity, swallowing
  - Mental: cognitive, forgetfulness, confusion
- Ability to obtain meds, access in home
- Use of adaptive devices, med planner, alarm reminder, environmental modifications
- Detailed description of assistance needed from another person

### Oral Medication Administration

- Knowledge of medication regimen: dose, time, how to take/administer med
- Knowledge of purpose, side effects, s/sx to report to pharmacy or physician
- Compliance with med regimen
- SN and/or OT plan of care interventions to address deficits, teaching, progress toward goals by patient/caregiver

### Injectable Medication Administration

- Impact of deficits on performance:
  - Physical: vision, manual dexterity
  - Mental: cognitive, forgetfulness, confusion
- Ability to obtain meds, access in home
- Use of adaptive devices, penlet, pre-filled syringes, pre-mixed medications, alarm reminder, environmental modifications
- Detailed description of assistance needed from another person
Injectable Medication Administration

- Knowledge of medication regimen: dose, time, how to store, prepare and administer med
- Knowledge of purpose, side effects, s/sx to report to pharmacy or physician
- Ability to demo site selection, skin prep, injection, proper disposal of syringe/needle
- Compliance with med regimen
- SN and/or OT plan of care interventions to address deficits, teaching, progress toward goals by patient/caregiver

Care Coordination

**RECERTIFICATION OR DISCHARGE?**

Recert “Red Flags”

- Recertifying for a “later episode”
- Continuing treatment that is no longer skilled
- Minor treatment changes that don’t support continued medical necessity
- Repetitive education or education that does not address a knowledge deficit

Patient/Caregiver Education

- Lack of documentation of knowledge deficit
- No explanation why further education needed when “full understanding” achieved
- “Teaching topics” vague
- Response to teaching not specific and measurable
- “Barriers to education” not supported by other documentation in record
- No follow up assessment of recall
Patient Performance

- Document assessment of pt/cg knowledge level, describe any deficit, tailor teaching interventions to address deficit
- If no knowledge deficit identified for patient or caregiver, no need for skilled teaching!
- Document assessment of pt/cg ability to demonstrate tasks, cues needed, assistance needed, safety concerns
- See example “CHF Teaching Checklist”

Caregiver Assistance

- If patient is unable to perform task safely, document the following:
  - Reason assistance is necessary
  - Degree and type of assist needed
  - Who will provide assist and their availability
  - Knowledge/ability of caregiver to perform task for patient, teaching done with caregiver
  - Caregiver demonstration of task performance

M2102 QA Check

- If you check 0 or 1 in any rows, this means you do not need to teach patient or caregiver anything about this category of activities
- If your plan of care includes instruction in any aspect of a category, consider 2 or higher
- If you answer 4 on any row, then cannot answer 1-3 on other rows (can’t have caregiver for some categories, but no caregiver for others)
- ALWAYS explain in narrative

M2250: Plan of Care Synopsis

- Collected at SOC and ROC
- Must complete risk assessments, include in clinical record
  - Can do formal or informal for M2250
- Must have documentation of physician approval to include interventions on POC
M2250: Plan of Care Synopsis

• “Physician-ordered plan of care” means:
  – Patient’s status/condition was communicated to physician either verbally or in writing
  – *Medical record contains documentation of agreement as to plan of care between physician and home health agency, including communication and approval of best practices in M2250*, and specific orders are listed on Plan of Care
  – Do NOT have to have signed orders or POC (485) returned to agency within 5 day window to answer “yes” to items on M2250

M2400: Intervention Synopsis

• Collected at Transfer and Discharge
• Builds on POC Synopsis (M2250) from SOC/ROC
• Interventions must be ordered on POC and implemented at time of or since the previous OASIS assessment visit
• Interventions only have to be documented *one time* to answer “yes” – but they *have to be documented* in the clinical record!

M2250 and M2400 difference

• For M2250, it is not required that the “formal” assessment as specified in the item be completed, just that “an” assessment revealed no pain, no risk for pressure ulcers, no risk for falls to select “NA”
• For M2400, it does require the “formal” assessment as referenced in M1240, M1300, M1730 and M1910 must have been conducted in order to select “NA” – *the assessment tool must be included in the medical record*

Reporting Parameters

—Examples of types of parameters
  – Vital signs, temp, BP (may be ranges)
  – Weight (may be ranges)
  – Wound measurements or conditions
  – Pain level
  – Intake/output
  – Blood sugars (may be ranges)
  – Other clinical assessment areas relevant to patient condition
Diabetic Foot Care + Education

• “Diabetic foot care” includes both monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care
• Agency Policy on diabetic foot care?
• Educational materials available?
• Staff trained and competent to perform?
• Documentation of implementation?

Falls Risk Assessment

• MAHC-10 Fall Risk Assessment Tool now
  – Multifactorial, standardized, validated
• Available free from Missouri Alliance for Home Care at
  www.homecaremissouri.org
• Risk assessment responses should match other documentation in record
• Include the risk assessment tool and documentation in the medical record

Fall Prevention Interventions

• Interventions and goals on POC?
  – Home environment modifications
  – Instruction in safety precautions
  – Appropriate use of assistive device(s)
• Documentation in visit notes?
  – Interventions instructed/implemented
  – Pt/cg compliance with interventions

Depression Interventions

• Documentation in visit notes
  – New or existing anti-depressant med
  – Referral for further treatment or eval
  – Teaching about meds, understanding
  – Teaching techniques like relaxation, meditation, guided imagery, exercise
  – Monitoring plan for current treatment
**Pain Interventions**

- Always complete a pain assessment using a standardized tool (M1240 will be 1 or 2).
- If tool identified patient has **any pain at all**, get orders for interventions to relieve pain and monitor effectiveness of interventions.
- If orders are obtained, may choose response 1 for M2250e regardless of whether or not patient has pain on day of assessment (M1242 may be 0); if orders implemented at least once, M2400d may be 1 instead of NA.

**Prevent Pressure Ulcers**

- What interventions are on POC to prevent pressure ulcers?
- Reminders to include these interventions in visit education?
- Educational materials available?
- Are interventions documented in visit notes at least one time?

**To Recert or not to Recert?**

- Still homebound?
- Continuing need for skilled services?
- Reasonable and necessary for home care?
- Diagnoses new or exacerbated?
- Revised plan of care?
- Reasonable progress toward goals?
- Outcome measures improved?
- Revised goals?
- Discharge plan?

**Reasonable and Necessary Examples**

- Recertification for SN for wound care to BLE stasis ulcers, assessment and teaching, and HHAide for bathing.
- OASIS assessment documented edema but no wounds listed or measured, SN visit notes “monitor legs for new ulcers and encourage good skin care and leg elevation” but no wound care documented and interim order 3 wks earlier to DC wound care.
- Reasonable and necessary for home care?
Reasonable and Necessary Examples

• Recertification for SN for wound care to BLE stasis ulcers, assessment and teaching, and HHAide for bathing.
• OASIS assessment documented edema but no wounds listed or measured, SN visit notes “monitor legs for new ulcers and encourage good skin care and leg elevation” but no wound care documented and interim order 3 wks earlier to DC wound care.
• Not medically reasonable and necessary for SN to monitor healed legs

Reasonable and Necessary Examples

• Recertification of patient with chronic atrial fib on long term Coumadin, requires ongoing lab draws for PT/INR monitoring; pt does have occasional changes in Coumadin dose but has made no errors in med administration and has had no s/sx of adverse reactions or side effects
• Reasonable and necessary for HH care?

Discharge of the Patient

• When to discharge patient?
  – Goals on POC are achieved
  – Patient and family/caregivers are agreeable and ready for DC
    • Able to follow up for medical care
  – Physician orders have been completed
• OR patient no longer meets Medicare eligibility criteria

Recertification Conference Points

• Evaluate progress toward goals on POC
• Review scores on SOC/ROC OASIS items for outcome measures, evaluate current scores
• Determine if outcome improvement possible and interventions needed to achieve
• Revise goals and plan of care if indicated
• Identify specific responsibilities for each discipline to prepare pt/cg for discharge, evaluate if achievable within this cert period
• Decide if recert or discharge
Discharge Conference Points

- Review goals on POC, evaluate if achieved
- Review scores on OASIS items, assess if improvement achieved on outcomes
- Identify if teaching done, understanding level:
  - All medications
  - Diabetes and foot care if DM diagnosis
  - Pain management
  - Prevention of falls, pressure ulcers
  - Follow up and s/sx to report to physician
- Assess patient/caregiver readiness for discharge

Why a Pre-billing Audit?

- Validate patient meets criteria for Medicare eligibility for home health services
- Ensure compliance with Medicare payment requirements before EOE bill submission to reduce risk of inappropriate claims
- Opportunity to obtain required documentation prior to final bill submission
Steps in Pre-Payment Review

- Identify End of Episode time points
- Gather all relevant documentation for episode
- Perform comprehensive audit of chart
  - See sample audit tool
- Address any missing actions or documentation
- Validate patient meets requirements for claim submission

ICD-10 ASSESSMENT KEY POINTS

Documentation Update

Infections

- Sepsis:
  - Identify underlying infection site
  - Identify causal organism, if known
  - Any associated acute organ dysfunction or failure
  - Any antibiotic resistance, if present
- Local infections:
  - Identify causal organism, if known

Blood and Blood-forming Organs

- Anemia:
  - Type of anemia
  - Any association with neoplasm, CKD, other chronic disease
- Lymphomas:
  - Cell type affected
  - Grade of disease, remission status
    - 5th digit 0-not having achieved remission, failed remission
    - 5th digit 1-in remission
    - 5th digit 2-in relapse
Neoplasms

- Type of neoplasm: benign, malignant, in-situ, or uncertain histological behavior
  - Avoid “mass”
- Location(s) of all sites – primary and secondary metastatic
  - Identify specific part of organ
  - Laterality is important!
- History of any neoplasms that are identified as eradicated

Cardiovascular

- Acute Myocardial Infarction
  - Identify date of acute MI: within 4 weeks?
  - Identify if STEMI or NSTEMI
  - Identify the location of the coronary artery blockage
  - Identify area of heart wall damage (anterior, inferior)
  - Identify if patient continues to have angina symptoms
- Heart Failure
  - Systolic / Diastolic / Congestive / Left ventricular
  - Acute / Chronic / Acute on Chronic
  - LVEF <50%, query physician

Heart Failure

- Systolic HF: ventricle pumping action is weakened. *Systolic heart failure has a decreased ejection fraction of less than 50%.* May be documented by physician as Heart Failure with reduced ejection fraction (HFrEF)
- Diastolic HF: heart contracts normally but is stiff, impedes filling of heart chambers, produces backup into lungs and CHF symptoms. In *diastolic heart failure, the ejection fraction is normal.* May be documented by physician as Heart Failure with preserved ejection fraction (HFpEF)
- Congestive HF: chronic congestion and edema in tissues, usually a result of right-sided HF caused by left-sided HF

Circulatory

- Coronary Artery Disease
  - Has the patient had a CABG? Is the CAD affecting the native coronary artery or a bypass graft?
  - Does patient have angina? What type of angina?
- CVA
  - Identify any residual deficits present
  - Identify laterality (right/left side affected)
  - Document functional impact of any deficits
Circulatory

- Atherosclerosis of the extremities
  - Identify if affecting the legs or other extremities
- Atherosclerosis of the legs
  - Identify laterality as right, left, or bilateral
  - Identify the artery affected
- Embolism, thrombosis, phlebitis, thrombophlebitis
  - Identify laterality
  - Identify specific lower extremity vein affected

