OASIS-C2

Plan for initial productivity declines, additional training to prepare for OASIS-C2

One of the most significant additional burdens agencies will face if CMS' draft OASIS-C2 becomes final is the extra time that will be involved with educating on and responding to new and changed measures at start of care (SOC)/resumption of care (ROC) assessments.

CMS released its OASIS-C2 draft Dec. 22, 2015, and says it will implement it Jan. 1, 2017. The new item set has been created to comply with the requirements for standardized, cross-setting measures for post-acute care under the IMPACT Act (OOS 2/16), the federal Medicare agency says.

(see OASIS-C2, p. 8)

Trends: ICD-10 impact

Consider training, focused info requests to doctors to meet ICD-10 challenges in 2016

Whether it’s rejected claims, documentation deficits or productivity declines, agencies nationwide are feeling the pinch from ICD-10’s implementation.

Many agencies anticipate these issues will continue to affect their operations in 2016.

More than 36% of 138 respondents to a question on DecisionHealth’s 2016 Trends Survey say the implementation of ICD-10 will be among the factors that will have the largest operational and financial impact on their businesses this year.

(see ICD-10, p. 10)

2016 Home Health Administrator’s Summit

The Home Health Administrator’s Summit, to be held May 11-13, 2016, in Las Vegas, is a must-attend annual event to network with industry leaders and gain valuable strategies and insights on how to successfully position your business for future growth. Check out the details at www.decisionhealth.com/HHAdminSummit.
Boost outcomes by tracking discharge data to prepare for CMS’ quality initiatives

Consider weekly tracking of data such as actual versus planned nursing visits and reasons for discharge as a means to boost quality outcomes in light of the sundry quality initiatives planned or underway by CMS.

Approximately one third of the 124 respondents to a question on DecisionHealth’s 2016 Trends Survey stated value-based purchasing and CMS’ 5-star rating system are among the top regulatory challenges they will face in 2016.

And many respondents say their agencies plan on improving quality outcomes in 2016 as a way to differentiate themselves from competition.

Assurance HealthCare in Tucson, Ariz., uses more specific data tracking, such as emergency room visits, readmissions, and medication management, within its electronic health records (EHR) system, Kinnser of Austin, Texas.

The decision to do so is part of the agency’s new focus on quality outcomes in light of the home health industry’s various quality initiatives, such as 5-star ratings and value-based purchasing. Arizona — where Assurance is based — is one of nine states CMS chose for agencies to participate in value-based purchasing beginning Jan. 1.

Enhanced data monitoring at Assurance began in July 2015 as the agency started involvement in a bundled initiative to reduce readmissions and care for patients treated at a local orthopedics group, says Susan Weber, the agency’s chief nursing officer.

For the bundle, Weber tracked outcomes for patient goals met and discharge to the community, as well as visit utilization for each therapist. This helped her figure out the best number of visits required for each patient, she says.

It also helped Assurance achieve a 2% readmission rate for patients involved in the bundle so far, by forcing the agency to focus on giving patients the number of visits needed to ensure better outcomes and educating clinicians when needed.

Assurance is among roughly 34% of DecisionHealth survey respondents who say they’ve taken steps to partner with providers like hospitals or physicians to prepare for accountable care organizations (ACOs), care-transitions demonstrations or other payment model demonstrations.

Meanwhile, 32% of respondents say they plan to do so in 2016.

Figuring out the most efficient number of visits per discipline per diagnosis, such as for those related to a hip or knee replacement surgery, will be an important step agencies need to take to efficiently achieve improved outcomes.
for CMS’ quality initiatives, says Barbara McCann, chief industry officer for Interim Healthcare of Sunrise, Fla.

For example, if one patient got seven PT visits and another patient got five PT and three OT visits, compare the outcomes for measures like improvement in ambulation, transferring or bathing next to this visit utilization to figure out the best mix of discipline type for the best outcome, McCann says.

Prepare for quality with training

Consider joining a home health state association to train on specific value-based demonstration measures or outcome improvement. You could save money by joining forces.

