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Home Health Clinical Manager Training

Agenda

- Home Health with Case Manager Boot Camp Info
- Documentation & Orders
- Coordination & Care Planning
- PDGM Payment & LUPA's
- Payments & Billing

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Home Health Case Management Basics

Home Health with Case Manager Boot Camp Info

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What is Home Health?

Home health care is a wide range of health care services that can be given in your home for an illness or injury. Home health care is usually less expensive, more convenient, and just as effective as care you may receive in a hospital or skilled nursing facility (SNF).

Home Health services under Medicare were expended when congress passed the Omnibus Reconciliation Act of 1980.

Home Health Goals

In general, the goal of home health care is to treat an illness or injury.

Home health care should:

- Help patients get better, regain independence, become as self-sufficient as possible, maintain or improve current level of functioning, and prevent hospitalizations.

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Logic of Home Health

- Home Health is cheaper to pay for then a hospital or SNF.
- Home Health saves Medicare money when the patient stays home, has no complications, and doesn't return to the hospital.
- Most services in these facilities can also be performed at home.
- Patient is more comfortable at home and typically recovers quicker.

Front Load Visits

- Part of the Quality of Patient Star Rating & Value Based Purchasing
- Unplanned hospital admission within 60 days of SOC
- Acute Care Hospitalization (claim-based) (outcome measure)

[Most Frequent Principal Diagnoses for Inpatient Stays in U.S. Hospitals, 2018 (ahrq.gov)]

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Case Manager Duties

- Set up patient's Plan of Care (Frequency, Interventions, Goals, Etc.)
- Coordinate with the patient's physician, patient/caregiver, other staff involved in the patient's care. (Document these conversations in either a visit note or communication note).
- Provide skilled interventions to patients.
- Perform supervised visits/documentation (HHA & LPN).
- Medication teaching/follow up (assess/teach every visit).
- Perform or delegate ALL interventions of the Plan of Care.
- Write orders to update/change POC, VO's, Frequency changes/extension.
- Assess patient's condition to determine when home health services should be discharged.
- Determine if patient should qualify for recertification.
- Coordinate with the billing department if diagnoses codes should be updated before recertification (codes for payment are based on the codes on the claim). Example: Patient has a new wound.
- Being an active part of IDT.
- Advocate for the patient.

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Home Health Starts with Admission

Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.

Initiation of Care

- Verify insurance, obtain prior authorization if required.
- Ensure provider is PECOs enrolled if a Medicare or MedAdvantage plan.
- Ensure a complete referral.
- Ensure a valid F2F (or work hard to get one done ASAP in rare situations).
- Ensure patient information into EMR.
- Ensure you have staff to meet the patient's needs.
- Schedule the SOC visit with an allowed clinician.
- Clinician schedules the visit with the patient (within 2 days from complete referral).
- Clinician must have the consent signed prior to ANY care being provided.
- Clinician to complete the comprehensive assessment and collecting data to be able to complete the OASIS.

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What is a Comprehensive Assessment?

The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of their knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient's clinical record.

Is the initial assessment and comprehensive assessment the same thing?

No, the initial assessment and comprehensive assessment can be performed at the same time, but also can be completed at different times. The comprehensive assessment (OASIS) is required to be completed within 5 days of SOC.

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The Requirement of the Comprehensive Assessment Comes from the COP's

§484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

Interpretive Guidelines §484.55(b)(1) The start of care date is considered to be the first visit where the HHA actually provides hands on, direct care services or treatments to the patient. If an initial assessment is completed without any direct care services being provided the the HHA during the assessment, the date of that initial assessment visit would not be the start of care date. The comprehensive assessment must be completed within 5 calendar days of the first visit where the HHA provides hands on, direct care services/treatments to the patient.

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The Requirement of the Comprehensive Assessment Comes from the COP's Cont.

§484.55(b)(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. G524 (Rev. 182, Issued: 09-28-18, Effective: 09-28-18, Implementation: 09-28-18)

§484.55(b)(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patient, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.

No Assistants or LPN's Can Complete the Comprehensive Assessment

Only a registered nurse or skilled therapist may perform the comprehensive assessment, evaluations, care planning and discharge planning.

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§484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include at a minimum, the following information

1. The patient's current health, psychosocial, functional, and cognitive status.
2. The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA.
3. The patient's continuing need for home care.
4. The patient's medical, nursing, rehabilitative, social, and discharge planning needs.
5. A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
6. The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules.
7. The patient's representative (if any)
8. Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, set specified by the Secretary. The OASIS data items determined by the Secretary must include clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

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§484.55(d) Standard: Update of the Comprehensive Assessment

The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than

Interpretive Guidelines §484.55(d) A marked improvement or worsening of a patient's condition, which changes, and was not anticipated in, the patient's plan of care would be considered a "major decline or improvement in the patient's health status" that would warrant update and revision of the comprehensive assessment.

The comprehensive assessment must be updated and revised

- §484.55(d)(1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a
    - (i) Beneficiary elected transfer;
    - (ii) Significant change in condition; or
    - (iii) Discharge and return to the same HHA during the 60-day episode.
- (Transfer/ROC) §484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date.

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Medicare Benefit Policy Manual
Chapter 7 – Home Health Services

Conditions Patient Must Meet to Qualify for Coverage for Home Health Services (Rev. 10438, Issues: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

- Be confined to the home;
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in need of skilled nursing care of an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy

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For purposes of the statue, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Criterion One:

- The patient must either:
  - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of specials transportation; or the assistance of another person in order to leave their place of residence
  - OR
  - Have a condition such that leaving his or her home is medically contraindicated.
- If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

Criterion Two:

- There must exist a normal inability to leave home; AND
- Leaving home must require a considerable and taxing effort.

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Homebound

- To clarify, in determining whether the patients meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met.

- For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

- Homebound must be documented on every visit note.

Infrequent/Short Duration

- If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the **absence from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive health care treatment.** Absences attributable to the need to receive health care treatment include, but are not limited to:
    - Attendance at adult day centers to receive medical care;
    - Ongoing receipt of outpatient kidney dialysis; or
    - The receipt of outpatient chemotherapy or radiation therapy.

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Plan of Care

- The plan of care must be reviewed and signed by the physician or allowed practitioner who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of patient's plan of care must contain the signature of the physician or allowed practitioner and the date of review.

- The plan of care is considered to be terminated if the patient *does not receive **at least one** covered skilled nursing, physical therapy, speech-language pathology service or occupational therapy visit in a 60-day certification period since these are qualifying services for the home health benefit*. An exception is if they physician or allowed practitioner documents that the interval without such care is appropriate to the treatment of the patient's illness or injury.

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Skilled Nursing Care

- To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

- Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the service must be s inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

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Skilled Nursing Care Cont.

- Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

- A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

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Skilled Nursing Care Cont.

- A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

- As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of participation (CoPs). The clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care.

The Home Health Clinical Notes Must Document as Appropriate:

- The history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- The patient/caregiver's response to the skilled services provided, and
- The plan for the next visit based on the rationale of prior results,
- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- The complexity of the service to be performed, and
- Any other pertinent characteristics of the beneficiary or home.

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Clinical Notes

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as “next steps” to be taken. Vague or subjective descriptions of the patient’s care should note be used.

For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

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Types of Skilled Nursing Categories

- Observation and Assessment
- Management and Evaluation of a Patient Care Plan
- Teaching and Training Activities
- Direct Skilled Services
- Psychiatric Nursing

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Observation & Assessment

Of the patient's condition when only the specialized skills of a medical professional can determine patient's status

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services **where there is a reasonable potential for change in a patient's condition** that requires skilled nursing personnel to identify and **evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and/or treatment regimen has stabilized.** Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode but did not develop a further acute episode or complication, the skilled observation services are still **covered for 3 weeks** or so long as there remains a reasonable potential for such a complication or further acute episode.

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Management & Evaluation

Of a Patient Care Plan

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in the view of the patient's overall condition.

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Teaching & Training Activities

- Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family or caregivers how to manage the treatment and regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing services is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

- Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, the further reaching and training would cease to be reasonable and necessary. **The reason why the training was unsuccessful should be documented in the record.** Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

Teaching & Training Activities

- In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

- Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

Teaching & Training Activities

That require the skills of a licensed nurse include, but are not limited to, the following:

- Teaching the self-administration of injectable medications, or a complex range of medications
- Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia
- Teaching self-administration of medical gases
- Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary
- Teaching care for a recent ostomy or where reinforcement of ostomy care is needed
- Teaching self-catheterization
- Teaching self-administration of gastrostomy or enteral feedings
- Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines
- Teaching bowel or bladder training when bowel or bladder dysfunction exists

Teaching & Training Activities

That require the skills of a licensed nurse include, but are not limited to, the following:

- Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food
- Teaching the use and care of braces, splints, and orthotics and associated skin care
- Teaching the preparation and maintenances of a therapeutic diet
- Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to the radiation treatments)

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Direct Skill Nursing

Injections

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

Vitamin B-12 injections are considered specific therapy only for the following conditions: Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia. Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome. Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

Insulin Injections: Where a patient is either **physically or mentally unable to self-inject** insulin and there is **no other person who is able and willing** to inject the patient, the injections would be considered a reasonable and necessary skilled nursing services, (prefilling syringes is not billable)

Skilled Nursing Services

- Tube Feedings
- Nasopharyngeal and Tracheostomy Aspiration
- Catheters (insertion and sterile irrigation, replacement)
- Wound Care (knot all wounds qualify)
- Ostomy Care (during the post-operative period or complication)

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Wound Care

Wounds with the following characteristics are usually reasonable and necessary for the skills of a licensed nurse:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the aptient is receiving antibiotic therapy
- Wounds with a drain or T-tube that require shortening or movement of such drains
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solutions into several layers of tissue and skin and/or packing with sterile gauze
- Recently debrided ulcers
- Pressure sores (decubitus ulcers) with the following characteristics; partial tissue loss (stage 2) with s/s of infection and full thickness tissue loss

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Other Wounds Considered Skilled:

Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dress is changed (e.g., post radical neck surgery, cancer of the vulva).

Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies.

Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes).

Third-degree burns, and second-degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed.

Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient.

Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

Non-Billable Skilled Nursing Tasks

- Administration of Oral Medications
- Filling Medications Boxes
- Administration of Eye Drops/Topical Ointments
- Blood Draws Only (Must have another skill you are performing)

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Psychiatric Nursing

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnoses psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have a special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician or allowed practitioner.

Services of a psychiatric nurse would NOT be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for non-psychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment bus is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

What's a Star Measure?

- Medicare built the Care Compare website on Medicare.gov as a key tool to help consumers choose a home health care provider. It's designed to be an easy-to access, convenient official source of information about provider quality.

- To make the information easier to use, Care Compare provides tools like 'star ratings' that summarize some of the current health care provider performance measures. The star ratings offer consumers another tool to help them make health care decisions. Consumers will still find value in the other quality information on Care Compare.

7 Measures Part of the Quality of Patient Star Rating

- Timely Initiation of Care (process measure)
- Improvement of Ambulation M1860 (outcome measure)
- Improvement of Bed Transferring M1850 (outcome measure)
- Improvement in Bathing M1830 (outcome measure)
- Improvement in Shortness of Breath (outcome measure)
- Improvement in Management of Oral Medications (outcome measure)
- Acute Care Hospitalization (claims-based) (outcome measure)

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M0102/M0104

Timely Initiation of Care

- M0102: is only answered if the physician states services should start a specific day

- M0104: the referral date
  - A valid referral date is considered when the agency received adequate info about a patient (name, address/content info, diagnosis and or general home care needs) and the agency has ensured that the referring MD or another MD will provide the plan of care and ongoing orders.
  - If SOC or ROC is delayed due to the patient's condition or physician request (for example extended hospitalization) then the date the agency received updated/revised referral info for home care to begin will be considered the date of referral.

- Did you know: if the patient requests to delay admission and we contact the MD and obtain a new SOC date within the 48-hour window we can update or referral date? This is also now true for ROC.

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M1860

Ambulation

Includes:
- Ability to safely
    - Walk, once in standing position or
    - Use wheelchair, once in seated position
    - On a variety of surfaces
        - Typical surfaces routinely encountered in the patient's environment

Excludes
- Transfer

Usual status DOES NOT apply when determining chairfast or bedfast
If need for devices varies between different surfaces and rooms, report the device that makes the patient safe on all surfaces.

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M1850

Transferring

Includes moving from

- Supine position on current sleeping surface (sleeping surface may vary – bed, recliner, couch, etc.) to a sitting position on the side.
- Some type of standing, stand-pivot, sitting pivot or sliding board transfer to sitting surface (chair, bench, toilet BSC, etc.)
- Some patients may need to ambulate to a chair in another room – this may impact scoring

1. Transfer safely with minimal assistance (individual contributing less than 25% of the effort) or use of an assistive device.
2. 2. Requires both assistance and a device

Bedfast defined

- Medically restricted to bed or
- Unable to tolerate being out of bed

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M1830

Bathing

Includes:
- Safely getting to the location where bathing occurs
- Transferring in/out
- Washing the entire body

Excludes:
- Gathering supplies
- Preparing the bath water
- Shampooing hair
- Washing face/hands
- Drying off after the bath

Medical restrictions can impact scoring
- Example: do not get into tub, keep cast dry

Focus on ability to ACCESS the tub/shower, transfer in and out and bathe the entire body once the needed items are in place

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M1400

Shortness of Breath

- If the patient uses oxygen continuously, enter the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, enter the response based on the patient's shortness of breath WITHOUT the use of oxygen
- Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.
- A chair fast patient can be assessed for the level of dyspnea while performing ADLs or at rest.
- FYI– if the patient does have oxygen it needs to be included on the medication list.

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M2020

Management of Oral Meds

- Proposed addition to the star rating
- Identify the ability – not performance
- Includes all prescribed and OTC PO meds currently taking and should be included on the POC
    - Excludes topical, injectable, IV meds, administered via gastrostomy, subligual, buccal
- Report what is true on the day of assessment
- If ability varies from med to med, consider the medication for which the most assistance is needed

- Includes:
    - Assessment of the patient's ability to obtain the meds from where it is routinely stored
        - Is the patient a fall risk? Does the patient need assistance to ambulate to where the meds are routinely stored? To get water? If so, mark 3.
    - The ability to read the label or otherwise identify the med correctly
    - Open the container
    - Select the correct amount and orally ingest it as the correct time
- Assess using observation and interview
- Resides in ALF or family keeps meds out of reach
    - Use clinical judgment to determine if the patient is able to take correct oral medications and proper dosages at the correct time

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Patient Survey Star Ratings Details

- The Patient Survey Star Ratings is based on the patient experience of care measures. The ratings were first posted in January of 2016 and all the information about the Patient Survey Star Ratings is posted on the HHCAHPS website.
- All Medicare-Certified HHAs have the potential to receive a Patient Survey Star Rating. However, HHAs must have 40 or more completed surveys over the four-quarter reporting period to receive Star Ratings for that reporting period. Home Health agencies that do not have 40 or more completed surveys for calculating Star Ratings will still have their HHCAHPS data publicly reported on the Home Health Compare website, but they will not receive star ratings.
- HHCAHPS scores based on fewer than 40 completed surveys do not have sufficient statistical reliability to ensure that those scores measure true performance and not noise in the date for reporting star ratings. More details about the methods for calculating Patient Survey Star Ratings can be found on the HHCAHPS survey website.
- Each HHA gets provider preview reports showing the Patient Survey Star Ratings about one month before the ratings are posted on Care Compare. Agencies have several weeks to review and send us proof that there's been a calculation error to ask us to review their rating.

Patient Survey Star Ratings Include 4 of the Measures Reported on Care Compare

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Each of the three composite measures consists of four or more questions from the survey that are about related topics. The results from the questions that comprise a composite are reported as one score.

Composite scores are compiled by calculating the proportion of cases that responded to each answer choice in the questions that comprise the composite.

Once the proportions of responses to all answer choices in the questions in the composite are calculated, the average proportion of those responding to each answer choice in all questions in the composite is calculated.

Only questions that are answered by survey respondents are included in the calculation of composite scores.

Composite Measures

HHCAHPS Composite Measurements/ Global Ratings	HHCAHPS Questions Included in Composite/Global Rating	Text Displayed on Medicare's Care Compare Website
Care of Patients	Q9, Q16, Q19, and Q24	How often the home health team gave care in a professional way
Communications Between Providers and Patients	Q2, Q15, Q17, Q18, Q22, and Q23	How well did the home health team communicate with patients
Specific Care Issues	Q3, Q4, Q5, Q10, Q12, Q13, and Q14	Did the home health team discuss medicines, pain, and home safety with patients
Overall Rating of Care	Q20	How did patients rate the overall care from the home health agency
Patient willingness to recommend HHA to family or friends	Q25	Would patients recommend the home health agency to friends and family

HHCAHPS Questions Integrated into Star Measures:

2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?

1. Yes
2. No
3. Do not remember

3. When you first started getting home health care from this agency, did someone from the agency **talk with you** about how to set up you r home so you can move around safely?

1. Yes
2. No
3. Do not remember

4. When you start getting home health care from this agency, did someone from the agency talk with you about all the **prescription and over-the-counter medicines** you were taking?

1. Yes
2. No
3. Do not remember

5. When you started getting home health care from this agency, did someone from the agency ask to **see** all the prescription and over-the-counter medicines you were taking?

1. Yes
2. No
3. Do not remember

9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?

1. Never
2. Sometimes
3. Usually
4. Always
5. I only had one provider in the last 2 months of care

10. In the last 2 months of care, did you and a home health provider form this agency talk about pain?

1. Yes
2. No

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HHCAHPS Questions Integrated into Star Measures:

12. In the last 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?

1. Yes
2. No
3. I did **not** take any new prescription medicines or change any medicines.

13. In the last 2 months of care, did home health provider from this agency talk wit you about **when** to take these medicines?

1. Yes
2. No
3. I did **not** take any new prescription medicines or change any medicines.

14. In the last 2 months of care, did home health providers from this agency talk with you about the **side effects** of these medicines?

1. Yes
2. No
3. I did **not** take any new prescription medicines or change any medicines.

15. In the last 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?

1. Never
2. Sometimes
3. Usually
4. Always

16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?

1. Never
2. Sometimes
3. Usually
4. Always

17. In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?

1. Never
2. Sometimes
3. Usually
4. Always

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HHCAHPS Questions Integrated into Star Measures:

18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you?

1. Never
2. Sometimes
3. Usually
4. Always
5. I only had one provider in the last 2 months of care

19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?

1. Never
2. Sometimes
3. Usually
4. Always
5. I only had one provider in the last 2 months of care

20. We want to know your rating of your care providers. Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?

- ❑ 0 Worst home health care
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Best home health care

22. In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?

1. Yes
2. No – If No, go to Q24
3. I did **not** contact this agency

23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed?

1. Same day
2. 1 to 5 days
3. 6 to 14 days
4. More than 14 days
5. I did **not** contact this agency

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HHCAHPS Questions Integrated into Star Measures:

24. In the last 2 months of care, did you have any problems with the care you got through this agency?

1. Yes
2. No

25. Would you recommend this agency to your family or friends if they needed home health care?

1. Definitely no
2. Probably no
3. Probably yes
4. Definitely yes

HHCAHPS survey areas listed on home health compare website:

- How often the home health team gave care in a professional way
- How well did the home health team communicate with patients
- Did the home health team discuss medicines, pain and home safety
- How do patients rate the overall care form the home health agency
- Would patients recommend the home health agency to friends and family

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Medicare Benefit Policy Manual
Chapter 7 – Home Health Services

Face-to-Face Encounter
(Rev.10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

Face to Face Encounter

Allowed Provider Types

- As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by:
    - The certifying physician or allowed practitioner himself or herself.
    - A physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

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NPP's Allowed to Perform the Encounter

- A nurse practitioner or a clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
- A certified nurse midwife, as authorized by State Law; under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
- A physician assistant under the supervision of the certifying physician or under the supervision of an acute or pos—acute care physician with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health.

- NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

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Timeframe Requirements

The encounter must occur no more than **90 days prior** to the home health start of care date or within **30 days after** the start of care.

In situations when a physician or allowed practitioner orders home health care for the patient based on a new condition that was not evident during a visit within the 90days prior to start of care, the physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

Exceptional Circumstances

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

Telehealth

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a metropolitan Statistical Area.

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30.5.1.2 Supporting Documentation Requirements

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

- As of January 1, 2015, documentation in the certifying physician or allowed practitioner's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) **will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined.**
- Documentation from the certifying physician or allowed practitioner's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS). In turn, an HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

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30.5.1.2 Supporting Documentation Requirements

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

- The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's"
    - Need for the skilled services; and
    - Homebound status

- The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:
    - Occurred within the required timeframe;
    - Was related to the primary reason the patient requires home health services; and
    - Was performed by an allowed provider type

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30.5.1.2 Supporting Documentation Requirements

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

- This information can be found most often in clinical and progress notes and discharge summaries. While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician or allowed practitioner, acute, post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

Information from the HHA, such as the plan of care required per 42 CFR 409.43 and the initial and/or comprehensive assessment of the patient required per 42.

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Face to Face

Must be a provider's visit note.
(Documentation of visit, assessment, etc.)

Must have the providers signature (electronic or handwritten) and date.

Must have the date of visit.

Must have the primary reason for home health documented.

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Documentation & Orders

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Note Documentation

- Each note must be able to “stand alone” showing skill.
- Notes should NOT look similar to each other.
- NO copy and pasting documentation from other notes.
- Thoroughly document in detail what you did on your visit, why it was necessary, and the patient’s response.
- Paint a picture of your patient. Give details that if someone who didn’t know the patient could picture how the patient functions and the needs of the patient.
- Documentation must provide sufficient support of the ongoing medical necessity of the services being provided. All interventions must be in direct response to the plan of care. Continual reassessment of patient/family/caregiver needs and goals throughout course of care.
- Note documentation should include the plans for the next visit.
- Note documentation should have a 2-part homebound statement.

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Example of SN Interventions:

- Clinician to educate patient and caregiver on high-risk Antiplatelet medication: Aspirin Hx of stroke uses, why it is a high-risk drug: Like anticoagulants, antiplatelets can cause internal bleeding, heavy bleeding or bruising. Specific Teaching Take antiplatelets exactly as prescribed. ASA can bother the stomach and should be taken with food. Other antiplatelets can be taken with or without food. Do not stop taking antiplatelets unless instructed by the doctor. Report signs and symptoms: dizziness or signs of bleeding: Bleeding gums, blood-tinged urine, bloody nose, bruises.
- Clinician to educate patient/caregiver on fall prevention measures using home health admission booklet (preventing falls-proper footwear, clear pathways, removing/securing throw rugs, cords/wires, proper lighting assistive devices(s))
- Clinicians to educate patient/caregiver on methods to decrease risk for pressure ulcers turning and repositioning, float heels, reducing friction and shear, proper nutrition

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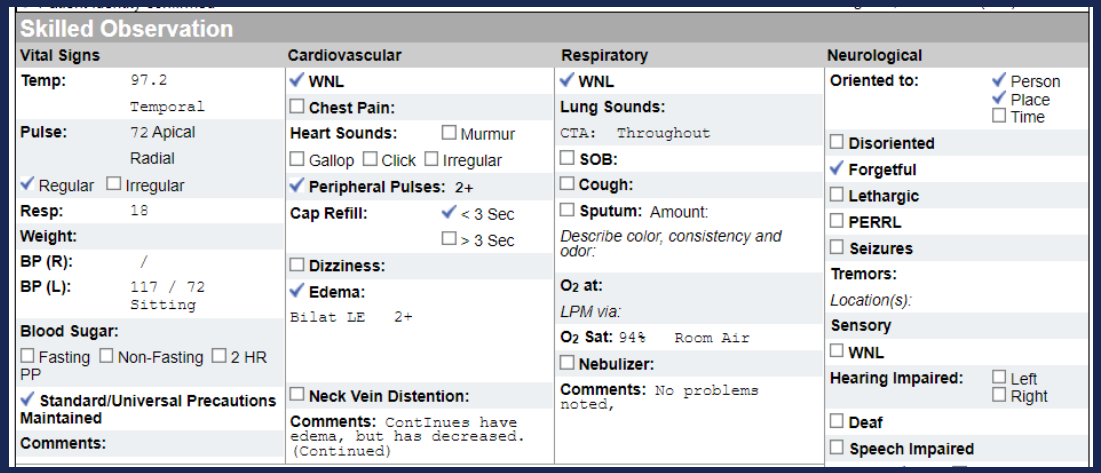
Do Your Nursing Assessments, Vs's



Skilled Observation

Vital Signs

Temp: 97.2 Temporal

Pulse: 72 Apical Radial

✓ Regular ☐ Irregular

Resp: 18

Weight:

BP (R): /

BP (L): 117 / 72 Sitting

Blood Sugar:

☐ Fasting ☐ Non-Fasting ☐ 2 HR PP

✓ **Standard/Universal Precautions Maintained**

Comments:

Cardiovascular

✓ **WNL**

☐ **Chest Pain:**

Heart Sounds: ☐ Murmur ☐ Gallop ☐ Click ☐ Irregular

✓ **Peripheral Pulses:** 2+

Cap Refill: ✓ < 3 Sec ☐ > 3 Sec

☐ **Dizziness:**

✓ **Edema:**

Bilat LE 2+

☐ **Neck Vein Distention:**

Comments: ContInues have edema, but has decreased. (Continued)

Respiratory

✓ **WNL**

Lung Sounds:

CTA: Throughout

☐ **SOB:**

☐ **Cough:**

☐ **Sputum:** Amount:

Describe color, consistency and odor:

O_2 at:

LPM via:

O_2 Sat: 94% Room Air

☐ **Nebulizer:**

Comments: No problems noted,

Neurological

Oriented to: ✓ Person ✓ Place ☐ Time

☐ **Disoriented**

✓ **Forgetful**

☐ **Lethargic**

☐ **PERRL**

☐ **Seizures**

Tremors:

Location(s):

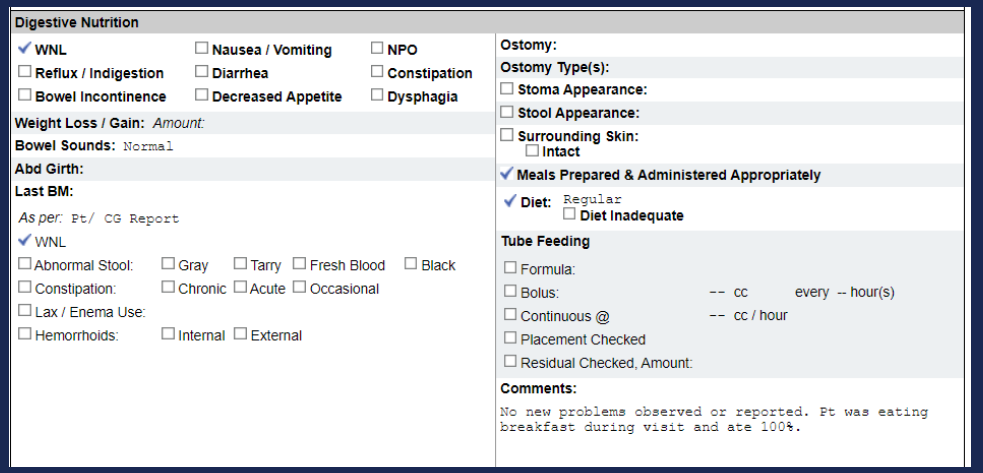
Sensory

☐ **WNL**

Hearing Impaired: ☐ Left ☐ Right

☐ **Deaf**

☐ **Speech Impaired**



Digestive Nutrition

✓ **WNL** ☐ **Nausea / Vomiting** ☐ **NPO**

☐ **Reflux / Indigestion** ☐ **Diarrhea** ☐ **Constipation**

☐ **Bowel Incontinence** ☐ **Decreased Appetite** ☐ **Dysphagia**

Weight Loss / Gain: *Amount:*

Bowel Sounds: Normal

Abd Girth:

Last BM:

As per: Pt/ CG Report

✓ WNL

☐ Abnormal Stool: ☐ Gray ☐ Tarry ☐ Fresh Blood ☐ Black

☐ Constipation: ☐ Chronic ☐ Acute ☐ Occasional

☐ Lax / Enema Use:

☐ Hemorrhoids: ☐ Internal ☐ External

Ostomy:

Ostomy Type(s):

☐ **Stoma Appearance:**

☐ **Stool Appearance:**

☐ **Surrounding Skin:** ☐ **Intact**

✓ **Meals Prepared & Administered Appropriately**

✓ **Diet:** Regular ☐ **Diet Inadequate**

Tube Feeding

☐ Formula:

☐ Bolus: -- cc every -- hour(s)

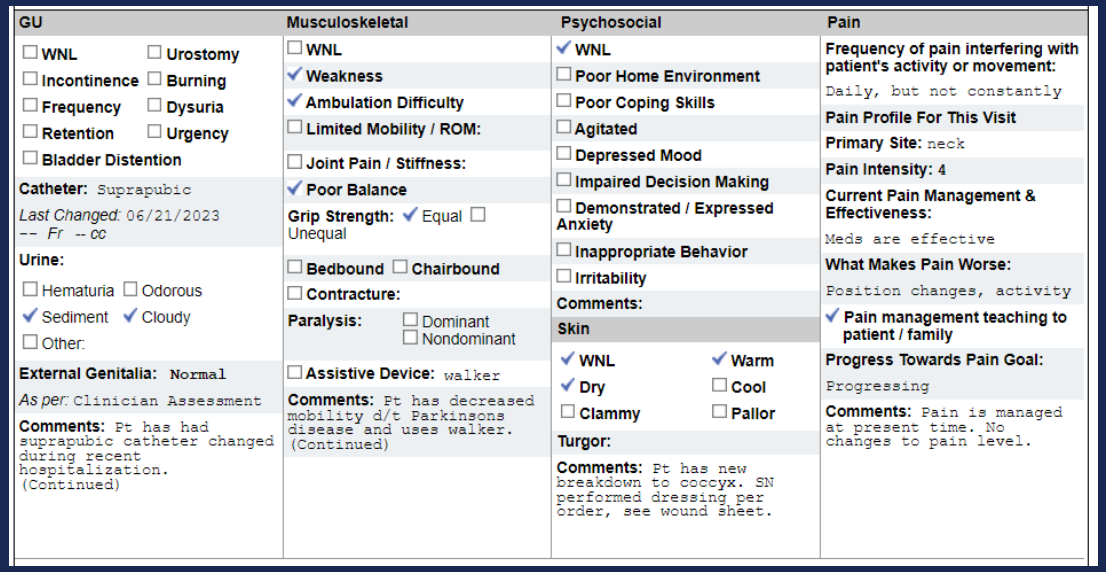
☐ Continuous @ -- cc / hour

☐ Placement Checked

☐ Residual Checked, Amount:

Comments:

No new problems observed or reported. Pt was eating breakfast during visit and ate 100%.



GU

☐ **WNL** ☐ **Urostomy**

☐ **Incontinence** ☐ **Burning**

☐ **Frequency** ☐ **Dysuria**

☐ **Retention** ☐ **Urgency**

☐ **Bladder Distention**

Catheter: Suprapubic

Last Changed: 06/21/2023

-- *Fr* -- *cc*

Urine:

☐ Hematuria ☐ Odorous

✓ Sediment ✓ Cloudy

☐ Other:

External Genitalia: Normal

As per: Clinician Assessment

Comments: Pt has had suprapubic catheter changed during recent hospitalization. (Continued)

Musculoskeletal

☐ **WNL**

✓ **Weakness**

✓ **Ambulation Difficulty**

☐ **Limited Mobility / ROM:**

☐ **Joint Pain / Stiffness:**

✓ **Poor Balance**

Grip Strength: ✓ Equal ☐ Unequal

☐ **Bedbound** ☐ **Chairbound**

☐ **Contracture:**

Paralysis: ☐ Dominant ☐ Nondominant

☐ **Assistive Device:** walker

Comments: Pt has decreased mobility d/t Parkinsons disease and uses walker. (Continued)

Psychosocial

✓ **WNL**

☐ **Poor Home Environment**

☐ **Poor Coping Skills**

☐ **Agitated**

☐ **Depressed Mood**

☐ **Impaired Decision Making**

☐ **Demonstrated / Expressed Anxiety**

☐ **Inappropriate Behavior**

☐ **Irritability**

Comments:

Skin

✓ **WNL** ✓ **Warm**

✓ **Dry** ☐ **Cool**

☐ **Clammy** ☐ **Pallor**

Turgor:

Comments: Pt has new breakdown to coccyx. SN performed dressing per order, see wound sheet.

Pain

Frequency of pain interfering with patient's activity or movement:

Daily, but not constantly

Pain Profile For This Visit

Primary Site: neck

Pain Intensity: 4

Current Pain Management & Effectiveness:

Meds are effective

What Makes Pain Worse:

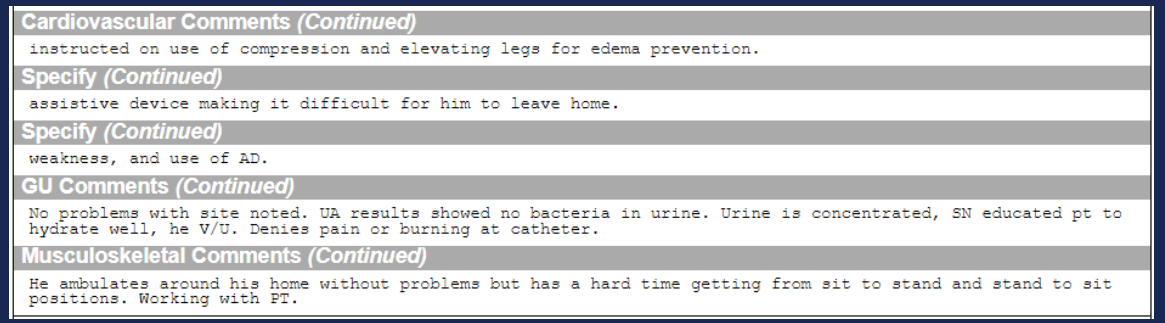
Position changes, activity

✓ **Pain management teaching to patient / family**

Progress Towards Pain Goal:

Progressing

Comments: Pain is managed at present time. No changes to pain level.



Cardiovascular Comments *(Continued)*

instructed on use of compression and elevating legs for edema prevention.

Specify *(Continued)*

assistive device making it difficult for him to leave home.

Specify *(Continued)*

weakness, and use of AD.

GU Comments *(Continued)*

No problems with site noted. UA results showed no bacteria in urine. Urine is concentrated, SN educated pt to hydrate well, he V/U. Denies pain or burning at catheter.

Musculoskeletal Comments *(Continued)*

He ambulates around his home without problems but has a hard time getting from sit to stand and stand to sit positions. Working with PT.

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Assess Medications Every Visit/ Write Homebound Statement (not just check boxes)

Medication change since last visit? ☑ No ☐ Yes **Demonstrated Medication Compliance:** ☐ No ☑ Yes

Comments: ALF manages all medications

Homebound? ☑ Yes ☐ No

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One:

☑ Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

AND/OR

☐ Patient has a condition such that leaving his or her home is medically contraindicated.

Specify:

Pt has weakness from recent surgery as well as PArkinsons disease and use of (Continued)

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

Criteria Two:

☑ Patient has a normal inability to leave home.

AND

☑ Leaving home requires a considerable and taxing effort for the patient.

Specify:

Pt cannot leave home without considerable effort d/t decreased mobility, (Continued)

Vision: ☑ WNL ☐ Glasses
☐ Contacts Left ☐ Contacts Right
☐ Blurred Vision ☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Other:

☐ **Blind**

☐ **Decreased Sensation:**

Comments: Pt has dementia and Parkinson's, pt was alert and pleasant and able to answer questions.

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What's Wrong...

Coordination Plan

Progress to Goals:

Conferenced with: **Name:**

Regarding:

Physician Contacted Re:

Order Changes:

Plans for Next Visit: Assessment, cath change.

Next Physician Visit:

Discharge Planning: When goals are met.

☐ Written notice of discharge provided to patient. Discharge scheduled for:

Treatment Goals and Plan Audits

Goal Summary

Unmet Goals (6)

Patient skin integrity will remain intact during this episode **Goal Term:** short **Target Date:** 08/28/23

Foley will remain patent during this episode and patient will be free of signs and symptoms of UTI **Goal Term:** short **Target Date:** 08/28/23

Patient's pain will be managed throughout the episode **Goal Term:** short **Target Date:** 08/28/23

All comorbidities will be managed throughout the episode comorbidities include: Atrial Fibrillation, Parkinsons Disease, Depression, Dementia, Anxiety . **Goal Term:** short **Target Date:** 08/28/23

The patient will be free from falls and hospitalizations during the certification period **Goal Term:** short **Target Date:** 08/28/23

Patient/caregiver will verbalize understanding on how to properly take all medications **Goal Term:** short **Target Date:** 08/28/23

Not Attained Goals (1)

Patient's pain will be managed throughout the episode **Goal Term:** short **Target Date:** 08/28/23

Goal Progress Summary For This Visit

Goals Addressed (5)

(1 of 5) Foley will remain patent during this episode and patient will be free of signs and symptoms of UTI

Progress: Unchanged

Progress Note:

Interventions Performed (2)

SN to instruct the Pt and CG on signs/symptoms of UTI to report to MD/SN. SN may obtain urinalysis and urine culture & sensitivity (C&S) test as needed for signs/symptoms of UTI, to include pain, foul odor, cloudy or blood-tinged urine and fever

Result: Verbalized Understanding **Performed On:** Patient, Caregiver

Note:

SN to instruct the Pt and CG on proper foley care

Result: Verbalized Understanding **Performed On:** Patient,

Wounds Addressed on this Visit

WOUND 1 - Location: Coccyx, **Status:** Open , **Onset Date:** 07/07/2023 , **Type:** Pressure Injury , **Stage:**1 , **Size:** Length: 1cm, Width: 1cm, Depth: .5cm , **Wound Bed:** Pink , **Pink/Red:** 100% , **Wound Edges:** ✓ Attached , **Drainage:** Bloody , **Amount:** Scant , **Odor:** None , **Surrounding Tissue:** ✓ Intact **Treatment:** Wound care performed per order , **Patient Response To Treatment:** Pt tolerated well , **Wound Pain:** None

Progress: Unchanged

Interventions Performed

Clinician to educate patient/caregiver to report any falls/injuries

Result: Verbalized Understanding **Performed On:** Patient,

Note: no falls reported

(4 of 5) Patient's pain will be managed throughout the episode

Progress: Unchanged

Interventions Performed

Clinician to assess pain every visit

Result: Verbalized Understanding **Performed On:** Patient,

Note: Pt states pain is well managed with meds

Patient skin integrity will remain intact during this episode

Progress: Unchanged

Interventions Performed

SN to assess skin for breakdown Q visit

Result: Verbalized Understanding **Performed On:** Patient,

Note:

Clinician to educate patient/caregiver on methods to decrease risk for pressure ulcers turning and repositioning, float heels, reducing friction and shear, proper nutrition.

Result: Verbalized Understanding **Performed On:** Patient, Caregiver

Note:

(FT) SN to perform wound care to coccyx as follows: remove old dressing, cleanse wound with wound cleanser, apply barrier cream and new adhesive foam dressing. Dressing to be changed Q 3-5 days and PRN if soiled. Wound care to be performed by HH or ALF SN.

Result: Verbalized Understanding **Performed On:** Patient

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(2 of 5) Patient/caregiver will verbalize understanding on how to properly take all medications

Progress: Unchanged

Progress Note:

Interventions Performed (1)

Clinician to review and education on all medications

Result: Verbalized Understanding **Performed On:** Patient,

Note:

(3 of 5) The patient will be free from falls and hospitalizations during the certification period (Continued)

Treatment Goals and Plan Audits Comments

Comments:

Focus of care/skilled care provided this visit: SN arrived to pt room at ALF to find pt sitting at his table waiting for breakfast. ALF tech brought his breakfast in during visit and pt ate 100% during visit. He c/o some back and neck pain but states it is tolerable with current meds. Pt has new breakdown to coccyx, see wound sheet. SN helped pt in to recliner and provided education on ambulating with assist as tolerated and repositioning off coccyx. SN spoke with ALF staff about monitoring dressing and they stated they would change PRN. Pt wife CHeryl was updated via text. No further questions or concerns at this time.

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All On One POC:

SN Interventions

SN to perform 2 additional visits as needed for foley catheter change or adjustment for dislodgement, blockage, or leakage of foley or drainage system
SN to change suprapubic tube with [text] Fr [text field] cc catheter every [text field] beginning on [date]. 18 FR 10 cc catheter every 4 weeks beginning on 7/19/2023
SN to instruct Pt and CG on measuring and recording intake and output
SN to instruct the Pt and CG on signs/symptoms of UTI to report to MD/SN. SN may obtain urinalysis and urine culture & sensitivity (C&S) test as needed for signs/symptoms of UTI, to include pain, foul odor, cloudy or blood-tinged urine and fever
SN to instruct the Pt and CG on proper foley care
Clinician to educate patient and caregiver on high risk opioid medication: Hydrocodon pain Uses, why it is high risk: Opioids are highly addictive, a growing problem throughout the United States. Overdose can cause respiratory depression. Specific teaching Opioids are safest when used for three or fewer days to manage acute pain, such as pain that follows surgery or a bone fracture. If opioids

(Continued) Orders and Treatments

are needed for acute pain, work with the doctor to take the lowest dose possible, for the shortest time needed, exactly as prescribed. Report signs and symptoms: Drowsiness, dizziness, nausea, vomiting, respiratory depression, constipation. DO NOT take with alcohol.
Clinician to educate patient/caregiver on high risk anticoagulant medication: Eliquis Blood thinner Why it is a high-risk drug: Anticoagulants can cause internal bleeding, symptoms of stroke and anemias. Specific teaching: Be careful mixing Medications. Some antibiotics and anti-fungal medications can make blood thinners more potent and increase risk of bleeding. Tell all health care providers, dentists, physicians, pharmacists that you're taking blood thinner. Always take anticoagulant as director by the doctor. Don't skip a dose and don't double up. If a dose is missed, take it as soon as possible. Watch for evidence of bleeding: Bleeding gums, blood tinged urine, bloody nose, bruises and signs of internal bleeding. Slow bleeding can cause fatigue, shortness of breath, pale skin color and black, tarry-looking stools. Rapid bleeding can cause stroke symptoms, abdominal and back pain. Take precautions to minimize the risk of falls or trauma that could potentially cause significant bleeding. Avoid alcohol. DO NOT take aspirin while on anticoagulants unless your doctor has prescribed this.
Clinician to educate patient and caregiver on high risk hypoglycemic medication: Metformin Blood sugar uses, why it is a high-risk drug: Hypoglycemics can cause low blood sugar resulting in visual disturbances, loss of consciousness, seizures, death Specific Teaching: A meal should be consumed within 30 minutes after administering regular insulin Having a strict insulin schedule is essential for keeping blood sugar levels within a healthy range. Watch for and report Signs and symptoms of hypoglycemia such as shakiness, dizziness, sweating, hunger, fast heartbeat, inability to concentrate, confusion, anxiety headache, drowsiness, blurry vision, muscle weakness. If these symptoms occur, drink a glass of fruit juice and eat hard candy. People at risk of hypoglycemia should wear a medical bracelet stating their type of diabetes, plus other necessary information, such as whether they control their condition with insulin.
Clinician to review and education on all medications
Clinician to assess for exacerbations of all diagnoses, provide education and report to the physician as needed

Your want to perform all of these?

Clinician to develop individualized symptom assessment emergency plan with patient found in the admission booklet to identify symptoms early and help prevent rehospitalization
Clinician to educate patient/caregiver on depression management and signs and symptoms to report.
SN to perform inspection of patient's lower extremities every visit and report any alteration in skin integrity to physician
Clinician to educate patient and caregiver on assessing feet daily and measures to take for maintaining proper diabetic foot care.
Clinician to assess for and educate on any new medications
Clinician to assess for signs and symptoms and monitor medication effectiveness for depression
Clinician to assess pain every visit
Clinician to educate patient/caregiver on pain management including pharmacological and non-pharmacological methods
Clinician to educate patient/caregiver on fall prevention measures using home health admission booklet (preventing falls- proper foot wear, clear pathways, removing/securing throw rugs, cords/wires, proper lighting assistive device(s))
Clinician to educate patient/caregiver to report any falls/injuries
Clinician to educate patient and caregiver on high risk antipsychotic medication: Aripirazole Antipsychotic Use, Why it is a high-risk drug: Common side-effects can be serious and must be reported immediately including: Parkinsons-like symptoms, hyperprolactinemia, neuroleptic malignant syndrome, postural hypotension, arrhythmias, sedation, seizures,sexual dysfunction diabetes, anticholinergic effects, dyslipidemia. Antipsychotics affect people differently. Different antipsychotic medications may be prescribed to find the right one that can control symptoms. Contact the doctor if the medication is not working. Don't stop taking antipsychotics suddenly. Antipsychotics can interact with other medications. Inform the doctor of all medicines being taken including homeopathic and other over-the-counter medications. Report if you Experience These Symptoms: Parkinsons-like symptoms, neuroleptic malignant syndrome, restlessness, postural hypotension, arrhythmias sedation, seizures, sexual dysfunction, dizziness, muscular contractions, spasm like movements, tense or stiff muscles, blurry vision.
SN to assess skin for breakdown Q visit
Clinician to educate patient/caregiver on methods to decrease risk for pressure ulcers turning and repositioning, float heels, reducing friction and shear, proper nutrition

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Ensuring Your POC Interventions Are Being Addressed on Visits

- Going into a visit blind?
- Are your clinicians reviewing the POC prior to visits?
- Are your clinicians copying and pasting interventions into their note(s)?
- Are updated orders being passed onto other staff seeing the patient?

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Case Manager to Ensure POC Updates:

- Changes = POC update
- This does not mean you open the current POC and change it!

Each patient must receive an individualized written plan of care, including any revisions or additions. The HHA must promptly alert the relevant physician)s_ to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plane of care should be altered.

484.60(c)(1) A revised plan of care must reflect current information from the patient's updated comprehensive assessment and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.

484.60(c)(3) Revisions to the plan of care must be communicated as follows:

- **484.60(c)(3)(I)** Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), and caregiver, and all physicians issuing orders for the HHA plan of care.
- **484.60(c)(3)(II)** Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).

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Standard: Exercise of Rights

484.50(c)(4)(iii) Establishing and revising the plan of care

484.50(c)(5) Receive all services outlined in the plan of care

484.60 The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.

Not Following POC

You're working outside your license.

Performing interventions without an order.

Will be sited in survey.

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Survey Tag Regarding the Plan of Care

- **484.50(c)(5)** – Receive all services in plan of care – G436
- **484.60(a)(1)** – Standard: Plan of Care – G572
- **484.60(a)(2)** – Plan of Care must include the following – G574
- **484.60(a)(3)** – All orders recorded in Plan of Care – G576
- **484.60(c)** – Standard: Review and revision of the Plan of Care – G586
- **484.60(c)(1)** – Reviewed, revised by physician every 60 days
- **484.60(c)(1)** – Promptly alert relevant physician of changes
- **484.60(c)(2)** – Revised Plan of Care – G592
- **484.60(c)(3)** – Plan of Care revisions must be communicated - G594
- **484.75(b)(2)** – Development and evaluation of Plan of Care – 708
- **484.75(b)(3)** – Provide services in the Plan of Care – G710
- **484.102(b)(1)** – Plans of HHA's patient in Plan of Care (Emergency Prep) – E0017
- **484.105(c)(5)** – Assure implementation of Plan of Care – G968

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M1033

Risk of Hospitalization

Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (check all that apply)

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

Four or more items selected between 1-7 gets you points. All or nothing.

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M1800

Grooming

Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

0. Able to groom self unaided, with or without the use of assistive devices or adapted methods.
1. Grooming utensils must be placed within reach before able to complete grooming activities.
2. Someone must assist the patient to groom self.
3. Patient depends entirely upon someone else for grooming needs.

Item Intent
Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.

Coding Instructions
- **Code 2, Someone must assist the patient,** if the patient can participate in grooming tasks but needs some assistance. The word 'assistance' in the items refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Dash** is **not** a valid response for this item.

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M1800

Grooming

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, **choose the response describing the patient's ability more than 50% of the time period under consideration.**
- Grooming includes several activities. **The frequency with which selected activities are performed** (such as washing face and hands vs. fingernail care) **must be considered in responding.** Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.
- In cases where a patient's ability is different for various grooming tasks, enter the response that best **describes the patient's level of ability to perform the majority of grooming tasks.**

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M1810

Current Ability to Dress Upper Body

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

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

Item Intent

Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.

Coding Instructions

- **Code 2, Someone must assist the patient,** if the patient can participate in upper body dressing tasks but needs some assistance. The word 'assistance' in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Code 3, Patient depends entirely upon another person to dress the upper body,** is selected only when the patient is dependent, relying entirely on another person to complete the majority of the upper body dressing tasks.
- **Dash** is **not** a valid response for this item.

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M1810

Current Ability to Dress Upper Body

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- For the purpose of coding this item, **prosthetic, orthotic, or other support devices applies to the upper body** (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as an upper body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are improved or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- In cases where a patient's ability is different for various upper body dressing tasks, enter the response that best describes the **patient's level of ability to perform the majority of upper body dressing tasks.**
- If the patient modifies the clothing, they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

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M1820

Current Ability to Dress Lower Body

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

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

Item Intent
Identifies the patient's ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.

Coding Instructions
- **Code 2, Someone must assist the patient,** if the patient can participate in lower body dressing tasks but needs some assistance. The word 'assistance' in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Code 3, Patient depends entirely upon another person to dress the lower body,** is selected only when the patient is dependent, relying entirely on another person to complete the majority of the lower body dressing tasks.
- **Dash** is **not** a valid response for this item.

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M1820

Current Ability to Dress Lower Body

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- For the purposes of coding this item, **prosthetic, orthotic, or other support devices applies to the lower body** (for example, **Lower extremity prothesis, ankle-foot orthosis** [AFO], **or anti-embolism stockings) should be considered** as lower body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. **If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.**
- In cases where a patient's ability is **different for various dressing lower body tasks,** enter the response that best describes the **patient's level of ability to perform the majority of dressing lower body tasks.**
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is not reasonable expectation that the patient could return to their previous style of dressing. There is not specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

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M1830

Bathing

Currently ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

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

Item Intent
Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower.

Coding Instructions
- **Code 4, 5 or 6,** depending on the patient's ability to participate in bathing activities:
    - If a patient is medically restricted from stair climbing, and the tub/shower requires climbing stairs
    - If the patient does not have a tub or shower in the home.
    - If the tub/shower is nonfunctioning or not safe for patient use
- **Dash** is **not** a valid response for this item.

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M1830

Bathing

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- Specifically **excludes washing face and hands, and shampooing hair.**
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If **ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.**
- **The patient's status should be coded based on a patient's ability to perform a task with equipment they have not been assessed using.**

Coding Tips

- For **Response 4,** the patient must be able to bathe outside the tub/shower safely and independently, including independently accessing water at the sink, or setting up a basin at the besides, etc.
- For **Response 5,** the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance.
- Enter **Response 6,** if the patient is totally unable to participate in bathing and it totally bathed by another person, regardless of where bathing occurs or if patient has a functioning tub or shower.

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M1840

Toilet Transferring

Current ability to get to and from the toilet or beside commode safely and transfer on and off toilet/commode.

0. Able to get to and from the toilet and transfer independently with or without a device.
1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
3. Unable to get to and from the toilet or bedside commode but is able to sue a bedpan/urinal independently.
4. Is totally dependent in toileting.

Item Intent
Identifies the patient's ability to safely get to and from and transfer on and off the toilet or beside commode.

Coding Instructions
- **Code 1,** if the patient:
    - Requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders.
    - If the patient needs assistance getting to/from the toilet or with toileting transfer or both.
    - If the patient can independently get to the toilet but requires assistance to get on and off the toilet.
- **Code 3,** if the patient who is unable to get to/from the toilet or bedside commode is able to place and remove a bedpan (and urinal if applicable) independently, whether or not a patient requires assistance to empty the bedpan/urinal.
- **Code 4,** if the patient who is unable to get to/from the toilet, is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment.
- **Dash** is **not** a valid response for this item.

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M1845

Toilet Hygiene

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

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

Item Intent
Identifies the patient's ability to manage personal hygiene and clothing when toileting.

Coding Instructions
- **Code 0,** if patient is independent in managing toilet hygiene and managing clothing.
- **Code 1,** if patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.
- **Code 2,** if the patient can participate in hygiene and/or clothing management but needs assistance with either or both activities. The word 'assistance' in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Dash** is **not** a valid response for this item.

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M1845

Toilet Hygiene

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- Toileting hygiene includes several activities, **including pulling clothes up or down and adequately cleaning (wiping) the perineal area.**
- Toileting hygiene includes the patient's ability to maintain hygiene related to **catheter care** and the **ability to cleanse around all stomas** that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must **consider what the patient is able to do on the day of the assessment.** If ability varies over time, enter the response describing the patient's ability more than **50% of the time period under consideration.**
- This item refers to the patient's ability to manage personal hygiene and clothing with or without assistive devices.

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M1850

Transferring

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

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

Item Intent
Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.

Coding Instructions
- **Code 1,** if the patient:
    - Transfers either with minimal human assistance (but not a device), or with the use of a device (but no human assistance).
- **Code 2,** if patient:
    - Requires both minimal human assistance AND an assistive device to transfer safely
    - Can both bear weight and pivot and is not bedfast
- **Dash** is **not** a valid response for this item.

Coding Tips
- 'Minimal human assistance' applies when the helper is contributing less than 25% of the total effort required to complete the task.
- Assistance may include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.

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M1850

Transferring

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input form other agency staff who have had direct patient contact.
- For most patients, the transfer between bed and chair will **include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed form the chair or sitting surface.**
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to sand and **then sit on what ever surface is applicable to the patient's environment and need,** (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). **Include the ability to return back into bed from the sitting surface.**
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. **If the ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.**
- **Able to bear weight** refers to the patient's ability to support the majority of their body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support their entire weight through the other lower extremity and upper extremities).
- **Bedfast** refers to being confined to the bed, **either per physician restriction or due to a patient's inability to tolerate being out of the bed.**

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M1860

Ambulation/Locomotion

Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

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

Item Intent
Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.

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M1860

Ambulation/Locomotion

Coding Instructions

- **Code 2 or 3,** if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, regardless of the need for an assistive device. **Code 2,** if the assistance required is intermittent. **Code 3,** if the assistance required is continuous.
- **Code 2,** if the patient is:
    - Able to safely ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven services.
    - Able to safely ambulate with a walker in the hallway or living room, even if there are some situations in the home where a cane provides adequate support as long as the patient does not require continuous human assistance.
- **Code 3,** if the patient does not have a walking device but is clearly not safe walking alone, unless the patient is chairfast.
- **Code 4 or 5,** if a patient:
    - Is unable to ambulate even with the use of assistive devices and/or continuous assistance.
    - Demonstrates or report's ability to take one or two steps to complete a transfer but is otherwise unable to ambulate.
- **Dash** is **not** a valid response for this item.

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M1860

Ambulation/Locomotion

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- **Variety of surfaces** refers to **typical surfaces that the patient would routinely encounter in their environment** an may very based on the individual residence.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), enter the response that **reflects the device that best supports safe ambulation on all surfaces** the patient routinely encounters.

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M1870

Feeding or Eating

Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

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

Item Intent

Identifies the patient's ability to feed themself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ability, not necessarily actual performance. 'Willingness' and 'adherence' are not the focus of this item.

Coding Instructions

- **Code 5, Unable to take in nutrients orally or by tube feeding,** if all nutrition is received intravenously (such as TPN) or for patients who are receiving only intravenous hydration.
- **Dash** is **not** a valid response for this item.

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M1870

Feeding or Eating

- Observation/demonstration is the preferred method for coding this item. Other sources of information include but are not limited to patient/caregiver interview, physical assessment, nutritional assessment, physician orders, plan of care, referral information, and review of past history. When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact.
- Code this item based on the **assistance needed by the patient to feed themselves once the food is place in front of them.** Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- Consider what the patient is able to do on the day of the assessment. **If ability varies over time,** enter the response describing the **patient's ability more than 50% of the time period under consideration.**
- Do not consider preparation of food, or transport of food to the table when coding this item.
- 'Meal set up', (Response 1, option a), refers to activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. - all of which are special adaptation of the meal for the patient.

Coding Tips

- If a patient is being weaned from the tube feeding, code 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, code 0, 1, or2. This is true, even if the tube remains in place, unused for a period of time.

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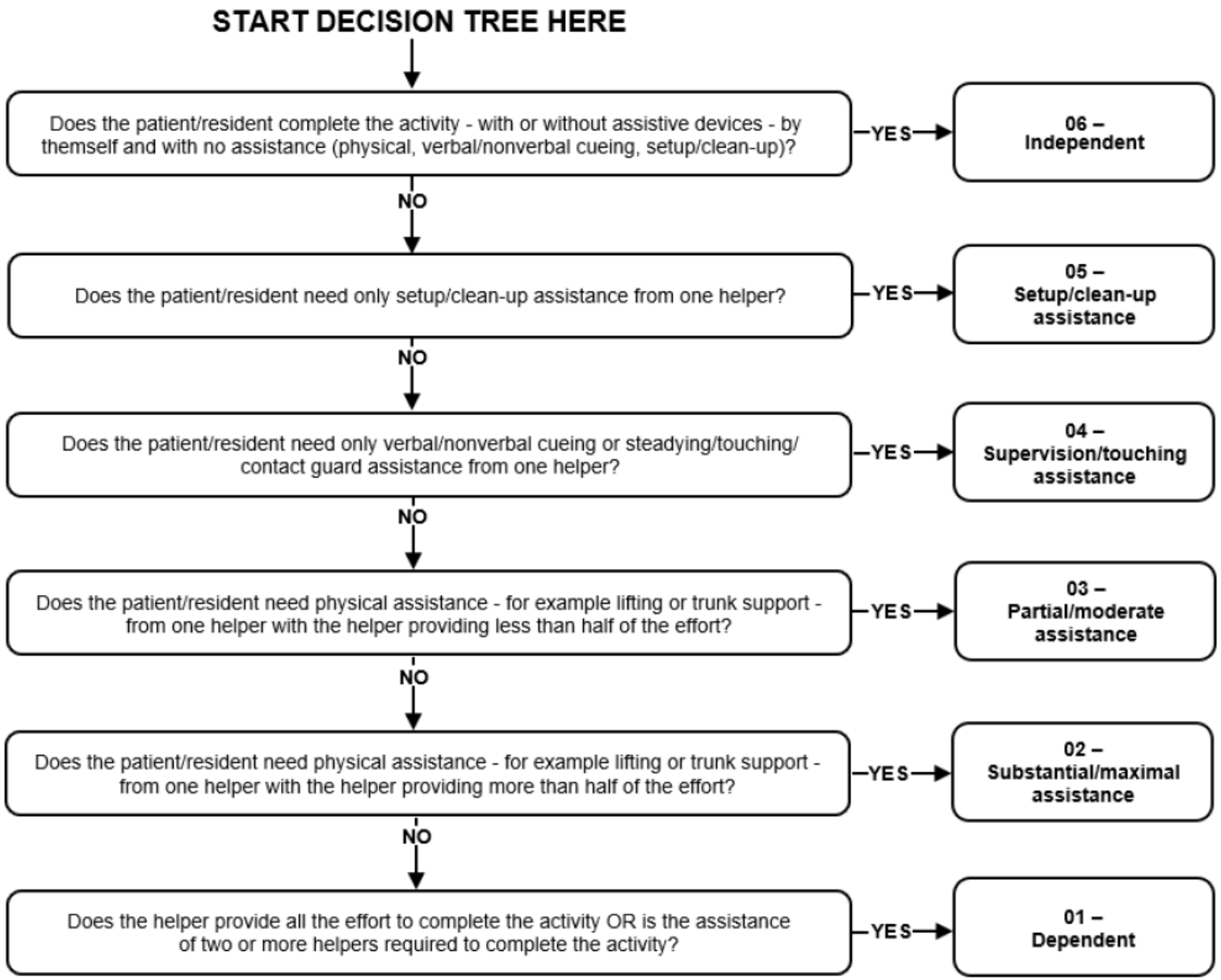
GG Questions

Usually marked more independent than the M ADL questions.

Don’t include getting to where the tasks are to be performed.



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SN Visits Should Include:

- Vital signs
- Assessment of body systems
- Interventions addressed from the POC
- Document how the patient tolerated care
- Progress toward goals

If appropriate for visit:

- Follow up on any concerns to MD. Update POC/write orders
- Coordination of care
- Supervisory visit

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Wound Care Documentation

- Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be skilled nursing service.

- For skilled nursing care to be reasonable and necessary to treat a wound, **the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented** in the clinical findings so that an assessment of the need for skilled nursing care can be made.

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Elements to Document for Wound Care:

Location: Use the correct anatomical terms to clearly document the wound's location.

Type of Wound: Many types of wounds can be assessed and documented, including surgical wounds, burns, and pressure injuries. Wounds can also be acute or chronic.

Measurement: The size of the wound should be measured in centimeters and listed in the wound care treatment chart as length times width times depth. Nurses must also document the location and depth of any tunneling or undermining.

Wound Bed: It's important to document tissue type (slough, eschar, epithelial, granulation, etc.), coloring, and level of adherence using percentages. For example, "40% of the wound is covered in non-adherent tan slough while 60% is covered with red granulation tissue."

Wound Edges: Indicate whether a wound's edges are defined or undefined, attached or unattached, rolled under, macerated, fibrotic, or callused.

Drainage: The amount and type of drainage must be documented in a wound care assessment. Common types of draining includes serous, sanguineous, serosanguineous, and purulent. Words like 'none,' 'scant,' 'small,' 'moderate,' and 'large/copious' are often used to describe the amount of drainage assessed.

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Elements to Document for Wound Care: (Continued)

Odor: Wounds can have different odors, including those that are strong, foul, pungent, fecal, musty, or sweet. Some have no odor at all.

Surrounding Tissue: Describe the color, firmness, and pallor of the surrounding skin. Note any signs of edema or induration, as well as any lesions, scarring, rashes, staining, moisture, or variations in texture.

Infection: Wounds are often prone to infection, which can significantly disrupt the healing process. A wound assessment should cite any indicators of infection, including redness or localized pain.

Pain: A comprehensive wound assessment describes a patient's pain in detail, noting its location and intensity as well as any patterns and variations in pain type. Common pain descriptors include throbbing, stabbing, burning, pulsing, pounding, pricking, hot, tingling, stinging, cramping, beating, gnawing, dull, thigh, squeezing, piercing, and electrical. The assessment should also address possible causative and alleviating factors, including any interventions that were taken.

Response to Care/Treatment Plan: It's important to document whether the wound has improved and to list any evidence of healing. Nurses will also need to document any pain that the patient experiences when the wound dressing is changes as well as any examples of adverse reaction. If the patient has not been adhering to treatment plans, that should be noted in the assessment.

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Example Wound Documentation

- SN removed old dressing and packing to left lower leg diabetic ulcer. Wound bed beefy red with granulation tissue noted on 50% surrounding skin is intact with no redness, large amount of serosanguineous drainage with no odor. Wound measurements are 7cm (L) x 5 cm (W) x 0.3 cm (D). No tunneling or undermining present. No s/s of infection present. Patient is diabetic and has PVD complicating wound healing. Wound care provided per MD order as following using aseptic technique: cleaned with NS, pat dry with gauze, applied med-honey, light packed with strip gauze to wound surface area, covered with duoderm dressing. Patient reported minimal pain (1-2) during dressing change. SN taught on s/s infection to report, taking pain medications 30-50 minutes prior to dressing change visits. Picture of wound taken and uploaded to the patient's chart.

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All Wound Care Needs an Order

Example of wound care orders:

- SN to perform dressing changes on stage 3 pressure ulcer of left buttocks. SN to cleanse with NS or wound cleanser, dry with gauze, apply Medi honey, apply self adhesive Opti foam dressing. SN to change dressing 2 times a week and PRN for saturation or loosening of dressing.

**Document: Location and type of wound, dressing change steps (clean with, dry with, apply dressing & secure with), how opten to be performed.

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Wound Terms

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Document Drainage Type

- Serous – thin, watery, clear
- Sanguineous – thin, bright red, fresh bleeding
- Serosanguinous – think, watery, pale-red to pink
- