

**Getting a Clean OASIS:
Balancing Speed and
Accuracy**

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Objectives



- 1 Discuss the impact of Intake on OASIS accuracy and timeliness
- 2 Examine the impact of clinician engagement on OASIS accuracy and timeliness
- 3 Explore the impact of the quality review process on OASIS accuracy and timeliness.

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What are the Concerns?



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Key Focus Areas





INTAKE



CLINICIANS



REVIEW

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The Role of Intake
in Establishing Eligibility
and Diagnosis Coding



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Establishing Eligibility (Ch 7)



- Eligibility requirements for care under the MEDICARE PART A Home Health Benefit:

Confined to the home

Need for Skilled Care

Under care of Physician

Physician-approved Plan of Care

Physician Certification (F2F)

- Eligibility for recertification = establish the continuing need for service(s)

Source: Medicare Benefit Policy Manual Chapter 7 – Home Health Services, Rev. 265, 01.10.20. Section 30– Conditions Patient Must Meet to Qualify for Coverage of Health Services

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Medicare Benefit Policy Manual – Chapter 7

As of 1/1/2015, documentation in the certifying physician's medical records (MR) and/or the acute/post-acute care facility's MR (if patient directly admitted to HH) will be used as the basis upon which patient eligibility for the Medicare HH benefit will be determined.

- Must be provided, upon request, to the HH agency, review entities, and/or CMS
- Without sufficient documentation to demonstrate the patient is/was eligible, payment will not be rendered for HH services
- Information to justify the referral of Medicare HH services includes:
 - Need for skilled services; and
 - Homebound status;
- The certifying physician and/or the acute/post-acute facility MR for the patient must contain the actual clinical note for the F2F encounter visit that demonstrates that the encounter:
 - Occurred within the required timeframe;
 - Was related to the primary reason the patient requires HH; and
 - Was performed by an allowed provider type

Section 30.5.1.2 – Supporting Documentation Requirements (Rev. 2/13, Issued: 02-24-17, Effective: 01-01-17, Implementation: 03-27-17)



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Where can this Information be Found?

- Clinical and progress notes
- Discharge summaries

• **NOTE: while the F2F encounter must be related to the primary reason for HH services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted MR documentation from the certifying physician, acute/post-acute care facility, and/or HH agency**



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Putting the Pieces Together

The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

- This information can be incorporated into the certifying physician's MR for the patient and used to support the patient's homebound status and need for skilled care.
- **MUST be corroborated by other medical record entries, meaning . . .**

HH info

Certifying MD &/or Acute/PAC facility MR

Clinically consistent picture of HH eligibility



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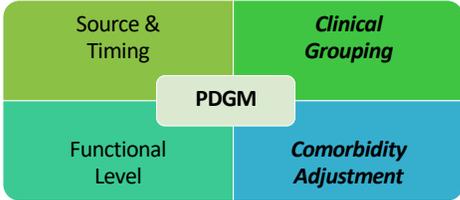
Key Questions - Intake

Under Care of Physician	F2F	Supportive Documentation
<p><i>What must you ensure is provided in the referral order for HH services, as written by the post-acute setting physician referring this patient for skilled care under the Medicare Part A HH benefit?</i></p>	<p><i>Which physician will provide the F2F encounter for this patient's HH services? What is included in the F2F documentation to support HH services for this patient?</i></p>	<p><i>What additional information should be requested to support eligibility for this patient's care under the Medicare Part A HH benefit?</i></p>

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PDGM and ICD-10 Coding



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Assignment of Diagnoses

- **Ultimate responsibility for diagnoses rests with the physician**
- The physician has the responsibility of **diagnosis assignment** for all services, testing performed or ordered, including home health care
- Medical coding of diagnoses uses the International Classification of Disease, 10th Edition (ICD10)
- Although the law provides for the physician to provide the diagnosis codes, HH providers do not always find this to be true.
 - Agency Goal: Referral documentation includes physician diagnoses to support primary and secondary diagnoses included on the HH claim

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Sourcing Physician-Confirmed Diagnoses

- *Recording diagnoses is the responsibility of the attending physician ("provider") per ICD10 Official Coding and Reporting Guidelines*
- Review referral information to ensure that physician has documented relevant conditions
 - ACH/IRF/SNF physician progress notes and discharge summaries
 - Operation reports
 - Current H&P from physician

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The Role of the Clinician in Timely Completion



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How Most Clinicians Feel About OASIS

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Why Are We Here?

- ✓ Making OASIS corrections can be a stressful process
- 🎯 Our goal is to help clinicians REDUCE ERRORS
- 📈 Trends have been identified and can be fixed

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Key Concepts

OASIS Is:

- Discipline Neutral
- Data Collection

OASIS Is Not:

- Thorough Assessment
- Creating Care Plans

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OASIS "Accuracy"

- There is NOT an OASIS item for every possible piece of information that will be gathered about a patient
- There is NOT a specific response option that is perfect in every patient situation
- The job of the clinician is to understand the item and the responses and select the best fit from what is available.

"Sometimes the correct answer is two and a half"



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OASIS Impact Areas



OUTCOMES



PROCESS MEASURES



RISK ADJUSTMENT



PAYMENT



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Quick Test

HOW MANY OF THE PUBLICLY REPORTED MEASURES CAN YOU LIST WITHOUT LOOKING IT UP?



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Functional Assessment: Chronic Problem Area

ASSISTANCE	SAFETY
<ul style="list-style-type: none"> • Defined as: "help, aid, support" • Anything another person would do to ensure the safe completion of the task: <ul style="list-style-type: none"> • Physical assistance • Verbal Cues • Supervision • Reminders • Ask "Would there be any concerns if no one was there when the task was being done?" 	<ul style="list-style-type: none"> • Defined as: "involving little or no risk of mishap" • Impacted by one or more issues: <ul style="list-style-type: none"> • Physical Ability • Cognitive Issues • Environment • Medical Restrictions • Sensory Issues • Equipment • Ask "Am I completely comfortable with how this task is being completed?"

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Function and Fall Risk

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- 0 - No multi-factor falls risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it indicates a risk for falls.

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Connecting M1910 to Function

Risk for Falls?

MAHC 10 < 4

No Assistance

Intermittent Assistance

MAHC 10 = 4+

Continuous Assistance

Specific Criteria Met

When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact.

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GG Response Options

When possible, CMS invites a multidisciplinary approach to patient assessment.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.

05 **Setup or clean-up assistance** – Helper sets up or cleans up, patient completes activity. Helper assists only prior to or following the activity.

04 **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02 **Substantial/minimal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07 **Patient refused**

09 **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10 **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88 **Not attempted due to medical conditions or safety concerns**

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Not Attempted Codes – 88 versus 09

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GG and Fall Risk

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Bonus Round!

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SOC/ROC
M2102. Types and Sources of Assistance
 Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code

F. Supervision and safety (for example, due to cognitive impairment)

0. No assistance needed – patient is independent or does not have needs in this area
1. Non-agency caregiver(s) currently provide assistance
2. Non-agency caregiver(s) need training/supportive services to provide assistance
3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
4. Assistance needed, but no non-agency caregiver(s) available

**Row f –
Supervision
& Safety**

• Such assistance may range from calls to remind the forgetful patient to take medications, to in-person visits to ensure that a patient with impaired decision making is safe, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, harm themselves or others or to monitor other safety risks related to cognitive/mental health concerns.

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Data Collection Check List

- ✓ Standardized orientation materials
 - ✓ Inclusive of knowledge application exercises
- ✓ Accessibility of Guidance Manual information
 - ✓ Teaching the clinician to "fish"
- ✓ Knowledge confirmation during patient care visit
 - ✓ Initial and annual proficiency
- ✓ Periodic education based on error trends
 - ✓ Use data to focus efforts

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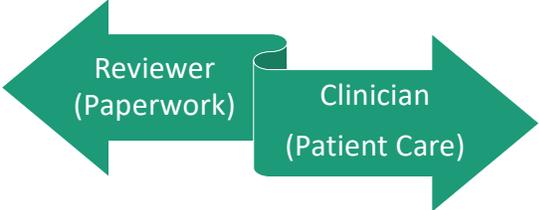


The Impact of the Review Process



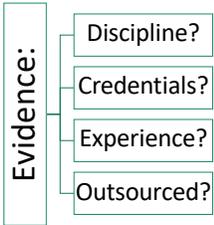
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Perceptions Matter

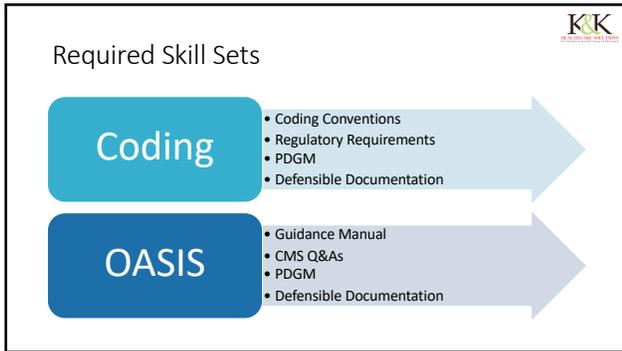


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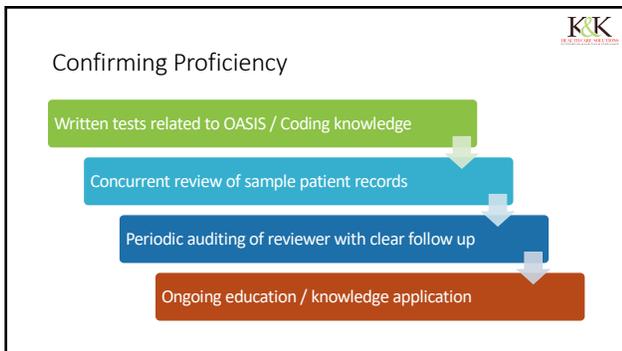
Choosing a Reviewer



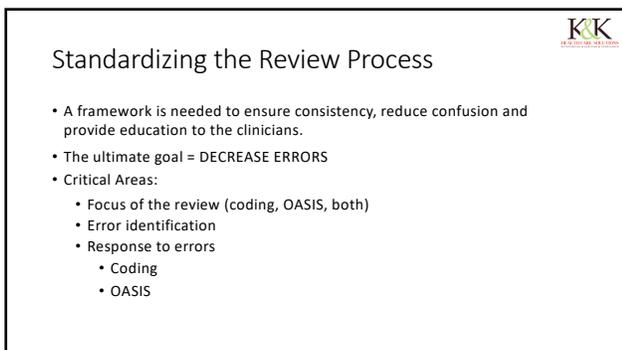
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Defining Errors

True Errors

- Unsigned documents for coding
- Missing responses
- Responses clearly conflicting with documentation

Potential Errors

- Inconsistency with care plan
- Conflicting information between clinicians
- Responses appearing to conflict with documentation

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Review Process Check List

- ✓ Standardized orientation materials
 - ✓ Inclusive of knowledge application exercises
- ✓ Accessibility of official guidance information
 - ✓ Teaching the reviewer to "fish"
- ✓ Knowledge and consistency auditing
 - ✓ Confirming initial and annual proficiency
- ✓ Implementation of standardized processes
 - ✓ Track and trend error rates

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Implementing the Standardized Tool

Key Considerations:

- No tool is perfect
 - Changes require approval
- Periodic modifications are expected
 - Must be coordinated effort
- Designated lead to monitor for official updates
 - Guidance Manuals, Q&A, Coding Updates

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Tracking and Trending

Data driven decision making key areas for both errors and corrections:

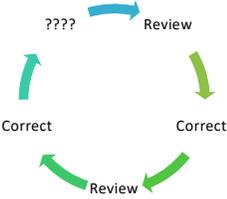
- Number
- Type
- By Clinician
- By Discipline

Don't only focus on the "negative"



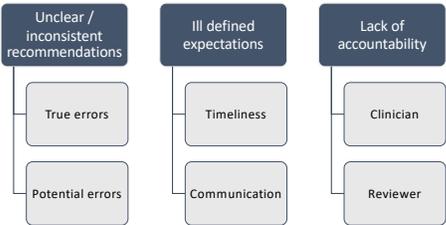
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How Many Times?



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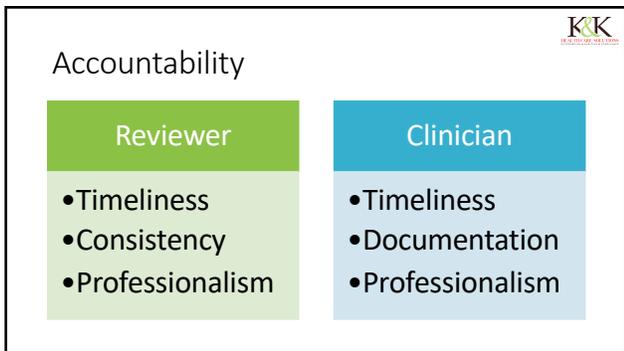
What Contributes to Delays?



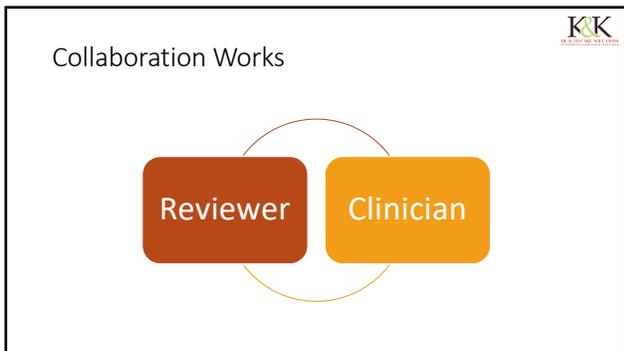
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Additional Resources

Kornetti & Krafft Health Care Solutions
www.valuebeyondthevisit.com

- Coding and OASIS Education
- Outsourced Coding and OASIS Reviews
- Coding and OASIS Audits



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Mission:
Empower home health agencies with revenue protection strategies.

Core Values:
Innovation / Trust / Integrity



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