About 51% of agencies responding to the DecisionHealth survey say they are preparing for the new quality initiatives by ramping up quality improvement training.

Meanwhile, nearly 70% of respondents to a survey question about 2016 budgeting say they plan on spending more on education and training in 2016.

About 62% of respondents say they will spend more on OASIS training in 2016.

Assurance HealthCare plans to continue quality improvement training at the Arizona Association for Home Care to specifically prepare for value-based purchasing, Weber says.

Trainings so far have been on the shingles vaccination and on advanced care planning. These new measures are included in the value-based purchasing model.

At a cost of $10 a nurse, the association also provided wound training to clinicians from a Wound, Ostomy and Continence Nurses (WOCN) Society nurse. That cost is significantly cheaper than if the agency hired a WOCN nurse to give her agency wound training, Weber says.

Tips for improving quality scores

• **Standardize assessment practices and include them in your EHR.** One example of how to be consistent: Make sure all your clinicians assess patients for M1400 (Shortness of breath) by asking patients to stand up and walk a specific distance, such as 20 feet, McCann says.

  To do this, convene a meeting of clinicians to focus on a specific measure and have them develop a standardized evaluation for the patient related to the measure, she says.

  After this standardized practice is finalized, include the practice in a note in your EHR alongside the OASIS item or create a PDF with the information. Clinicians can take the information with them to patient visits.

• **Develop definitions for confusion and anxiety.** These terms are key to consistently answering M1710 (When confused) and M1720 (When anxious), both of which are risk-adjustment items and impact patient outcomes, McCann says.

  Make sure a competent staff member, such as a social worker, develops a single definition for anxiety and confusion. This will bring more consistency to responses.

  A better understanding of confusion and anxiety can help clinicians reach out to patients’ physicians early in the home health episode and get a referral to treat any psychological issues, McCann says. This in turn will improve patients’ adherence to the home health treatment plan, and ultimately, outcomes.

• **Use data vendors to uncover issues with individual clinicians.** Florida Home Health in Sebring, Fla., will continue to use Santa Barbara, Calif.-based data vendor Strategic Healthcare Programs to highlight whether outcomes scores are impacted by individual clinicians, such as activities of daily living (ADLs), says Michele Garges, the agency’s director of operations.

  Clinical managers at the agency are focusing on training clinicians to respond accurately to ADL measures in the OASIS at the start of care so that a proper sense of outcome improvement is reflected in the OASIS at discharge, Garges says. — **Nicholas Stern (nstern@decisionhealth.com)**

**Trends: Face-to-face compliance**

**Agencies should expect a significant increase in denials involving face to face**

When it comes to face-to-face denials, 2015 may have been the calm before the storm. The home health industry should expect many more denials and much more activity from auditors involving face to face in 2016.

A nationwide “Probe and Educate” review began last month for home health and is expected to serve as a test of how successfully agencies have adapted to the new requirements, says Harry Feliciano, senior medical director for Medicare Administrative Contractor (MAC) Palmetto GBA.
MACs backed off issuing denials in 2015, and far fewer agencies received denials for 5FF2F — face-to-face encounter requirements not met — than in 2014.

The industry as a whole is “holding its breath” about the probe's results, however, says attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath and Lyman. It will be a true indicator about how closely auditors will scrutinize patient records and issue denials due to a lack of physician documentation that supports the patient is homebound and requires skilled care, Markette adds.

The industry should expect to be “inundated with denials” beginning in early 2016, warns consultant Arlene Maxim of A.D. Maxim Consulting in Troy, Mich.

Overall, the probe will have the second-biggest impact on home health operations and financials among all regulatory changes and requirements, according to 138 respondents to a question on DecisionHealth’s 2016 Trends Survey.

More than 41% of respondents expect to receive more denials in 2016 than in 2015 due to revisions to the face-to-face requirement, as well as the ongoing face-to-face probe.

Probes will lead to many denials

CMS removed the narrative requirement for face-to-face documentation for episodes beginning Jan. 1, 2015. And it was clear there would be a learning curve for agencies as they adapted to the requirement change, Feliciano says.

But CMS has directed MACs to select a sample of five claims for pre-payment review from every agency nationwide, according to MLN Matters article SE1524, released Nov. 9.

Although there is no more need for physicians to write a narrative, CMS has made clear that documentation in the physician's medical records, and/or the acute/post-acute care facility's medical records if the patient was directly admitted to home health, is going to be used as the basis for certification of home health eligibility. Agencies that have two to five claims out of compliance during the first wave will be subjected to another five-claim probe.

Markette believes millions of dollars will be denied during the probe and that on average, agencies will receive denials on about 40% of claims.

“That's assuming that agencies have taken the opportunity to supplement the physician's record through some form of post-assessment communication that clarifies the link between the issues for which the patient was seen by the physician and the need for home health,” he notes.

MACs were expected to begin sending additional documentation requests to agencies in late 2015. The first round of claim denials likely will occur within months.

RAC reviews are coming too

New contracts for recovery audit contractors (RACs) will be awarded soon, and that too should be a concern for the industry in 2016.

Under the contracts, there will be five RACs instead of four. The new RAC will be nationwide and focus on performing reviews for home health, hospice and durable medical equipment (DME).

This likely will lead to more scrutiny from a RAC on home health and hospice claims than ever before, says Emily Evans, a partner and legislative/regulatory analyst for Nashville-based Obsidian Research Group. Obsidian is a research firm serving investment professionals and health care executives.

Key steps to bolster documentation

Continue to educate doctors. Reiterate that the face-to-face requirement wasn't eliminated — some doctors mistakenly believe this to be the case, says Kathy Merrill, an independent consultant Palmetto tasked with helping improve face-to-face processes.

Explain to doctors that documentation should address: What is the structural impairment? What is the functional impairment? What is the activity limitation? How do the skills of a nurse or therapist address the specific structural and functional impairments and activity limitations you have identified when answering the first three questions?

Answers to such questions should be in the patient's chart in an office visit note, discharge summary or progress note. That's according to a practice manager with Concord Internal Medicine in Concord, N.C., who participated in a recent Palmetto project to identify gaps in processes.

Figure out gaps and where confusion exists. Palmetto's project found that while agencies might think they get all the necessary face-to-face information at intake 70% of the time, in reality only 2% to 3% of the time do agencies immediately receive enough documentation at intake to pass muster with auditors, Merrill says. Then agencies must chase down needed information.

One way to improve the flow of information: Better communication with referral sources. In some situations,
the project showed, agencies would see documentation was lacking and fax another face-to-face form to doctors, requesting resubmission. But the doctor’s office would believe it already had filled out the form and, rather than duplicating efforts, would shred the follow-up fax instead of providing the agency with information.

Remember you can supplement physicians’ records. The 2015 PPS final rule lets agencies provide certifying physicians additional homebound/skilled need explanation to sign and incorporate into the medical record. But the documentation agencies provide must corroborate what the referral source writes in his own assessment of the patient, Feliciano reminds. — Josh Poltilove (jpoltilove@decisionhealth.com)

**Related links:** Read the MLN article at http://go.cms.gov/1iTOWl9. View slides from videos from Palmetto’s project at http://bit.ly/1I1L0p5.

Quality improvement

**Make best practices short list, consistently implement it to see gains in value-based world**

The list of quality measures for home health CMS may ultimately use to help determine payments to agencies just grew six measures longer.

The National Quality Forum’s Measures Applications Partnership (MAP) on Dec. 1 released its measures under consideration list (MUC) list, which may be selected by CMS for national pay-for-performance and public reporting programs in the future. (See related box, right, for a list of the new measures.)

Some of the new measures — such as improvement in dyspnea in patients with a primary diagnosis of CHF, COPD and/or asthma — seem like a good idea for the industry, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, owner of Rambusch3 Consulting, Georgetown, Texas.

Focusing on these specific diagnoses, which typically lead to symptoms of dyspnea may be a helpful way to show more precisely how and whether patients’ shortness of breath improves over a home health episode, Rambusch says.

Regardless, it’s likely the proposed measures will just add to agencies’ anxiety over several new CMS quality initiatives like star ratings and value-based purchasing that place an emphasis on outcomes improvement, she says.

It’s therefore advisable that clinical managers keep it simple when approaching outcomes improvement and teach clinicians to consistently adhere to one or two evidenced-based best practices, such as checking for weight gain and dyspnea in patients with CHF, Rambusch says.

If not, they soon could become overwhelmed and wind up not realizing any outcomes improvement, she says.

The MUC list contains measures submitted to CMS by the public and those measures CMS actually will adopt to comply with mandatory reporting programs, such as the IMPACT Act.

The IMPACT Act requires home health agencies, long-term care hospitals, inpatient rehabilitation facilities and skilled nursing facilities to report standardized patient assessment data using the assessment instruments, like the OASIS for home health, already in use to submit data to CMS.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure description</th>
<th>Measure type</th>
<th>Provider type</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUC15-207</td>
<td>Falls risk composite process measure</td>
<td>Composite</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-234</td>
<td>Potentially preventable 30-day post discharge readmission</td>
<td>Outcome</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-235</td>
<td>Improvement in dyspnea in patients with a primary diagnosis of CHF, COPD and/or asthma</td>
<td>Outcome</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-523</td>
<td>Discharge to community</td>
<td>Outcome</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-1127</td>
<td>Drug regimen review conducted with follow-up</td>
<td>Process</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-1134</td>
<td>Medicare spending per beneficiary</td>
<td>Cost/resource use</td>
<td>Home health</td>
</tr>
<tr>
<td>MUC15-227</td>
<td>Hospice visits when death is imminent</td>
<td>Process</td>
<td>Hospice</td>
</tr>
<tr>
<td>MUC15-231</td>
<td>Potentially preventable 30-day post-discharge readmission</td>
<td>Composite</td>
<td>Hospice</td>
</tr>
</tbody>
</table>
Measures under consideration are on a fast track to meet statutorily required 2017 timelines, CMS says. Home health agencies will have to submit new, standardized quality data under the IMPACT Act by no later than Jan. 1, 2019.

Figuring out where agencies have the best opportunity to improve outcomes related to a particular measure in the most cost-effective way will be important to showing gains in CMS programs like value-based purchasing and star ratings, says Chris Attaya, vice president of business intelligence at Santa Barbara, Calif.-based Strategic Healthcare Programs.

Evaluate dyspnea at each visit

When answering M1400 (Short of breath?) for patients with CHF, clinicians want to make sure they’re evaluating patients at every visit, and not just at the start of care (SOC)/resumption of care (ROC), Rambusch advises. That has to be done to accurately gauge whether these patients’ dyspnea is improving over the course of the episode.

And remember, M1400 is a case-mix item and is used to calculate an agency’s 5-star rating. It also will be a measure used in value-based purchasing to determine agencies’ payment adjustments.

Clinicians also have to assess patients in a systematic way to properly gauge dyspnea, she says. For example, are clinicians assessing patients by just looking at them and deciding, or are they, as should be done, asking them about their dyspnea over the preceding 24 hours as well and having them demonstrate activities like walking, which cause the dyspnea, Rambusch asks.

Note, for example, that just because Response 2 — “With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)” contains an example of dressing as a cause for dyspnea doesn’t mean clinicians are limited to this response when answering M1400, she says.

A patient who becomes short of breath when putting her arm through a jacket sleeve and requires frequent rest periods when doing so should be marked with Response 3 — “With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation,” Rambusch says.

This patient would more than likely also become short of breath while eating or performing other activities that require minimal exertion. Also, the clinician would more accurately reflect dyspnea improvement by discharge by initially marking Response 3 in this case.

More tips to track outcomes

• **Track individual clinician performance.** For instance, your agency may have an overall average of 60% improvement on a given measure, but different clinicians may have averages of 70%, 80% and 40%, Attaya says. In this hypothetical, agencies likely would want to target education to improve scores for the clinician scoring 40%, instead of educating all the clinicians, thus reducing the overall time spent educating staff.

• **Don’t just consider your agency’s improvement goal** when setting future outcomes targets. Also factor in the expected improvement in the measure nation-and/or state-wide, Attaya says. For example, national ambulation improvement scores have shown gains for the past four years — to 63% in 2014 from 56% in 2011.

Therefore, quality and clinical managers also need to consider potential improvements from national and state competitors on this measure as they set future outcomes targets in order to rise above the competition in star ratings and value-based purchasing, he says.

• **Manage your CHF patients with phone calls.** Have an aide or office clerk call these patients between nursing visits to see if the patients weighed themselves and are taking the proper medications, Rambusch says. If there is a sudden weight gain, say, have the aide notify the nurse for follow-up with the patient, either with another phone call or visit. — Nicholas Stern (nstern@decisionhealth.com)

**Related link:** View current and previous MUC lists and measures at [http://go.cms.gov/1QCu0P3](http://go.cms.gov/1QCu0P3).

---

**Coding Corner**

**Coding Basics: Detangle Alzheimer’s disease coding to keep claims compliant**

*By Cynthia Cooke, RN, BSN, COS-C, HCS-D, BCHH-C*

You now have four codes to capture Alzheimer’s disease in ICD-10, allowing you to be more specific but also making it more critical to get the most specific diagnosis from the physician.

The four Alzheimer’s disease codes, compared to the single code ICD-9 provided, are found in Chapter 6, Diseases of the Nervous System, in the G30.- category (Alzheimer’s disease). The fourth character on the code identifies the disease as early onset (G30.0), late onset (G30.1), other (G30.8) or unspecified (G30.9).
Alzheimer's disease (AD) is a chronic neurodegenerative disease that accounts for 50% to 70% of diagnosed cases of dementia. Diffuse atrophy occurs within the brain as the disease progresses, resulting in a gradual cognitive decline through several stages of recognizable emotional and behavioral symptoms including memory loss, personality changes, profound dementia and eventually death. Early-onset, also known as presenile AD, is diagnosed in individuals younger than 65 years of age. It accounts for less than 10% of all Alzheimer's cases worldwide. This diagnosis is captured with G30.0. Note that a physician still must specify that a patient's Alzheimer's is early-onset; you may not assume this is the correct code choice just because the diagnosis is there and the patient is under 65.

Late-onset or senile AD is the most common type of Alzheimer's disease. It's diagnosed in people 65 years of age and older, affecting roughly 6% of that age group. It is coded in ICD-10 with G30.1. You also must have a physician's specific diagnosis to assign this code.

Code G30.8 (Other Alzheimer's disease) should be assigned when physician documentation states a specific form of Alzheimer's disease that is not captured by any of the other specific codes (early or late onset). A diagnosis of Familial Alzheimer's Disease (FAD), which is a form definitively linked to genes, would fall under this category.

When the only information you have is “Alzheimer’s disease,” and you cannot get more specific information from the physician, G30.9 (Alzheimer's disease, unspecified) is the appropriate code choice.

Know the details, assign the right codes

It's important to obtain the most specific information possible about when a patient was diagnosed with Alzheimer's disease and whether the physician has confirmed “early onset” or “late onset” or another type of specified disease.

For example, there may be information in the record that indicates that a 66-year-old patient has had dementia for 10 years, but unless the physician's documentation specifically states she has Alzheimer's disease that's early-onset, it cannot be assumed as Alzheimer's disease, or for that matter, early-onset Alzheimer's disease.

Additionally, you need to pay particular attention to the “use additional code” note on category G30.- (Alzheimer’s disease) to identify delirium or dementia. This note is telling you that there is an etiology/manifestation convention that must be followed to identify whether the dementia that exists with Alzheimer's disease has caused behavioral disturbance.

For example, if the patient is diagnosed with Alzheimer's disease, the documentation should indicate if the patient is experiencing behavioral disturbance. Thus, you must sequence a code from F02.8- (Dementia in other diseases classified elsewhere) immediately following the G30.- code.

It's important to note that you're not adding a code to identify whether an Alzheimer's patient has dementia. Alzheimer's is a form of dementia; it's the third most common type. Thus, the additional dementia code is
to identify the level of dementia — i.e. whether there is behavioral disturbance or not.

Similarly if the Alzheimer's patient exhibits delirium, you must assign F05 (Delirium due to known physiological condition) as an additional code immediately following the G30.- code and the F02.8- code.

The most common type of delirium affecting an Alzheimer's patient is known as “sundowning.” When you look at the instructional note for the F05 code, you will see an instruction to “use an additional code to identify, if applicable” (emphasis added).

The “if applicable” indicates not all Alzheimer's patients will experience delirium but if it's present, you need to assign the F05 code in addition to an F02.8.- code.

If an Alzheimer’s patient also has documented wandering episodes, you should also assign Z91.83 (Wandering in diseases classified elsewhere).

**Scenario: Alzheimer’s disease, dementia**

A 79-year-old woman with diagnoses of anxiety and Alzheimer's dementia was recently seen at her physician's office. She's lost nine pounds in the last three months. Her husband reports she is more anxious, agitated and demands that he drive her on long drives daily.

Her prescribed dose of Lorazepam has been less effective lately and she has had recent falls. Her dose of Lorazepam was adjusted and a referral was made to home health for skilled nursing and social work to address the medication change, diet, and for counseling and supportive community referrals.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1025 Additional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1021a:</strong> Alzheimer's disease, unspecified</td>
<td>G30.9</td>
</tr>
<tr>
<td><strong>M1023b:</strong> Dementia in other diseases classified elsewhere with behavioral disturbance</td>
<td>F02.81</td>
</tr>
<tr>
<td><strong>M1023c:</strong> Repeated falls</td>
<td>R29.6</td>
</tr>
</tbody>
</table>

**Rationale:**

The patient has confirmed diagnoses of Alzheimer's dementia. She is experiencing behavioral disturbance and so the dementia code indicating this, F02.81, is assigned.

The type of Alzheimer's disease is not specified and thus G30.9 is assigned to capture it.

It's not necessary to include an additional code for the patient’s anxiety because anxiety is a behavioral disturbance that is integral to the behavioral disturbance that is already captured by the F02.81.

**About the author:** Cynthia Cooke, RN, BSN, COS-C, HCS-D, BCHH-C, is the clinical coding/OASIS nurse specialist for Concord Regional VNA in N.H. She has a clinical background in critical care and has worked in home health for more than 25 years, where she's held positions in management, administration and performance improvement.

**OASIS-C2**

(continued from p. 1)

It could initially take agencies an extra hour at least for clinicians to respond to — and for quality managers to review answers on — the three new items in OASIS-C2, such as GG0170C (Mobility) with its nine response options that have to be scored at SOC/ROC and at discharge, says Brandi Whitemeyer, RN, COS-C, HCS-D, HCS-O, AHIMA-approved ICD-trainer, product specialist at DecisionHealth. (See insert for a summary of changes in OASIS-C2.)

Over time, as clinicians grow more familiar with the item, that additional time could be reduced to an extra half hour on top of the hour to an hour-and-a-half it typically takes clinicians to complete the SOC/ROC.

Further, agencies should plan to set aside at least two to three full days of training over the course of the year to prepare for the implementation of OASIS-C2 — a consultant’s onsite training for a day could be $7,500 or more, Whitemeyer says.

The OASIS-C2 has three new items, M1028 (Active diagnoses, comorbidities and co-existing conditions), M1060 (Height and weight) and GC0170c (Functional abilities and goals at SOC/ROC). Five items had changed look-back periods to “…at the time of or at any time since the most recent SOC/ROC assessment...” from “…at the time of or at any time since the previous OASIS assessment.”

Also, formatting changes were made through the item set to convert multiple check boxes to a single box for data entry and to change the numbering for pressure ulcer staging from Roman to Arabic numerals.

So far, CMS has not given an indication of when stakeholders like quality managers will be able to submit comments on the draft. The federal Medicare agency has also yet to release item-specific guidance that will be
necessary to properly educate trainers and prepare clinicians to implement OASIS-C2, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, owner of Rambusch3 Consulting, Georgetown, Texas.

In the meantime, quality and clinical managers should read through the draft (see link below) and prepare themselves for the changes in the item set.

**Documentation key to success**

CMS added a new section not seen in the item set previously: GG, Functional abilities and goals - SOC/ROC. It’s located below M1850 (Transferring) in the activities of daily living (ADLs) section of the item set. Industry experts believe CMS will eventually add more items to this section.

Within this section, CMS has added one new item: GG0170C (Mobility).

The mobility item appears to be another way for CMS to capture data that demonstrates functional improvement over the course of the episode, Whitemyer says.

GG0170C also looks like a component or extension of M1850 and Rambusch worries the new item just adds redundancy to the OASIS.

GG0170C’s six coding options deal with mobility and levels of assistance, including moderate and maximal assistance provided by caregivers, while M1850 speaks more generally to transfer assistance by another person. The new item also has a second column to code safety and quality performance at discharge, which is not available in M1850.

Having clinicians clearly document and not just check boxes for their responses to items like GG0170C, will be vital to accurate scoring in OASIS-C2 and avoiding surveyor scrutiny, Whitemyer says.

For instance, if a patient requires the RN to answer Response 04 for GG0170C — “Supervision or touching assistance,” the RN needs to also document in the record that the patient requires one-on-one assistance or verbal cueing, particularly if doctor’s orders say something like “…as much as tolerated with a cane…,” she says. An example would be: “Patient can tolerate ambulation with cane and assistance with verbal cues or belt assist.”

And while this item helps clinicians somewhat in that each response provides some sort of answering guidance, clinicians will have to be as specific as possible to avoid additional documentation requests (ADRs), Whitemyer says.

For example, when choosing between Response 03 — “Partial/moderate assistance” or Response 02 — “Substantial/maximal assistance,” clinicians will need to write down percentages of how much assistance is required and why, such as the patient can only use the left leg because of paraplegia or neuropathy.

**Wound items renumbered, changed**

Clinicians may be confused at first by the appearance of M1311 (Current number of unhealed pressure ulcers at each stage), which has been renumbered from OASIS-C1’s M1308, experts say.

The potential confusion lies in when to choose new responses A2, B2, C2, D2, E2 and F2, which will involve recording the number of unhealed pressure ulcers noted at the time of the most recent SOC/ROC. Options A1, B1, C1, D1, E1 and F2 for the item will be answered at follow-up and discharge, Rambusch says. The item basically looks like a reversion to the OASIS-C version of M1308 that had two columns to detect the number of unhealed pressure ulcers at each stage.

These responses will not be required to be answered about half the time on SOC/ROC assessments, she says. And if you have a patient with only one episode, it appears you’ll only have to answer the item at discharge, Rambusch says. Further, Rambusch would like to see CMS release a list of exclusions, such as for patients who are discharged to another facility, like an inpatient facility.

Changes to M1313 (Worsening in pressure ulcer status since SOC/ROC), which is currently M1309 in OASIS-C1, are for the most part positive for clinicians, Rambusch says. That’s because they now have two new options for unstageable ulcers — those that are unstageable due to non-removable dressings or suspected deep tissue injuries.

**More tips to prepare for OASIS-C2:**

- **Wait for guidance on M1028.** Also new in OASIS-C2, M1028 (Active diagnoses, comorbidities and co-existing conditions) could be a source for confusion for agency coders. CMS has yet to release guidance as to whether responses to the item should also be included in the top six diagnoses listed in M1021 (Primary diagnosis) and M1023 (Other diagnoses), Whitemyer says. The item’s two response options are — Response 1 — “Peripheral Vascular Disease or Peripheral Arterial Disease” and Response 2 — “Diabetes Mellitus.”

The draft OASIS-C2 mentions that the OASIS Guidance Manual will have a complete list of relevant ICD-10 codes for the item.
Still, clinicians should be cautious about not including these diagnoses in the top six diagnoses, Rambusch says. That’s in part because they would likely impact the agency’s risk adjustment, particularly as these diagnoses will make treating patients’ wounds more difficult, she says.

- **Train on look-back period changes.** Quality managers and reviewers should be aware CMS has changed the look-back period to the most recent SOC/ROC from the previous OASIS assessment for items M2005 (Medication intervention), M1501 (Symptoms in heart failure patients), M2016 (Patient/caregiver drug education intervention) and others, Rambusch says. — Nicholas Stern (nstern@decisionhealth.com)

**Related links:** See a draft of the all-time points version at: http://tinyurl.com/z2a705s, while data specifications can be found at: http://tinyurl.com/qc65uqs.

**ICD-10**

*(continued from p. 1)*

The biggest challenges related to ICD-10 include referral source documentation deficits (40%), clinical documentation deficits (29%) and coder knowledge deficits (18%). And more than one quarter of respondents say they have experienced a 20% to 40% loss in productivity.

Coding specificity is and will remain a big issue in 2016 as agencies struggle to get adequate or relevant information from referral sources, as well as their own clinicians, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA-approved ICD-10 trainer, product specialist at DecisionHealth.

One trouble area is fractures and the greater detail needed for fractures in ICD-10, Whitemyer says.

For example, agencies need to have physicians document whether patients have osteoporosis that led to the fracture. If so, a combination code would be required, Whitemyer says. Agencies should prepare a list of such questions for intake staff to ask doctors at the start of care.

For home health clinicians, documentation for treating wounds remains an issue, Whitemyer says. Clinicians need to use clinical terms. “Beefy red” is not a clinical description that should be used to describe a wound bed, for example.

Instead, clinicians should use the clinical term granulation, she advises.

Clinicians also need to accurately document the location of wounds. For example, does it occur on the right or left side?

**Documentation affects productivity**

As anticipated by industry experts, coding productivity has taken a hit with the transition to ICD-10, DecisionHealth survey results show.

About one quarter of the survey’s respondents say coder productivity has declined less than 10%, while nearly half of respondents say productivity has dipped anywhere from 10% to 39%.

But many agencies believe productivity will return to normal in 2016.

Intrepid USA Healthcare Services, for instance, initially saw about a 25% decline in coding productivity, mostly due to the increased complexity of ICD-10. But Denise Hopkins, the agency’s administrator, anticipates that with coder training slated for this year, productivity should return to normal.

Getting better documentation from referral sources also will be important to normalizing productivity in 2016, Whitemyer predicts.

About 16% of survey respondents anticipated coding productivity to return to normal by the end of 2015. More than one-third say productivity will return to normal sometime in 2016 and 9% say productivity won’t ever return to normal.

**Tips to ease the ICD-10 transition**

- **Consider creating specific intake forms for each specialist.** Having a targeted intake form for orthopedics, endocrinology and cardiology, for instance, can improve the quality of documentation from referral sources so you can code more accurately in ICD-10, Whitemyer says.

- **Conduct an audit of your claims before you start training.** Make sure a quality or clinical director audits at least 15% of your agency’s charts to see where problems exist, Whitemyer advises. Make sure your audit accurately captures the range of services and patient diagnoses your agency treats.

- **Train on code updates.** Your employees will need at least two full days of ICD-10 training this year even if they’ve already been trained on ICD-10, Whitemyer says.

That’s true in part because sometime in July 2016, the industry will see the first major coding update it’s had in more than three years. These changes will become effective Oct. 1, says Trish Twombly, BSN, RN, HCS-D, HCS-O, COS-C, CHCE, AHIMA-approved ICD-10 trainer, senior director at DecisionHealth. — Nicholas Stern (nstern@decisionhealth.com)