Part 1: OASIS-C2 Accuracy

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For:
HealthCare Synergy

Keys to Content

- Guidance is based on the latest revisions to the OASIS-C2 Guidance Manual, CMS Q&As, WOCN guidance, and the Medicare Conditions of Participation (CoPs).

- \( P \) = Process measure

- \( $$$ \) = Data item that contributes to the episode payment (Home Health Resource Group)

See links to resources at end of presentation.
Do you know?

- “OASIS” is an acronym for: **Outcome and ASsessment Information Set**
- It is a group of data elements that:
  - Represent core items of a comprehensive assessment for an adult, non-maternity home care patient;
  - Form the basis for measuring patient outcomes for the purpose of outcome-based quality monitoring (OBQM), outcome-based quality improvement (OBQI), and the reporting initiative;
  - Provide the foundation data on which provider reimbursement for Medicare PPS patients is calculated; and
  - Are used in the enhanced survey process to promote a standardized approach to agency compliance surveys.

Why is OASIS so challenging?

- Multiple uses of the tool:
  - Data collection
  - Quality measurement
  - Reimbursement
  - Identification of patterns of fraud and abuse
- Guidance not always clear...is sometimes confusing
- Requires significant depth of knowledge
- Pressure to “get it right” for:
  - Staying compliant with rules and regulations
  - Best possible reimbursement for care provided
Evolution of OASIS

History of OASIS

- To provide services reimbursed by Medicare and Medicaid, home health agencies must demonstrate compliance with Medicare Conditions of Participation (CoPs).
- The Centers for Medicare and Medicaid Services (CMS) is required to monitor the quality of home health care with a “standardized, reproducible assessment instrument.”
- The **Outcome and Assessment Information Set (OASIS)** was the instrument selected to improve quality of care and to comply with the law.
- The use of OASIS by HHAs on **adult, non-maternity patients receiving skilled care** under the Medicare and Medicaid programs has been mandated since January 25, 1999.
**OASIS-B1 was born!**

- CMS added this new assessment standard to its Conditions for Medicare-certified HHA to:
  - Standardize assessment process;
  - Track results (outcomes);
  - Identify hospitalization risk factors;
  - Capture data for agency, state, and national outcome reports – Patient demographics, OBQI, and OBQM
    - Expanded to public reports through Home Health Compare
  - Calculate Prospective Payment System (PPS) reimbursement

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**Then...OASIS-C and OASIS-C1**

**OASIS-C**
- Implemented Jan. 1, 2010
- Included process measures, which promoted:
  - Increased awareness of, and attention to, patient needs;
  - Improved data accountability; and
  - Improved patient outcomes.

**OASIS-C1**
- Developed to accommodate ICD-10 coding on 10/1/15
- Simplified and clarified some data items
- Eliminated redundant wording
- Harmonized with other CMS data-collection tools and quality measurement initiatives
And now...OASIS-C2!

Effective January 1, 2017, it’s a step toward CMS compliance with the IMPACT Act.

The IMPACT Act

- The Improving Medicare Post-Acute Care Transformation (IM[ PAC ]T) Act of 2014:
  - Standardizes PAC cross-setting measures
    - Inpatient rehabilitation facilities (IRFs)
    - Skilled nursing facilities (SNFs)
    - Long-term care hospitals (LTCHs)
    - Home health agencies (HHAs)
IMPACT Act Domains

1. Function and cognitive status and changes
2. Skin integrity and changes
3. Medication reconciliation
4. Fall incidents
5. Transition of care
6. Resource use measures – total Medicare spending per beneficiary
7. Discharge to community
8. Potentially preventable hospital readmissions

OASIS Changes since 2009
What’s different with OASIS-C2?

- Formatting changes for one-response items to single entry boxes ( ), instead of multiple check boxes and lines (_ _)
- Conversion of pressure ulcers stages from Roman numerals (I, II, III, IV) to Arabic numbers (1, 2, 3, 4)
- Renumbering and change in look-back period for 6 items: M1500, M1510, M2004, M2015, M2300, M2400
- Addition of 3 new standardized items: M1028, M1060, GG0170c
- Renumbering and modification of integumentary and medication items to standardize with other post acute settings: M1308, M1309, M2000, M2002, M2004
- Use of a dash (–) valid in 7 items

Dash-able Items

- A dash (–) value indicates that no information is available, and/or an item could not be assessed.
- This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed.
- **CMS expects dash use to be a rare occurrence.**
- **Items that allow the use of a dash are:**
  - M1028: Active Diagnoses – Comorbidities and Coexisting Conditions
  - M1060: Height and Weight
  - M1313: Worsening in Pressure Ulcer since SOC/ROC
  - M2001: Drug Regimen Review
  - M2003: Medication Follow-up
  - M2005: Medication Intervention
  - GG0170C: Mobility
Item Number Revisions

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<tr>
<th>OASIS-C1</th>
<th>OASIS-C2</th>
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Use of One Check Box

One of the formatting changes from OASIS-C1 to OASIS-C2 is the removal of the check box for individual responses. If the item permits only a single response (as opposed to “Mark all that apply”), then a central response box is indicated.

**OASIS-C1**

**OASIS-C2**
Revised “Look Back” Period

“Look back” period revised to reflect a change in timing for the period under consideration in 6 items collected at Transfer and Discharge.

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OASIC-C1
“At the time of or any time since the previous OASIS assessment”

OASIC-C2
“At the time of or at any time since the most recent SOC/ROC assessment”
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Revised Look Back Items

M1501: Symptoms in Heart Failure
M1511: Heart Failure Follow-up
M2005: Medication Intervention
M2016: Patient/Caregiver Drug Education
M2301: Emergent Care
M2401: Intervention Synopsis
Changed “Look Back” Period and Re-wording

OASIS-C1

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?

- 0 - No (Go to M2004 at TRN; Go to M1600 at DC)
- 1 - Yes
- 2 - Not assessed (Go to M2004 at TRN; Go to M1600 at DC)
- NA - Patient does not have diagnosis of heart failure (Go to M2004 at TRN; Go to M1600 at DC)

OASIS-C2

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?

- 0 - No
- 1 - Yes
- 2 - Not assessed
- NA - Patient does not have diagnosis of heart failure

OASIS-C1

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes
- NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment

OASIS-C2

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since SOC/ROC?

- 0 - No
- 1 - Yes
- NA - There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

What else?

- Clarification of terms “specifically” and “for example.”
  - “Specifically” means scoring of the item should be limited to only the circumstances listed.
  - “For example” means the clinician may consider other relevant circumstances or attributes when scoring the item.
  - **OASIS-C1 guidance states the use of “that is” means scoring of the item should be limited to only the circumstances listed.**

- Decrease in number of general conventions from 15 to 14:
  - Deleted definition of “one calendar day”

- Increase in ADL/IADL specific conventions from 5 to 6:
  - Added guidance related to the presence of a caregiver.
New ADL/IADL Convention

Presence of a Caregiver
While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician’s ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete the task.

For example:
Q. If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840?
A. The OASIS item response should reflect the patient’s ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet and transfer with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home. (CMS Q&A #146, 4/15)

OASIS Data

[Image of OASIS Data]
How is OASIS data used?

- Outcome-Based Quality Improvement (OBQI)
  - Gauges how well an entity provides care to its patients based on scientific evidence

- Outcome-Based Quality Management (OBQM)
  - Potential avoidable events – markers for potential problems in care, which are adjusted for variations in patient characteristics

- Process-Based Quality Improvement (PBQI)
  - Use of specific best care processes recommended for providing effective care to promote outcome improvement

- Home Health Compare Reports and Star Ratings
- Home Health Value-Based Purchasing

Outcome versus Process Measures

**Outcome Measures**
- Assess the results of health care experienced by patients between two time points – from SOC or ROC to discharge or transfer to an inpatient facility
  - ✓ Stabilization;
  - ✓ Improvement; or
  - ✓ Decline
- Measure specific care quality related to process measures
- Are risk-adjusted

**Process Measures**
- Evaluate the rate of HHA use of specific evidence-based processes of care
- Deemed to be under the control of HHAs
- Focus on high-risk, high-volume, problem-prone areas
- Facilitate good patient outcomes
- Are not risk-adjusted
Other Measures

- **Utilization Measures:**
  - Show whether home care helps keep patients out of the ER and hospital

- **Potentially Avoidable Events:**
  - Show injuries/adverse effects patients incur while receiving home-health services
  - Particularly significant now with civil monetary penalties for placing clients in immediate jeopardy

Risk Adjustment

- "Risk adjustment" describes methods for determining whether patient characteristics will necessitate higher utilization of medical services.

- It attempts to control differences in client populations that may bias the outcomes.
  - Maximizes fair comparisons across providers
  - Is essential when comparing care quality between agencies providing services to populations with different characteristics
Risk Adjustment and Outcome Measures

- **Risk-adjusted outcome measures:**
  - SOC items *not* answered ‘0’ affect outcome measures.