Digestive

- Gastric ulcers, gastritis and duodenitis no longer classified as with/without mention of obstruction
- Crohn’s disease, ulcerative colitis, and inflammatory polyps (pseudopolyposis) must be documented by area of the GI tract affected, and as with or without complications; complications must be specifically documented as:
  - Rectal bleeding
  - Intestinal obstruction
  - Fistula
  - Abscess or other specific complication or unspecified complication
Digestive

- Alcoholic disease of liver: document with or without ascites
- Toxic liver disease is no longer classified under unspecified hepatitis and requires documentation of the presence or absence of:
  - Cholestasis
  - Hepatic necrosis
  - Acute or chronic hepatitis and type of chronic hepatitis (persistent, lobular, active)
  - Ascites
  - Coma
- Hepatitis: document as acute/subacute/chronic and with or without hepatic coma

Endocrine

- Specific information will be required to code the type of congenital hypothyroidism
- More specific information will be required to code iodine deficiency thyroid disease
- More specific information will be required to code disorders of the parathyroid gland
- Cushing’s syndrome is differentiated by type and cause
- Vitamin, mineral, and other nutritional deficiencies will require more information on the specific vitamin(s) and/or mineral(s) that are lacking

Endocrine

- Disorders related to hyperalimentation will require documentation of the specific condition that is related to the need for hyperalimentation
- Metabolic disorders will require greater detail related to the specific amino-acid, carbohydrate, or lipid enzyme deficiency responsible for the disorder
- Overweight/obesity/morbid obesity will require cause (due to excess calories, drug-induced) and complications if present (Pickwickian syndrome)
- Clinician documentation of height and weight allows coding of BMI (does not require physician verification)

Diabetes

- Diabetes documentation requires type of DM, body system affected, and the complications that affect that body system
  - If Type is not identified, default is Type II
- Diabetes no longer requires “uncontrolled” status to be identified by physician – must document current blood sugar readings to use additional code for “hyperglycemia” or “hypoglycemia” with type of diabetes
**Diabetes**

- Secondary Diabetes requires determination of whether DM is due to an underlying condition or whether it is drug or chemical induced, and identification of condition or drug/chemical
- Pancreatic cancer, Pancreatitits, and trauma
- Malnutrition
- Cushing’s syndrome
- Cystic fibrosis
- Glucocorticoids, Agent Orange
- Document use of long-term Insulin, coded if any type of Diabetes except Type I

**Integumentary**

- Document etiology of wounds and skin conditions, any underlying conditions/diagnoses
- More specificity required for conditions such as: furuncle and carbuncle, cellulitis and abscess; identify causal organism
- More site specificity required for location of an abscess: “trunk” must be identified as the chest wall, abdominal wall, umbilicus, back, (except buttock), groin, or perineum

**Integumentary**

- Contact dermatitis: document as allergic or irritant, specify substance causing the dermatitis and whether it is local external contact or due to ingested substance
- Laterality: document the side of the body affected as right, left, or bilateral
- Pressure ulcer site and stage must BOTH be documented for ALL pressure ulcers
  - Etiology from physician
  - Stage from clinician assessment

**Pressure Injury Definition**

- A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Integumentary

- Non-pressure ulcers will require assessment and identification of the depth of tissue injury:
  - Limited to breakdown of skin
  - With fat layer exposed
  - With necrosis of muscle
  - With necrosis of bone
- May be documented by clinician, based on clinical assessment

Non pressure ulcer limited to breakdown of the skin

Non pressure ulcer with fat layer (subcutaneous layer) exposed

Non pressure ulcer with necrosis of muscle or bone
Burns

- Burns classified as to whether they are due to heat (thermal) or due to chemicals (corrosive)
- Episode of care is required for injuries and other external causes of mortality/morbidity, specified as:
  - Initial encounter
  - Subsequent encounter
  - Sequela

Musculoskeletal

- Document fracture as open or closed (default closed)
- Document as displaced or non-displaced (default displaced)
- Document specific type of fracture if known
- Document fractures as traumatic or pathologic
  - Traumatic: bone breaks due to fall or injury
  - Pathological: bone breaks due to a disease of the bone, a tumor or infection
  - New guideline in ICD-10: in a patient with a diagnosis of osteoporosis that suffers a fracture, it is considered a pathological fracture even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal healthy bone

Types of Fractures

Musculoskeletal

- Seventh digit characters are required to identify:
  - Episode of care as initial, subsequent, or sequela with subsequent episode of care
  - Identify the fracture with routine healing, with delayed healing, nonunion, or malunion
  - Further classification of open fractures using the Gustilo fracture classification system which identifies the fractures as Type I, II, IIIA, IIIB, IIIC
Gustilo Grades for Fractures

<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration/damage/loss or an open segmental fracture; also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury</td>
</tr>
</tbody>
</table>

Musculoskeletal

- Most diseases, disorders and injuries of muscles are reported by location or body region rather than by a specific muscle name
- Document laterality: left, right, bilateral
- Document if conditions are related to a prior injury or disease
- Documentation of physician verification of musculoskeletal diagnoses

Neurological

- Assessment of Level of Consciousness
  - Baseline status if known
  - Ability to verbalize
  - Ability to follow commands
  - Orientation to person, time, place, situation
  - Response to pain, light pressure
  - Pupillary response
  - Glasgow Coma Scale

Neurological

Hemiplegia or monoplegia:
- Dominant versus non-dominant side
- Laterality: right, left, bilateral

**New Guidance in ICD-10:**

*Should the affected side be documented, but not specified as dominant or non-dominant and the classification system does not indicate a default, code selection as follows:*

- For ambidextrous patients, the default is dominant
- If the left side is affected, the default is non dominant
- If the right side is affected, the default is dominant
Neurological

- Traumatic or non-traumatic etiology of condition
  - CHI, TBI, CVA, infectious, drug-induced
- Episode of care for injuries and other external causes of mortality or morbidity:
  - Initial encounter, Subsequent encounter, Sequela
- Loss of consciousness time duration
- Type of neuropathy
- Neuropathy vs neuralgia
- Level of spinal cord injury
- Quadriplegia, paraplegia, monoplegia

Alzheimer’s Disease

- Early or late onset
- With or without behavior disturbance: document type of behaviors observed or reported
- Parkinson’s Disease vs Parkinsonism
- Seizures
  - Localized onset
  - Complex partial seizure
  - Intractable
  - Status epilepticus

Mental and Behavioral

- Include tools used to assess mental status
- Describe functional impact of mental or behavioral disorders
- Substance use, abuse and dependence
  - Document all conditions present
    - Use, abuse, and/or dependence
  - Use: document what you observe
    - Abuse or dependence requires physician confirmation
  - Document blood alcohol level, if known

Mental / Behavioral

- Dementia
  - Any underlying conditions
  - With or without behavior disturbances
  - Cognitive disorders present, functional impact
- Vascular dementia
  - Any underlying conditions or physiological cause
  - Late effect (sequela) of CVA
  - With or without behavior disturbances
    - Including wandering
**Respiratory**

- COPD: (acute/chronic bronchitis, bronchiolitis, asthma, emphysema or any combination of conditions)
- Identify as uncomplicated or exacerbated
- “Flare-ups” (exacerbations) are episodes of new or increasing symptoms that last at least three days. These symptoms may include: cough, mucus, wheezing, shortness of breath, or tightness in the chest. A COPD flare-up may require treatment beyond normal medications and, in some cases, exacerbations may require hospitalization.
- Does the physician include exacerbation or flare-up in the documentation? If not, clue to query MD for verification – *cannot code exacerbation w/out physician documentation*

**Respiratory**

- Pneumonia:
  - Identify organism if known
  - Identify if related to ventilator treatment
- Lung Cancer:
  - Identify left/right lung, upper/middle/lower lobe
  - Identify any overlapping or adjacent sites
  - Identify small cell or non-small cell CA
  - Identify primary or metastatic site
  - Identify any smoking or tobacco use

**Respiratory**

- If asthma is diagnosed, what type?
- Document any use of oxygen (intermittent or continuous)
- Document any tobacco use, abuse or dependence, or exposure to second hand smoke
  – This could get a little tricky!

**Urinary**

- CKD: document Stage I-V or ESRD
  - document any associated condition (DM, HTN)
- For dialysis patients: document type of access, location, appearance, bruit/thrill for AVF or AV graft
- Kidney transplant: document any complications
- Infection: document organism if known
- Document presence of hematuria
- Document laterality for all paired organs
- Male: document site of stricture or inflammation
- Female: document site of inflammation, any organ prolapse
All Diagnoses on Plan of Care

• All diagnoses on the home health plan of care must be documented in the referral or intake information or in the medical record from the inpatient facility or physician office
• Any additional diagnoses suggested by the patient/family, medication profile, etc. must be verified with the physician
• *This verification must be documented by the agency in the medical record in order to place these diagnoses on the home health plan of care!*

IN SUMMARY...

Documentation Points

• Support CMS requirements
• Check boxes are a start, but need more
• Provide details to show why OASIS items are answered correctly
• Individualize with specific information for each patient
• Include detail and specificity needed for coding diagnoses and conditions
• Avoid repeating “canned” phrases

Documentation Points

• Avoid non-descriptive words like stable, normal, and within normal limits.
  — EX: “diabetic status is stable within normal limits.”
• Instead use objective patient-stated documentation to describe the disease process and progress toward goal.
  — EX: “pt reported checking blood sugar morning and evening. For past 5 days blood sugars in AM have been 82-175, PM blood sugars range 100-186.”
**Documentation Concerns**

- Incomplete assessments
- Generic plan of care, non-specific goals
- Insufficient re-assessment, lack of evaluation of progress toward goals
- Vague interventions and teaching
- Lack of assessment of patient/caregiver’s response to interventions
- Repetitive visits without changes in patient condition or abilities, lack of follow through on problems

**Diagnosis Documentation**

- Determination of diagnoses for the Plan of Care is the responsibility of the clinician that authored the comprehensive assessment. (One Clinician Rule)
- Example clinical narrative note at SOC:
  
  "Patient admitted to home care after hospitalization for (M1011). Focus of home care services is (M1021). Other diagnoses pertinent to home health plan of care include (M1023 and diagnosis list)."

**Format for Visit Notes**

- **S** – Subjective
- **O** – Objective
- **A** – Assessment
- **P** – Plan

  
  **P** – Problem
  **I** – Intervention
  **E** – Evaluation

**Watch out for Red Flags**

- M0090 date assessment completed frequently same as M0030 SOC date
- No documentation of physician contact, approval of orders for POC
- All M2250 and M2400 responses are “yes”
- EHR cautions:
  - “copy” or “copy forward”
  - Use of “smart phrases”
  - “normal,” “within normal limits,” “no change from prior assessment” or “N/A”
Legal Considerations

• Remember: “If it isn’t documented in the record, it wasn’t done”
• Timeliness of documentation impacts accuracy of information
• Correction policy
  – By clinician/author of visit
  – By QA as a result of review

Potential Pitfalls of Pre-Claim Review

• How often is a referral missing some information, like the F2F? Verification of the physician that will sign POC?
• Who reviews your agency’s F2F documents when they are received to make sure they meet the CMS requirements?
• What is your agency’s process to correct F2F documentation that is missing key points? How long does that take?
• Do all your staff that do admissions know the Medicare coverage criteria? Do they know what to do if the initial assessment shows the patient does not meet the eligibility requirements for home care?
• How long does it take to process the SOC (review the OASIS, do the coding, verify diagnoses and orders with the physician) and get the 485 POC sent to the physician?

When the course is rough -

Still steer!
Jimmy Buffett
“The Captain and the Kid”
What questions do you have?

Lisa@selmanholman.com
Teresa@selmanholman.com

• Selman-Holman & Associates, LLC
  • Home Health Insight
• CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
• CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice