FREE WEBINAR

PDGM and OASIS-D1/ Comprehensive Assessment

Sharon Hamilton &
Lisa Selman-Holman

Participants will be able to

- Explain at least 3 changes from the current PPS payment system to the future PPS PDGM system
- Identify the increasing importance of documentation with the shift from OASIS-D to OASIS-D1
- Explain the benefit of integrating the OASIS items into the comprehensive assessment
- Identify ways your agency can promote and support a balance of skills between the agency's department

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PDGM—Major Changes

- Relies more heavily on clinical characteristics and other patient information
- Places patients into meaningful payment categories and
- Eliminates the use of therapy service thresholds (by statute)
- Home health periods of care beginning on or after January 1, 2020
- 30 day payment period (by statute)

Unchanged

- Conditions of Participation
- Comprehensive assessment (including OASIS items) required at SOC, Recertification, Other Follow-Up (SCIC), Resumption of Care, Discharge
  - OASIS D1
  - OASIS transmitted within 30 days of M0090 (Date Assessment Completed)
- Plan of Care every 60 days
- HIPPS code based on SOC, recert and ROC

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PDGM Basics

Timing—Early and Late
30 day payment period

Admission Source—Community or Institutional

Clinical Grouping from Principal Diagnosis

Comorbidity Adjustment—Secondary Diagnoses (up to 24 additional diagnoses)

Functional Score (only part of payment equation from OASIS)

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30 Day Payment Period

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"Unit of Payment"

- The initial certification of patient eligibility, plan of care, and comprehensive assessment are valid for two 30-day periods of care (that is, for 60 days of home health care) in accordance with the home health regulations at 42 CFR 409.43 and 424.22, and the home health CoPs at 42 CFR 484.55.
- Each recertification, care plan update, and comprehensive assessment update will also be valid for two 30-day periods of care, also in accordance with the home health regulations at 42 CFR 409.43(e) and 424.22(b), and the home health CoPs at 484.60(c).

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Double the Billing?

- Many of the data elements that are used to populate an electronic claims submission will remain the same from one 30-day period to the next.
- HHAs are required to line-item bill each visit performed and whether each visit is recorded on a single 60-day claim or the visits are recorded on two different 30-day claims should not result in a measurable burden increase.
  - 16 total visits for 60 days vs 8 total visits for 30 days

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RAPs

- Requirements for submitting RAP unchanged
  - Plan of Care out the door
  - OASIS ready to transmit
  - First billable visit
- Days to RAP average 12 days
- Newly-enrolled HHAs (certified on or after January 1, 2019) will not receive RAP payments as of January 1, 2020.
  - Still have to submit a "no-pay" RAP at the beginning of care in order to establish the home health period of care in the Common Working File (CWF)

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Action Item

- What are days to RAP in your agency?
- Where is your bottleneck?
  - Staff to complete OASIS?
  - OASIS review?
    - Clinicians completing or
    - Actual review
  - Coding?
    - Getting enough info to code
    - Who is doing the coding?
    - Matching the F2F
  - Plan of Care development?
    - Therapy eval and plan?

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Request for Anticipated Payment

2019	2020
• All agencies can RAP	• Newly enrolled agencies (after Jan 1, 2019) submit a "no-pay RAP"
• RAP is 60% or 50% of the 60 day episode payment	• RAP is 60% or 50% of the 30 day unit payment
• RAP every 60 days	• RAP every 30 days
• New OASIS each time	• New OASIS only every other time (unless there is a ROC)

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What About Second RAP?

Second 30 Day Unit of Payment (every other time)

- Plan of Care is already done
- OASIS has already been transmitted (the one at the beginning of the 60 days—SOC or recert)
  - An Other Follow-Up does not provide an HHRG at this time, BUT…

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Claim Requirements Unchanged

- Before a provider submits a final claim, the HHA will need to have:
  - A completed OASIS assessment transmitted within 30 days,
  - Signed certification,
  - Signed interim orders, and
  - Signed plan of care.
- CMS expectation is that the HHA will obtain the signed physician certification and plan of care timely
- How long does it take after the 60 day episode before the final claim can be submitted in your agency?

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Any Other Changes?

- No changes to frequency of OASIS (still every 60 days)
  - Many items on recert will be optional in OASIS D1
- No changes to frequency of Plan of Care (still every 60 days)

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Functional Score & the 30 Day Period

- Start of care: Functional score *from OASIS* would be used for determining the functional impairment level for both the *first and second* 30-day periods.
- The follow-up OASIS completed near the time of recertification would be used for the third and fourth 30-day periods of care.
- If there was a hospitalization in the first 30 day period, the ROC would be used to determine functional score in 2nd 30 day period.
    - Just a reminder…currently the ROC is not used for HIPPS code unless performed in last 5 days of episode
    - At this point the SCIC does not change the HIPPS

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Coding and the 30 Day Period

- The diagnoses from the home health *claim* are used to group a 30-day home health period of care into a clinical group and to determine if there is a comorbidity adjustment.
- If a home health patient has any changes in diagnoses (either the principal or secondary), this would be *reflected on the home health claim* and the case-mix weight could change accordingly.

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Coding and the 30 Day Period

- However, CMS expects that the HHA clinical documentation would also reflect these changes and any communication/coordination with the certifying physician would also be documented.

Who is auditing clinical record for changes in the condition, new orders, exacerbations? The coder? The biller? How is the home health claim updated?

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What is a LUPA?

- Low Utilization Payment Adjustment
- Currently 4 or fewer visits per 60 days
- Payment is Per Visit instead of Per Episode

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CMS Assumption LUPA Threshold

- Under the proposed PDGM, the CMS proposed assumption was that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.

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LUPAs

- Approximately 8% of claims are currently LUPAs
  - Visits cluster around 5 visits to avoid LUPAs
- Reducing payment period to 30 days will result in significantly more LUPAs.
- LUPA thresholds will correspond to HIPPS.
- 2 – 6 visits per 30-day payment period depending on HIPPS
- Table 14

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Action Item

- What is your LUPA rate?
  - What kind of patients usually result in LUPA episodes?
  - Problems: Missed visits
    - Why?
    - Patient is not homebound?
  - RN Admit and 4 therapy visits
  - Are those extra visits to avoid a LUPA medically necessary visits?

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Timing—Early and Late
30 day payment period

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Early v Late

- Early: Only the 1st 30 day period
- Late: 2nd and later 30 day period
- Costs are typically higher in the first 30 days
  - Does this put the agency with patients with complex, chronic conditions with long term needs at a disadvantage?
- Gap of more than 60 days before early 30 day period
- Early v Late comes from claims data
- How many new admissions do you have?
- LOS?

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Early v Late

PDGM

- Early: 1st 30 day period
- Late: 2nd and later 30 day period
- Switches back to early only if a gap in services of more than 60 days
- M0110 useless
- Automatically assigned appropriate timing category by claims system

PPS

- Early: 1st and 2nd 60 day episode
- Late: 3rd and later 60 day episode
- Switches back to early only if a gap in services of more than 60 days
- Uses response to M0110 to pay RAP
- Adjusted automatically based on claims data

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M0110

(M0110)	Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?	
Enter Code	1	Early
	2	Later
	UK	Unknown
	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.

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Admission Source—Community or Institutional

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Institutional

- Inpatient acute care hospitals (Occurrence code 61)
  - NOT observation stays
  - NOT ER visits
- SNF
- IRF
- LTCH
- Inpatient Psych
- Sicker upon admission, being discharged rapidly back to community and are more likely to be re-hospitalized, have more functional decline

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Institutional

- Healthcare setting utilized in the 14 days prior to home health admission
- *Acute care hospital* stay during a previous 30-day period and within 14 days prior to a subsequent, contiguous 30-day period of care and for which the patient *was not discharged from HH and readmitted*
    - Does not apply to PAC stays

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Examples

- Patient goes to ER and is admitted on day 17 of 30 day period. Discharged after 4 days. A ROC is completed.
- The ROC will determine Institutional payment and functional score. Any changes in diagnoses may come from ROC.
- Patient goes to ER and is admitted for observation. Released 2 days later. No ROC and no change to Institutional payment.
- Patient is admitted to hospital on day 28 and is discharged home on day 2 of new 30 day payment period. Depends…

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What about this?

- What if the patient was in a VA hospital and there was no Medicare claim?
  - Occurrence code entered on claim
- What if the patient was under observation and they changed to inpatient later without notifying us?
- All from claims data…Will look for institutional claim with dates of stay within 14 days. Will also check institutional claims to see if home health claim within 14 days.
- Patient on observation. Home health admits. Claims data will say Community. Hospital switches to inpatient later. Inpatient claim will prompt a search for a HH stay within 14 days

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Clinical Grouping from Principal Diagnosis

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CMS Assumption Clinical Group Coding

- This is based on the principal diagnosis code for the patient as reported by the HHA on the home health claim. Our proposed assumption was that HHAs will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group.

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Coding Assumptions

- In the current HH PPS, the assignment of points as part of the clinical level in the case-mix methodology is dependent upon the reporting of diagnoses. However, the points assigned are not generally dependent on whether the diagnosis is reported as the primary diagnosis or other diagnosis, except for a few exceptions.
- This means, that for most of the clinical point assignments, the ordering of the diagnosis does not matter as much as whether the diagnosis is present or not.
- For example, if a cancer diagnosis is reported, there are the same number of associated clinical points regardless of whether the cancer diagnosis is reported as a principal diagnosis or as a secondary diagnosis.

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Coding Assumption

- Under PDGM, the ordering of diagnoses is important in determining the clinical group and the comorbidity adjustment, so we do expect that HHAs will improve the ordering of diagnosis codes to ensure that the home health period of care is representative of patient characteristics and paid accordingly.

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Coding Assumption

- More opportunity to report all comorbid conditions that may affect the home health plan of care.
- The OASIS item set only allows HHAs to designate up to 5 secondary diagnoses, while the home health claim allows HHAs to report up to 24 secondary diagnoses

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Coding Assumption

- ICD–10 coding guidelines require reporting of all secondary diagnoses that affect the plan of care, we would expect that more secondary diagnoses would be reported on the home health claim given the increased number of secondary diagnosis fields on the home health claim compared to the OASIS item set.
- The comorbidity adjustment in the PDGM can increase payment by up to 20 percent.
- Assume that HHAs will ensure that secondary diagnoses affecting the home health plan of care would be reported to more accurately identify the conditions affecting resource use.
- Opportunity to report conditions supported in the medical documentation for which home health services are being provided

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Clinical Groups

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Clinical Grouping

- 432 case-mix groups when the MMTA sub-groups added
- Unspecified codes mostly removed
- R codes removed
- Laterality important
- If the code is not in the Clinical Group list, it is not acceptable as a PRIMARY code (previously known as Questionable Encounter)
- Will be RTP'ed
- Change the code. Ensure that clinical documentation supports the new code.

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Action Item

- Compare your top diagnoses to clinical grouper list.
- R codes as primary
- Unspecified codes
- F2F Encounter process for matching diagnosis prompting F2F encounter to primary diagnosis

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Top 200 Diagnoses—What's wrong?

Z47.1	Aftercare following joint replacement surgery	260,895	4.35%	1	MS_REHAB
I10	Essential (primary) hypertension	214,730	3.58%	2	MMTA_OTHER
M62.81	Muscle weakness (generalized)	187,013	3.12%	3	None

Comorbidity Adjustment—Secondary Diagnoses (up to 24 additional diagnoses)

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Co-Morbidity Groups

- Heart Disease.
- Respiratory Disease.
- Circulatory Disease and Blood Disorders.
- Cerebral Vascular Disease.
- Gastrointestinal Disease.
- Neurological Disease and Associated Conditions.
- Endocrine Disease.
- Neoplasms.
- Genitourinary and Renal Disease.
- Skin Disease.
- Musculoskeletal Disease or Injury.
- Behavioral Health (including Substance Use Disorders).
- Infectious Disease

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Comorbidities

- Patients with certain comorbidities and interactions of certain comorbid conditions have home health periods of care with higher resource use than home health periods of care without those comorbidities or interactions.
- Identified individual comorbidity subgroups that were statistically and clinically significant for case-mix adjustment and these are identified in Table 10

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Table 10

Comorbidity Subgroup	Description
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins with ulceration
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Heart 10	Includes cardiac dysrhythmias
Heart 11	Includes heart failure
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
Neuro 5	Includes Parkinson's disease
Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018.

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Table 10 *Low comorbidity adjustment*

- A 30-day period of care would receive a low comorbidity adjustment if there is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups, as listed in Table 10, for example, Heart 11, Cerebral 4, etc., associated with higher resource use, *or*

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Table 11 High Comorbidity Adjustment

- A 30-day period of care would receive a high comorbidity adjustment if a 30-day period has two or more secondary diagnoses reported that fall within one or more of the comorbidity subgroup interactions, as listed in Table 11, for example, Heart 11 plus Neuro 5, that are associated with higher resource use.

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Table 11

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
5	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
6	Circulatory 4	Include hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
7	Circulatory 4	Include hypertensive chronic kidney disease	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
8	Circulatory 7	Includes atherosclerosis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
9	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's disease
10	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
11	Endocrine 3	Includes diabetes with complications	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
12	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
13	Heart 10	Includes cardiac dysrhythmias	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
14	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
15	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
16	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's disease
17	Heart 11	Includes heart failure	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
18	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
19	Heart 11	Includes heart failure	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
20	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
21	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
22	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's disease
23	Neuro 10	Includes peripheral and polyneuropathies	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
24	Neuro 3	Includes dementias	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
25	Neuro 3	Includes dementias	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
26	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
27	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus
28	Renal 1	Includes Chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Renal 1	Includes Chronic kidney disease and ESRD	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
30	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
31	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
32	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
33	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
34	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018.

CMS Assumption: Comorbidity Coding

- The PDGM further adjusts payments based on patients' secondary diagnoses as reported by the HHA on the home health claim. OASIS only allows HHAs to designate 1 principal diagnosis and 5 secondary diagnoses while the home health claim allows HHAs to designate 1 principal diagnosis and 24 secondary diagnoses.
- Our proposed assumption was that by taking into account additional ICD–10–CM diagnosis codes listed on the home health claim (beyond the 6 allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment

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Action Items

- How many diagnoses are you coding now?
- Are you limited by software?
  - DDE accepts 25
- When will your software be updated?
- CoP requirements are NOW
  - Code all pertinent (all Known) diagnoses
- How are diagnoses substantiated with physicians? How is that documented? Who is querying?

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DDE

- DDE supports 25 diagnoses just like the electronic 837I claim format.
- The difference between the DDE and the electronic formats is that for the DDE format, the reporting of diagnosis codes is split between two screens, meaning the first 9 diagnosis codes are entered on the first screen, and diagnosis codes 10–25 are entered on the second screen.
- To reach the second screen to enter these codes, the person entering the claim information would hit the F6 key to move from the first screen to the second screen.

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Assumptions Reduce Payment Amount

TABLE 12: CY 2020 PROPOSED, ESTIMATED 30-DAY BUDGET-NEUTRAL PAYMENT AMOUNTS

Behavior Assumption	30-day Budget Neutral (BN) Standard Amount	Percent Change from No Behavior Assumptions [1]	FDL Ratio
No Behavior Assumptions	$1,907.11		0.56
LUPA Threshold (1/3 of LUPAs 1-2 visits away from threshold get extra visits and become case-mix adjusted)	$1,871.67	-1.86%	0.59
Clinical Group Coding [2] (among available diagnoses, one leading to highest payment clinical grouping classification designated as principal)	$1,794.42	-5.91%	0.60
Comorbidity Coding (assigns comorbidity level based on comorbidities appearing on HHA claims and not just OASIS)	$1,900.05	-0.37%	0.56
Clinical Group Coding + Comorbidity Coding + LUPA Threshold	$1,754.37	-8.01%	0.63

Notes:

[1] Adding all the percent decreases for each behavior assumption results in a total percent decrease of -8.14 percent. However, there is overlap and interactions between the behavior assumptions and when combined, the budget-neutral payment amount results in a -8.01 percent decrease from the payment amount without these assumptions applied.

[2] The clinical group coding assumption has a higher percent decrease (-5.91 percent) in this year's proposed rule compared to the percent decrease in the CY 2019 HH PPS proposed rule (-4.28 percent). This is because the CY 2019 clinical coding assumption was based on the six proposed clinical groups and the CY 2020 clinical coding assumption is based on the finalized 12 clinical groups.

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Functional Score (only part of payment equation from OASIS)

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PDGM Functional (only part of HIPPS that comes from OASIS)

- M1033 Risk for Hospitalization
- M1800 Grooming
- M1810/M1820 Dressing
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation

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Functional Status

- Relationship exists between functional status, rates of hospital readmission, and the overall costs of health care services.
- Functional status is defined in a number of ways, but generally, functional status reflects an individual's ability to carry out activities of daily living (ADLs) and to participate in various life situations and in society.
- As functional status declines, resource use increases.

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M1033

(M1033) **Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

- At least 4 responses checked excluding 8, 9 ,10

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Functional

- Low, medium, high with approx. 1/3 in each functional group
- Future use of GG items
- Thresholds by functional level
- Each of the responses associated with the functional OASIS items which are then converted into a table of points corresponding to increased resource use (see Table 28).

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Table 8: Functional Scoring

	Responses	Points (2018)	Percent of Periods in 2018 with this Response Category
M1800: Grooming	0 or 1	0	39.6%
	2 or 3	5	60.4%
M1810: Current Ability to Dress Upper Body	0 or 1	0	37.5%
	2 or 3	6	62.5%
M1820: Current Ability to Dress Lower Body	0 or 1	0	18.1%
	2	6	60.5%
	3	12	21.4%
M1830: Bathing	0 or 1	0	4.6%
	2	3	16.6%
	3 or 4	12	54.0%
	5 or 6	20	24.9%
M1840: Toilet Transferring	0 or 1	0	66.3%
	2, 3 or 4	5	33.7%
M1850: Transferring	0	0	2.5%
	1	3	32.3%
	2, 3, 4 or 5	6	65.2%
M1860: Ambulation/Locomotion	0 or 1	0	6.2%
	2	9	22.6%
	3	11	55.9%
	4, 5 or 6	23	15.3%
M1032: Risk of Hospitalization	Three or fewer items marked (Excluding responses 8, 9 or 10)	0	81.2%
	Four or more items marked (Excluding responses 8, 9 or 10)	11	18.8%

Source: CY 2018 home health claims and OASIS data.

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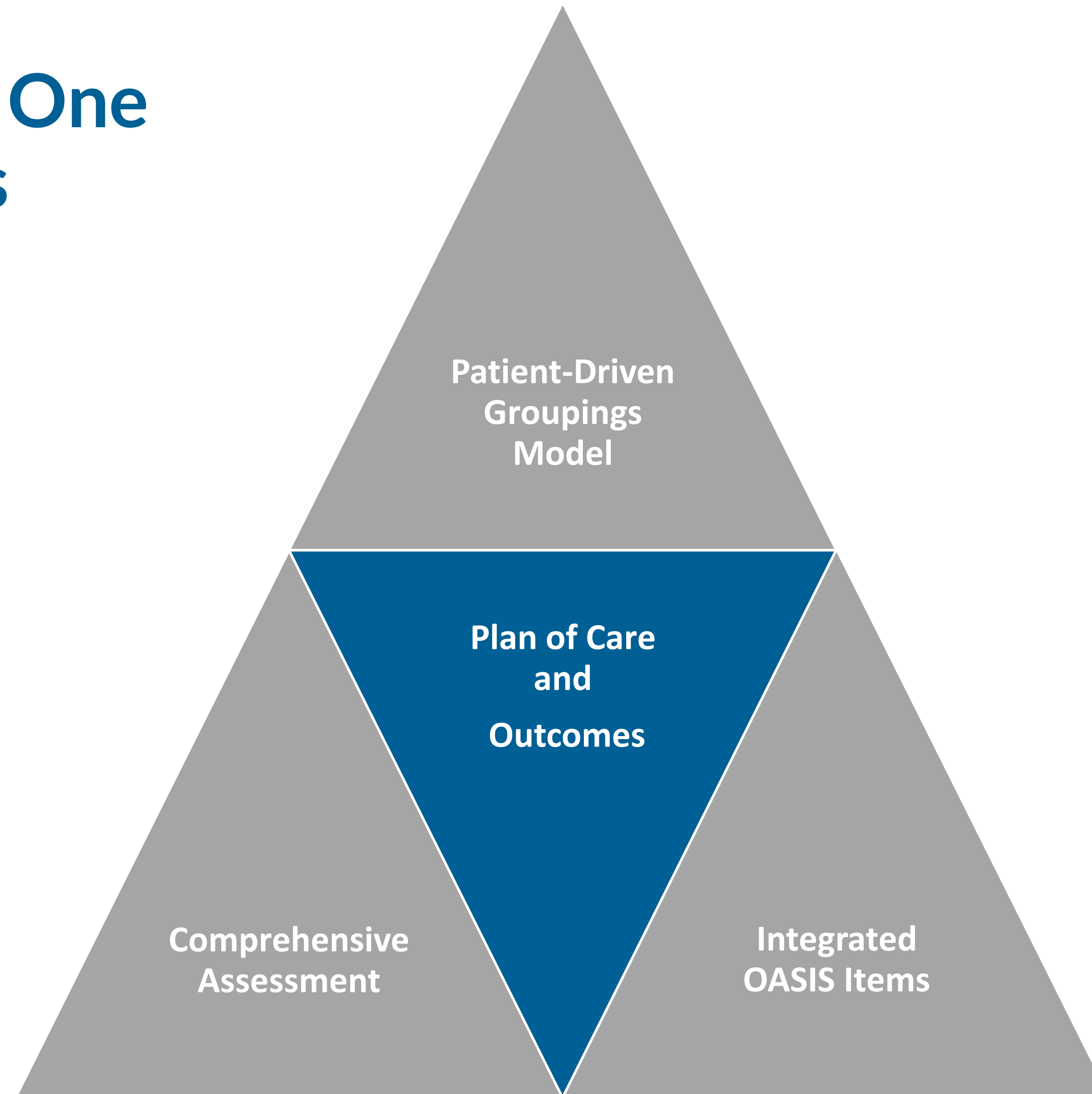
Action Item

- Evaluation of functional scoring and documentation to support
- Additional training as necessary

The Value of the One Thought Process



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What does one thought process mean?

- It's about working together as a group from intake to discharge and that includes a discharge plan that addresses care after discharge, so the patient doesn't come back in a few weeks.
- A plan that addresses the patient remaining safely in their home, able to function as independently as possible with or without a device or helper.
- Working to meet the mandates of the IMPACT Act, CMS has identified that the various health care providers work within silos. That translates to poor communication at the patient's expense.

What does one thought process mean?

- Home care clinicians know how hard it is to assess and create a realistic care plan for a patient when the transfer paperwork is lacking a history and physical or there are multiple medication lists, none of which match.
- To promote communication among post-acute providers, we now have standardized data items. OASIS-D1 will continue to have GG0100, 0110, 0130, 0170, and J1800 and 1900.

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What does one thought process mean?

- The implementation of the Conditions of Participation and expansion of the One Clinician Convention serve to **promote communication** between
  - clinical staff and their patients
  - the patient's family
  - the patient's representative (if any)
  - the patient's caregiver

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What does one thought process mean?

- With PDGM, agencies will need to work closely with EMR vendors to meet needs associated with data analysis, guided coding alignment, and transitioning to the new billing cycle, while not losing sight of the need to improve the patient's experience.
- Outside of the agency walls, clinicians need to interact with providers to ensure they receive complete medical records and when needed to query the physician for diagnostic information and/or orders etc.

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Briggs' OASIS forms prompt the clinician for details and offer comment areas for narrative summaries, which supports the collection of the specific patient's characteristics and easing the creation of an individualized care plan.

Patient Name ______________________ ID# __________

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

Primary caregiver(s) other than patient: ☐ N/A ☐ None available
☐ Family member(s) ☐ Friend(s)
☐ Paid service other than home health staff:
Company name: ____________
Phone number: ____________
Contact name: ____________

Prior to this admission, how often did the patient receive assistance with their ADLs/IADLs, from any caregiver(s)?
☐ None received ☐ At least daily ☐ One to two times per week
☐ Three or more times per week ☐ Less often than weekly
☐ Unknown

Primary Caregiver(s) Information:
Name: ____________
Relationship: ____________ Phone Number: ____________
Mailing address: ____________
Email address: ____________
Name: ____________
Relationship: ____________ Phone Number: ____________
Mailing address: ____________
Email address: ____________

Caregiver(s) assist with (ADLs, IADLs and/or medical cares): ____________

Caregiver(s) willing to assist? ☐ Yes ☐ No ☐ Unknown If no or unknown, explain: ____________

Does the caregiver feel safe assisting the patient? ☐ Yes ☐ No
☐ Unknown If no or unknown, explain: ____________

List below the hours and days a caregiver is available to provide cares.
☐ There is no set schedule for availability

AM Hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

PM Hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Nights

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Explain any available time that a caregiver might be present: ____________

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them): PRA

Enter Code ☐
0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.
1 Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

☐ No Problem ☐ PERRLA
☐ Pupils unequal ☐ Glasses
☐ Glaucoma: ☐ R ☐ L ☐ Cataract(s): ☐ R ☐ L
☐ Scleral icterus/yellowing ☐ Contacts: ☐ R ☐ L
☐ Blurred vision: ☐ R ☐ L ☐ Ptosis: ☐ R ☐ L
☐ Prosthesis: ☐ R ☐ L ☐ Blind: ☐ R ☐ L
☐ Other: ____________
☐ Infections: ____________
☐ Cataract surgery: (Right) Date: ________ (Left) Date: ________
How does the impaired vision interfere/impact their function/safety? (explain): ____________

NOSE

☐ No Problem
☐ Congestion ☐ Epistaxis ☐ Loss of smell ☐ Sinus problem
☐ Other (specify): ____________

THROAT

☐ No Problem
☐ Dysphagia ☐ Hoarseness ☐ Lesion(s) ☐ Sore throat
☐ Other (specify): ____________

MOUTH

☐ No Problem
☐ Dentures: ☐ Upper ☐ Lower ☐ Partial ☐ Mass(es) ☐ Tumor(s)
☐ Gingivitis ☐ Ulceration(s) ☐ Toothache ☐ Lesion(s)
☐ Other (specify): ____________

EARS

Ability to hear (with hearing aid or hearing appliance if normally used):
☐ Adequate: hears normal conversation without difficulty
☐ Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
☐ Severely Impaired: absence of useful hearing
☐ Unable to assess hearing

☐ No Problem
☐ HOH: ☐ R ☐ L ☐ Deaf: ☐ R ☐ L ☐ Hearing aid: ☐ R ☐ L
☐ Vertigo ☐ Tinnitus: ☐ R ☐ L
☐ Other (specify): ____________

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COMPREHENSIVE ADULT NURSING ASSESSMENT with OASIS ELEMENTS

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Briggs integrates the OASIS items into the comprehensive assessment to support the clinician's responses and promote critical thinking.

Patient Name ______________________ ID# ____________

ADL/IADLs (Cont'd)

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment. (PRA)

Enter Code ☐
- 0 Able to manage toileting hygiene and clothing management without assistance.
- 1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- 2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code ☐
- 0 Able to independently transfer. (PRA)
- 1 Able to transfer with minimal human assistance or with use of an assistive device.
- 2 Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. (PRA)

Enter Code ☐
- 0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- 1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 Able to walk only with the supervision or assistance of another person at all times.
- 4 Chairfast, unable to ambulate but is able to wheel self independently.
- 5 Chairfast, unable to ambulate and is unable to wheel self.
- 6 Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten. (PRA)

Enter Code ☐
- 0 Able to independently feed self.
- 1 Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 Unable to take in nutrients orally or by tube feeding.

Patient's current ability to plan and safely prepare light meals (for example, cereal, sandwich):
- ☐ Able to independently plan, prepare and reheat light meals
- ☐ Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past
- ☐ Unable to prepare light meals due to physical, cognitive, or mental limitations
- ☐ Unable to prepare or reheat any light meals

Patient's current ability to use the telephone safely:
- ☐ Able to dial numbers and answer calls appropriately
- ☐ Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers
- ☐ Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls
- ☐ Able to answer the telephone some of the time or is able to carry on a limited conversation
- ☐ Unable to answer the telephone at all but can listen if assisted with equipment
- ☐ Totally unable to use the telephone
- ☐ Patient does not have a telephone

Indications for Home Health Aides: ☐ Yes ☐ No ☐ Refused
Order obtained: ☐ Yes ☐ No
Reason for need: ______________________

M1910 is on page 17 of 29

ACTIVITIES PERMITTED

☐ Complete bedrest	☐ No restrictions
☐ Bathroom privileges	☐ Other (specify): ________
☐ Up as tolerated	
☐ Transfer bed/chair	
☐ Exercises prescribed	☐ Other (specify): ________
☐ Partial weight bearing	
☐ Independent in home	
☐ Crutches	☐ Other (specify): ________
☐ Cane	
☐ Wheelchair	
☐ Walker	

ALLERGIES

Allergies: ☐ None known
☐ Aspirin ☐ Penicillin ☐ Sulfa ☐ Pollen ☐ Eggs
☐ Milk products ☐ Insect bites
☐ Other: ________

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One Last Thought

- Agencies need to educate the clinicians about the importance of documentation and how it may affect the HHA's reimbursement.
- There are 432 possible case-mix adjusted payment groups to accurately align payment with each specific patient's characteristics.
- PDGM will place a greater demand on clinical documentation for clinicians completing the comprehensive assessment with OASIS items in the OASIS-D1 data set.

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One Last Thought

- Gone are the days of cookie cutter care plans. CMS expects each patient to be identifiable, in writing, by their unique characteristics. Two people have the same diagnosis, but not exhibit the same level of symptomology.
  - Example: A pain level one person can tolerate may be unacceptable by another.
- Throughout the Briggs OASIS, there are areas for narratives. Between visits, a skilled note or communication note can be written. Communication notes are particularly good to show communication between the interdisciplinary team.
- **Lastly, take credit for what you do and don't forget to document.**

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The following slide is for information purposes only.

Do your Own Research

CY 2020 PDGM Grouper Tool

HH PPS Proposed PDGM

Disclaimer This file was prepared as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended for use as a learning tool for determining the HIPPS codes assigned to 30-day periods. It does not include information related to partial payments and outliers. It does not contain the edits (such as those related to the guidelines associated with etiology and manifestation codes) included in the official CMS grouper software designed and published by 3M. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Number of visits provided for this 30-day period of care==============> Please enter a number of visits for the 30-day period of care.

Timing

Early
Late

Admission Source

Community
Institutional

	Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)		
Primary diagnosis: Enter a valid ICD-10-CM code===================>		
Comorbidity Adjustment (from secondary dx)		

Grouping | HIPPS Code Structure | OASIS items | ICD10 DXs | Comorbidities | Comorbidity - High | Comorbidity - Low | Functional Thresholds | ...

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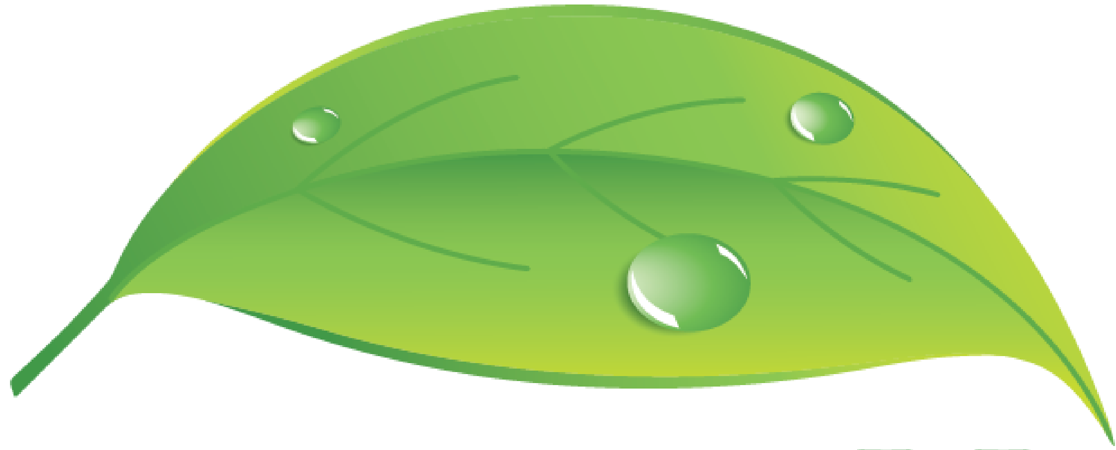

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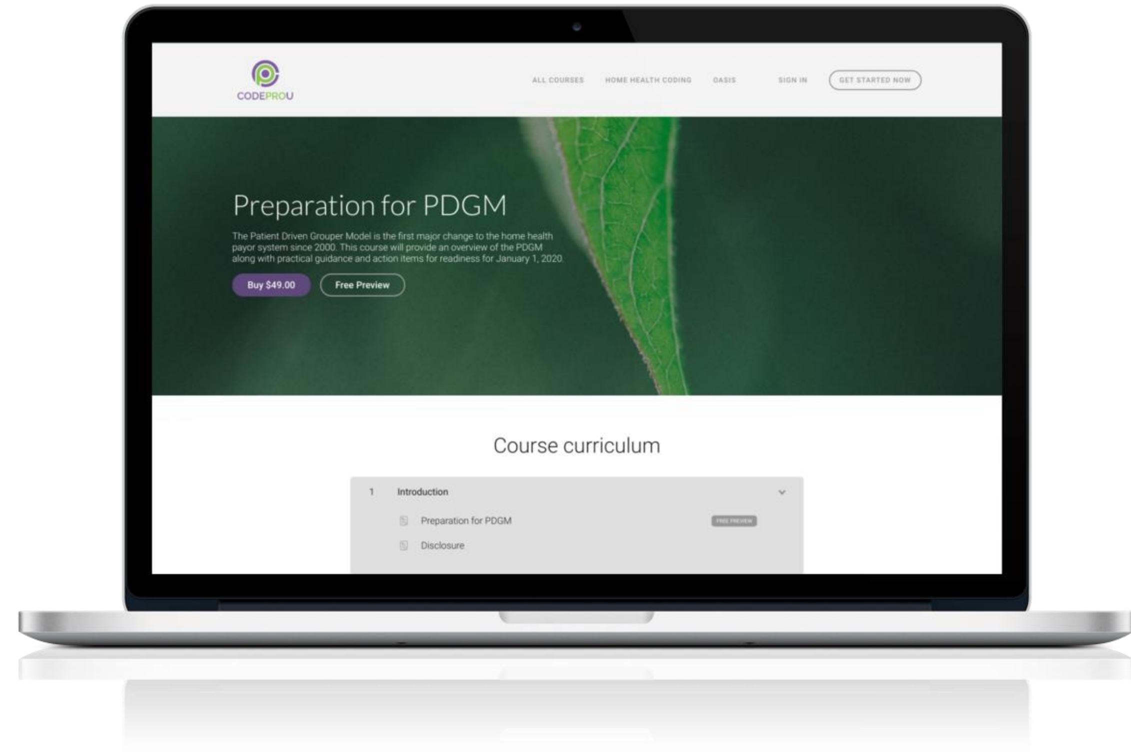

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Q&A

Our speakers

Sharon Hamilton

MS, RN, CFDS
Clinical Consultant, Briggs Healthcare
Hamilton.Sharon@BriggsCorp.com
https://Briggshealthcare.blog

Lisa Selman-Holman

JD, BSN, RN, HCS-D, COS-C, HCS-O, HCS-H, AHIMA ICD-10-CM
Founder, Selman-Holman
lisa@selmanholman.com
www.selmanholman.com

Thank you for attending!

Recording and slides available at

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