- **“Care episode”** (quality episode):
  - Begins at SOC or ROC;
  - Ends at Transfer or Discharge;
  - Compares patient status between time points;
  - May be less than 60 days or span multiple “payment episodes.”

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**QUIZ**

- **True or False?**
  - If the nurse marks that the patient is able to take injectable meds:
    - ❌ Independently (M2030 = 0) at SOC, and
    - ❌ With assistance (M2030 = 1) at Recertification
  - ✔ This outcome measure will show a decline.
Answer

- **True or False?**
  - If the nurse marks that the patient is able to take injectable meds:
    - Independently (M2030 = 0) at SOC, and
    - With assistance (M2030 = 1) at Recertification
  - This outcome measure will show a decline.

- **False:** Outcome measures are *not* calculated at Recertification – only from SOC or ROC to discharge or transfer to an inpatient facility.

Outcomes and Process Measures

- **Process Measures:**
  - Encourage evidence-based care processes.
  - Medicare Payment and Advisory Committee (MedPAC) report to Congress in 2008:
    - “If Medicare were to adopt and use process measures, it could speed the adoption of best practices and reduce some of the variation in care that arises from failures to adhere to best practices.”
Why implement process measures?

- They provide data addressing the “why” for some patient outcomes.
- They address:
  - Health care services provided;
  - Adherence to recommendations based on evidence or consensus; and
  - Care that may require improvement.
- They were developed from evidence-based practice that HHAs can use to:
  - Help prevent exacerbations;
  - Improve patient care; and
  - Avoid adverse events.

OASIS-C2 Process Measures

1. Timely Initiation of Care
2. Depression Assessment Conducted
3. Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate
4. Pressure Ulcer Prevention and Care
5. Diabetic Foot Care and Patient Education in Plan of Care
6. Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care
7. Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care
OASIS-C2 Process Measures (cont.)

8. Influenza Immunization Received for Current Flu Season
9. Influenza Immunization Offered and Refused for Current Flu Season
10. Influenza Immunization Contraindicated
11. Pneumococcal Polysaccharide Vaccine Ever Received
12. Pneumococcal Polysaccharide Vaccine Offered and Refused
13. Pneumococcal Polysaccharide Vaccine Contraindicated
14. Drug Regimen Review Conducted with Follow-Up for Identified Issues – HHQRP (Home Health Quality Reporting Program)

Agencies are Encouraged to Aim High, but...

- CMS acknowledges that the process measures do not pertain to every patient.
  - 100% is not expected for any agency for any measure.
  - When a process of care has no application for a particular patient, no related assessment or intervention is needed.
  - Clinicians should document in the patient record the rationale for clinical decisions and actions.
    - e.g., why a process was not appropriate or possible
Measures are NOT Mandated

- OASIS care processes are NOT mandated under the Conditions of Participation.
  - Home health agencies may elect *not* to practice OASIS process measures.
  - *but...*
  - Home Health Compare and Quality of Patient Care Star Rating scores will be poor for those who do *not* adopt publically reported care processes.

Home Health Compare and Star Ratings

- Since fall 2003, CMS has posted OASIS-based quality performance information on Home Health Compare (HHC).
- In July, 2015, Quality of Patient Care 5-Star Ratings were added to HHC, based on:
  - Patient outcomes;
  - Use of best practices; and
  - Patient survey results.
Home Health Star Ratings

- CMS established the Home Health Compare (HHC) website on Medicare.gov as a key tool for consumers to use when choosing a home health care provider.
  - Consumers faced with urgent need to make a choice may find this to be too much information and too many measures to consider.

- CMS added “star ratings” to HHC, as a tool to make the information there easier to use.
  - They summarize some of the current measures of health care provider performance that the site already offers.

Two Types of Star Ratings

1. **Quality of Patient Care Star Rating:**
   - Based on OASIS assessments and Medicare claims data
   - Rating first published on HHC in July, 2015

2. **Patient Survey Star Ratings:**
   - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey (HHCAHPS)
   - Based on the patient experience of care measures
   - Published on HHC in January 2016
Quality of Patient Care 5-Star Ratings

- Based on HHA performance on 9 of the 24 process and outcome quality measures currently reported on Home Health Compare.

  - **Process measures:**
    1. Timely initiation of care
    2. Drug education on All Medications Provided to Patient/Caregiver
    3. Influenza Immunization Received for Current Flu Season

  - **Outcome measures:**
    4. Improvement in Ambulation
    5. Improvement in Bed Transferring
    6. Improvement in Bathing
    7. Improvement in Pain Interfering with Activity
    8. Improvement in Shortness of Breath
    9. Acute Care Hospitalization

OASIS data also used for...

- Determining the Home Health Resource Group (HHRG) and Non-Routine Supply (NRS) resources needed

  - Calculation of the Home Health Prospective Payment System (HHPPS) episode rate is based on a 60-day episode of care (“payment episode”).

- Value-Based Purchasing, which will ultimately improve quality and cost outcomes and will link payments to:
  - Improvements in patient outcomes;
  - Adoption of evidence-based care practices; and
  - Prevention of ER visits and hospitalizations.
Home Health Value-Based Purchasing

- Home Health Value-Based Purchasing (HHVBP) Model
  - Implemented on January 1, 2016
  - In 9 states, representing each geographic area in the nation
  - Medicare-certified HHAs to compete on value in HHVBP Model where payment is tied to quality performance

Illustration from CMS
HHVBP Webinar 12-17-15

Purpose of the HHVBP Model

- The overall purpose of the HHVBP Model is to improve the quality and delivery of home health care services to Medicare beneficiaries with specific goals to:
  1. Provide incentives for better quality care with greater efficiency;
  2. Study new potential quality and efficiency measures for appropriateness in the home health setting; and
  3. Enhance the current public reporting process.
OASIS and the HHVBP Model

➢ The majority of measures in the HHVBP Model are OASIS-based.

○ Process Measures:
  • Influenza Immunization Received during Current Flu Season (M1046)
  • Pneumococcal Vaccine Ever Received (M1051)
  • Drug Education on All Medications provided to Patient/Caregiver during All Episodes of Care (M2015)

○ Outcome Measures:
  • Improvement in Pain Interfering with Activity (M1242)
  • Improvement in Dyspnea (M1400)
  • Improvement in Bathing (M1830)
  • Improvement in Bed Transferring (M1850)
  • Improvement in Ambulation-Locomotion (M1860)
  • Improvement in Management of Oral Medications (M2020)
  • Discharged to Community (M2420)

Claims-Based Measures and HHVBP

○ Claims-based measure data is not submitted on the Home Health episode claims.

○ CMS will use two claims-based measures for calculations in the HHVBP Model:
  1. Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health; and
  2. Emergency Department Use without Hospitalization.
Other HHVBP Measures

- Five performance measures from the HHCAHPS survey:
  1. Care of Patients
  2. Communication between Providers and Patients
  3. Specific Care Issues
  4. Overall Rating of Home Health Care
  5. Willingness to Recommend the Agency

- Three measures reported via HHVBP Secure Web Portal:
  1. Influenza Vaccination Coverage for Home Health Personnel
     *(10/01/16 then in April 2017, for the period October 1, 2016
     (or when the vaccine became available) through March 31,
     2017, and annually in April thereafter)*
  2. Herpes zoster (Shingles) vaccination: Has the patient ever
     received the shingles vaccination? *(Quarterly)*
  3. Advance Care Planning *(Quarterly)*

OASIS and Reimbursement

- Reimbursement for a 60-day episode of care is determined by
  the amount of resources needed to care for the patient.

- Patient resource use is based on characteristics determined by
  information collected using the OASIS data set, and payment is
  calculated by certain OASIS responses in three dimensions:
  - Clinical Severity *(C1-C3)*
  - Functional Status *(F1-F3)*
  - Service utilization *(based on therapy) (S1-S5)*

- Scores in these three dimensions classify patients into case-mix
  groups or home health resource groups *(HHRGs).*
  - 45 HHRGs; 153 case-mix weights – C1F1S1 to C3F3S5
  - Each case-mix weights = a different payment

  ➢ Certain diagnoses and OASIS items also contribute to payment for
    non-routine supplies, which is in addition to the episode payment.
$$$ OASIS Data Items that Impact Payment

- M0110 (Episode timing)
- M1021 (Primary diagnosis)
- M1023 (Other diagnosis)
- M1030 (Therapy at home)
- M1242 (Pain)
- M1311 (Two or more pressure ulcers at stage 3 or 4)
- M1324 (Most problematic stage)
- M1334 (Stasis ulcer status)
- M1342 (Surgical wound status)
- M1400 (Dyspnea)
- M1620 (Bowel incontinence)
- M1630 (Bowel ostomy)
- M1810 or M1820 (Dressing)
- M1830 (Bathing)
- M1840 (Toileting)
- M1850 (Transferring)
- M1860 (Ambulation)
- M2200 (Therapy need)

2014-2017 Final Rule Impact

- There has been reduced reimbursement for home health agencies nationwide every year – 0.7% reduction ($130 million) in 2017.
- The case-mix values for commonly assigned diagnosis categories – pulmonary (to be re-instated 01/17), psych 1, psych 2, and blindness/low vision diagnosis categories – as well as other case-mix diagnoses and two OASIS items – vision and injectable medications – were removed.
- Common diagnoses, such as diabetes, blood and GI disorders, neoplasms, and urostomy/cystostomy care, no longer get case-mix points in an early episode with low therapy visits (Equation 1).
- Case-mix diagnoses placed in M1025 (changed from “payment” to “optional” diagnoses) do not impact payment.
What can we do to maximize our revenue and remain compliant?

Have a strong OASIS Foundation!
Understanding OASIS-C2

Ignorance ≠ Innocence

Accuracy is key!

Understanding the OASIS is critical ~

Like rocket science, knowledge and precision are the keys to success!
Painting the Picture

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

OASIS Core Reference Documents

- The OASIS-C2 Guidance Manual *(Published 06/29/16 - eff. 01/01/17)*
  - Chapter 1: Conventions
  - Chapter 3: Item Guidance
- CMS OASIS Q&As *(revised 10/16)*
  - Consolidated into 4 Categories
- Quarterly CMS Q&As
  - January, April, July, October
- WOCN Guidance on OASIS-C2 Integumentary Items *(11/16)*
- OASIS Considerations for Medicare PPS Patients *(11/10)*
What CMS Expects of Home Health Agencies (HHAs)

- CMS provides resources free of charge, and expects HHAs to:
  - Accurately complete the comprehensive assessment and OASIS.
  - Follow OASIS Response-Specific Guidance found in Chapter 3.

More CMS expectations...

- Select and assign OASIS diagnoses:
  - Based on comprehensive assessment of each patient’s overall medical condition and care needs;
  - Verified by the physician;
  - Following diagnosis coding rules; and
  - According to clinical correctness, NOT to case-mix status.
CMS also expects HHAs to...

- Report any indication of fraudulent coding directly to the HHA administrator.

- Follow CMS OASIS correction policy, keeping OASIS corrections transparent.

- Stay current with guidance & updates.
  - When guidance from two CMS sources vary, follow the most recent.
  - Updates in Q&As supersede other guidance.

Qualifying Criteria
First things first...Qualifying Criteria

- These criteria must be met in order to qualify for home care service under the Medicare benefit:
  - MUST have a **physician** to provide orders
  - MUST be **homebound**
  - Physician MUST **participate**, as required:
    - Complete a **Face-to-Face encounter**.
    - **Establish a Plan of Care** (collaborate with HHA) and review/update, as needed and at ROC, SCIC, Recert, and DC.
  - MUST have a **problem** covered by the regulations
- See Medicare Benefit Policy Manual – Chapter 7 (rev. 05-11-15)

Patient’s Physician Must Certify

- Home health agencies must ensure certifying physicians establish all qualifying criteria as published by Medicare.

Certifying Patients for the Medicare Home Health Benefit

Note: This article was revised on December 31, 2014, to add clarifying language. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Special Edition (SE) 1436 is intended for Medicare-eligible physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.
Homebound Requirement
(Updated 11/19/13)

- 30.1.1 - Patient Confined to the Home
  - For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Confined to the Home

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<th>Criteria-Two:</th>
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<td><strong>One</strong> of the following must be met:</td>
<td><strong>Both</strong> of the following must be met:</td>
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<td>1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their residence.</td>
<td>1. There must be a normal inability to leave home.</td>
</tr>
<tr>
<td>2. Have a condition such that leaving his or her home is medically contraindicated.</td>
<td>2. Leaving home must require a considerable and taxing effort.</td>
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Skilled Need

- Patient must have a Medicare-covered skilled service need
  - SN intermittent, skilled need, or
  - PT or SLP qualifying service, or
  - Continued OT need after SOC.

Certifying Physician Must...

- Be a doctor of medicine, osteopathy, or podiatry
- Have no financial relationship with the HHA
- Have the patient under his/her care
- Establish, review, and update the home health POC
- Provide and sign orders
- Certify a face-to-face encounter was:
  - Done 90 days before or within 30 days after SOC
  - Related to the primary reason for home care
  - Performed by a physician or allowed NPP
Face-to-Face Documentation

- Must include:
  - Certifying physician’s signature and date and
  - Date of encounter

- Physician’s narrative is not required.
  - The Medicare Administrative Contractor (MAC) will seek supporting documentation from certifying physician or inpatient facility.
    ➢ Best practice: Agency should obtain this documentation from physician or facility for the patient record.

Assessments:
Initial and Comprehensive
Initial Assessment

- Determines eligibility, immediate care needs, and homebound status

- Must be conducted either:
  - Within 48 hours of referral
  - Within 48 hours of return home from inpatient admission (or upon notification of discharge)
  - On the physician-ordered SOC date

rocess measure – Timeliness of Care

Who performs the initial assessment?

- This must be conducted by RN, unless therapy-only case, before any other discipline visit.

- If therapy-only:
  - Appropriate therapist – PT or SLP/ST – may perform the initial assessment.
  - OT may only complete this assessment, if the need for OT establishes program eligibility.

  Note: OT alone does not establish eligibility for the Medicare home health benefit at SOC. However, it may under other programs, such as Medicaid, some Medicare Advantage plans, or private insurers. The payer must be queried regarding coverage guidelines.
Comprehensive Assessment

- Must be completed in a timely manner
  - Consistent with patient's immediate needs
  - No later than 5 days after SOC (SOC date is day 0)
  - Within 2 days of discharge from an inpatient facility or notification of discharge (ROC)
- At SOC, must be completed by RN, unless therapy-only
- May perform initial assessment and comprehensive assessment on same visit or on different visits
- Must deliver a *skilled* service to be the SOC or a reimbursable visit

Who can conduct the assessment?

- If an order for nursing is *known* at SOC (even if only one visit), the case is **NOT** therapy-only.
  - The RN must do both the initial assessment, to establish eligibility for home care, and the comprehensive assessment.
- If the order for nursing is *not known* at SOC and originates from a verbal order after SOC, the case is therapy-only at SOC, and the therapist may perform the SOC assessment.
Therapy-Only?

- For skilled PT or SLP to perform the SOC visit for a Medicare patient:
  - The HHA is expected to have orders from the patient’s physician indicating the need for PT or SLP prior to the initial assessment visit;
  - No orders are present for nursing at SOC;
  - A reimbursable service must be provided; and
  - The need for this service establishes program eligibility for the Medicare home health benefit.

(42 CFR 484.55(a)(2))

When RN Does Therapy Admit

- The RN can conduct the comprehensive assessment within the first five days of the episode, but it must be done on the same date as the therapist’s SOC date or after.
  - The nursing visit for the therapy admit is not billable.

- Therapy can do the initial assessment prior to or on the same day as the RN completes the OASIS.
Who can perform the updates?

- The discipline is **not** mandated after SOC.
  - RN, PT, ST/SLP or OT may perform the updates.
  - RN is **not** required to perform the follow-up (recertification), resumption, and discharge OASIS, just because the nurse did the admission.

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QUIZ

- Mr. Z was referred for home care following (R) hand surgery. An RN did the initial assessment on 11/15 and determined that this was a therapy-only case. PT did an evaluation the next day and noted there was no need for continued PT and that Mr. Z only needed OT services.

- **✓** Does Mr. Z qualify for home health services under the Medicare benefit?
Answer

- Mr. Z was referred for home care following (R) hand surgery. An RN did the initial assessment on 11/15 and determined that this was a therapy-only case. PT did an evaluation the next day and noted there was no need for continued PT and that Mr. Z only needed OT services.

- Does Mr. Z qualify for home health services under the Medicare benefit?

- **No.** For Medicare beneficiaries to qualify for OT services at SOC, the patient must have an intermittent need for SN, PT, or ST.

OASIS Requirements
Is OASIS required or not?

- OASIS is required for Medicare and Medicaid patients:
  - 18 years of age or older
  - Receiving *skilled* non-maternity services

- OASIS is *not* required for patients:
  - Under 18 years of age
  - Receiving skilled pre- and post-natal services
  - Receiving personal care, housekeeping, or chore services only
  - With single visit quality episodes

OASIS Data Collection Time Points

- Start of Care (SOC)
- Resumption of Care (ROC) following inpatient facility stay
- Follow-Up (Recertification) within last 5 days of each 60-day episode
- Other Follow-Up during the HH episode of care
- Transfer to inpatient facility
- Discharge, not to a facility
- Death at Home

- *All time points, except* transfer to an inpatient facility and death at home, *require a comprehensive assessment.*
- *Only SOC and Follow-Up assessments are used for determining payment based on a HHRG.*
OASIS Management of Single Visit (SOC)

- OASIS is *not* required by regulation if:
  - Only one visit planned and provided
  - More visits planned but not provided after SOC
  - One visit made, then patient admitted for qualifying inpatient stay before 2\textsuperscript{nd} visit
  - One visit made, but patient died before 2\textsuperscript{nd} visit
  - One visit made, but patient not taken under care
  - A ROC visit made and patient refuses further visits

- If SOC OASIS is *not* required, a discharge OASIS is *not* required.
- A discharge summary is required, if the patient was admitted.

If OASIS is *Not* Required

- HHAs *must* provide each patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient’s current health status.
  - Only exception is housekeeping and chore services

- The comprehensive assessment *must*:
  - Identify the patient’s *continuing* need for home care, including medical, nursing, rehabilitation, social, and discharge planning needs; and
  - Include a drug regimen review.

- HHAs may collect OASIS data on their non-Medicare and non-Medicaid patients for their own use.
What if OASIS done and no further visits?

- What if the OASIS has already been completed, encoded, and/or transmitted, and then no further visits are made?
  - Conduct no further assessments.
  - Document that no further visits occurred and why.
  - Patient’s name will appear in the data system for 6 months.
  - If patient is re-admitted, a warning will show the OASIS as out of sequence, but will not prevent transmission of further OASIS assessments.

Physician Communication Requirements
Physician Orders

- The plan of care/orders, including OASIS data items requiring physician orders, (e.g., M2250 Plan of Care Synopsis), must be received from one of the following physicians practicing within their legal scope of practice:
  - Doctor of Medicine (MD);
  - Doctor of Osteopathic Medicine (DO); or
  - Doctor of Podiatric Medicine (DPM)

Plan of Care

- The “physician-ordered plan of care,” as stated in M2250, means that “the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.”

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

- For process measure items, reporting communication to/from the physician or physician-designee, (such as reporting heart failure symptoms for M1511, or communication to report/resolve medication issues for M2003) communication may be:
  - Directly to/from the physician; or
  - Indirectly through the physician’s office staff on behalf of the physician within the legal scope of practice.

Let’s see what’s in OASIS-C2!
OASIS Conventions

- Conventions are general rules that should be observed when completing the OASIS.
  - Chapter 1, OASIS-C2 Guidance Manual
    - 14 general Conventions
    - 6 ADL/IADL-specific Conventions
- Updated through the quarterly Q&As
  - [https://www.qtso.com/hhatrain.html](https://www.qtso.com/hhatrain.html)
- Anyone may submit questions on how to complete OASIS items, if a patient’s situation has **not** been addressed by CMS-published or accepted resources.
  - [HomeHealthQualityQuestions@cms.hhs.gov](mailto:HomeHealthQualityQuestions@cms.hhs.gov)
General Conventions

Know and Follow the Rules!

- Complete OASIS items accurately and comprehensively, and adhere to skip patterns.

- Follow rules included in the Item Specific Guidance (Chapter 3 of the Guidance manual).

- Stay current with evolving CMS OASIS guidance updates. CMS may post updates to the guidance manual up to twice per year, and releases OASIS Q&As quarterly.
One-Clinician Rule

- Only one clinician may take responsibility for accurately completing a comprehensive assessment.
  - Collaboration is appropriate for selected items (for example, Medication items M2001-M2005).
  - These exceptions are noted in the item specific guidance.

Time Period under Consideration

- Understand the time period under consideration for each item. Report what is true on the day of assessment:
  - The 24 hours immediately preceding the home visit; and
  - The time spent by the clinician in the home; and
  - Unless a different time period has been indicated in the item or related guidance.

- Examples of other time periods in OASIS:
  - Same day
  - By midnight of the next calendar day
  - Last 14 days
  - Recent pertinent past
  - Prior to the current illness, exacerbation, or injury
  - At the time of or at any time since the most recent SOC/ROC assessment
Care Episode

- A care episode (also referred to as a quality episode) must have a beginning (a SOC or ROC assessment) and a conclusion (a Transfer or Discharge assessment) to be considered a complete care episode.  
  
  *Note: Care episodes are the basis for quality measurements.*

**Scenario:** The patient was admitted to home health on 10/1 and transferred to the hospital on 10/15. Care was resumed by the agency on 10/23. The patient was discharged from the agency on 11/20.

1. How many complete “care episode(s)” did the patient have?
2. What were the start and end point(s) for the care episode(s)?
3. How many “payment episodes” did patient have?

Answers

**Scenario:** The patient was admitted to home health on 10/1 and transferred to the hospital on 10/15. Care was resumed by the agency on 10/23. The patient was discharged from the agency on 11/20.

1. How many complete “care episode(s)” did the patient have?  
   *Two “care episodes”*
2. What were the start and end point(s) for the care episode(s)?  
   *10/1 (SOC) - 10/15 (Transfer) and 10/23 (ROC) - 11/20 (DC)*
3. How many “payment episodes” did patient have?  
   *One “payment episode” – 10/1 (SOC) - 11/23 (DC)*
Usual Status

- If the patient’s ability or status varies on the day of the assessment, report the patient’s “usual status” or what is true greater than 50% of the assessment time frame, unless the item specifies differently.

  - Example: For M2020 (Management of Oral Medications), M2030 (Management of Injectable Medications), and M2102e (Types and Sources of Assistance - Management of Equipment), instead of “usual status” or “greater than 50% of the time,” consider the medication or equipment for which the most assistance is needed.

Current Status

- Responses to items documenting a patient’s current status should be based on:
  - Independent observation of the patient’s condition and ability at the time of the assessment
  - Without referring back to prior assessments.
“Look Back”

- Several process items require documentation of prior care, *at the time or since the time of the most recent SOC or ROC OASIS assessment*.
  - Review the record, and
  - Consult with other disciplines.

- These instructions are included in item guidance for the relevant OASIS questions.

Assessing Patient Status

- Combine observation, interview, and other relevant strategies to complete OASIS data items as needed. For example, it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge.

- Direct observation is the preferred strategy when assessing physiologic or functional health status.
  - Ask the patient to perform specific tasks, and
  - Observe the patient’s performance.
Use of “NA” and “Unknown”

- Minimize the use of “NA” and “Unknown” responses.
  - Instead, do some searching to find the answers.

Use of a Dash (–)

- Some items allow a dash response.
- A dash (–) value indicates that:
  - No information is available, and/or
  - An item could not be assessed.
- This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed.

> CMS expects dash use to be a rare occurrence.
**Process of Care Data Review**

- Accurately complete “look back” items.
  - Consider care provided by all disciplines.
  - Requires knowledge of:
    - Patient symptoms;
    - Initial and subsequent physician orders; and
    - Clinical interventions performed to address patient symptoms and if a physician-ordered intervention was on the Plan of Care and implemented.
- Review may include:
  - Clinical record, including POC, updated orders, visit notes;
  - Flow sheets completed at each visit; and
  - Report template in the electronic record that pulls information from visit notes.

**Understand Definitions**

- “Specifically” means scoring of item should be limited to only the circumstances listed.
- “For example” means clinician may consider other relevant circumstances or attributes when scoring the item.
- “Assistance” means assistance from another person, unless otherwise specified within the item.
  - Includes verbal cues, supervision, and stand-by assist.
Standardized Tool

- “One that has been scientifically tested on a population with characteristics similar to that of the patient being assessed.”

- The standardized tool:
  - Must be appropriate for the patient
    - Must be able to understand and participate
  - Must have a standard response scale – e.g., TUG, numeric scales
  - Must be appropriately administered, as indicated in the instructions
  - Must be conducted by clinician responsible for completing assessment
  - Must be completed during the CMS-specified assessment time frame
    - SOC – within 5 days
    - ROC – within 48 hours following inpatient facility discharge or knowledge of discharge

Items Using Standardized Tools

<table>
<thead>
<tr>
<th>OASIS-C Data Item</th>
<th>Standardized Assessment Tool Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1240 Pain</td>
<td>Yes</td>
</tr>
<tr>
<td>M1300 Pressure Ulcer</td>
<td>No; Optional</td>
</tr>
<tr>
<td>M1730 Depression</td>
<td>Yes</td>
</tr>
<tr>
<td>M1910 Falls</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Collected at SOC and ROC. Must be performed by the clinician responsible for completing the comprehensive assessment within 5 days of SOC or within 2 days of ROC, in order to answer “Yes.”
Resources

- OASIS-C2 Guidance Manual

- CMS OASIS Q&As
  https://www.qtso.com/hhatrain.html

- Medicare Benefit Policy Manual Chapter 7

- CY2017 HH PPS Final Rule

Resources (cont.)

- IMPACT Act of 2014

- Quality Measures

- OASIS PBQI / Process Measures

- Home Health Compare
  https://www.medicare.gov/homehealthcompare/search.html
Resources (cont.)

- Home Health Star Ratings

- Home Health Care CAHPS Survey
  https://homehealthcahps.org/

- Home Health Value-Based Purchasing Model

- OASIS Considerations for Medicare PPS Patients

Join me!

For Part 2:

**Patient Tracking Items:**
M0010-M0150

**Clinical Record Items:**
M0080-M0110

**History and Diagnosis:**
M1000-M1028

Thursday, December 1st
1:00 – 3:00 EST
Thank you for attending!

Sharon Molinari, RN, HCS-D, HCS-O
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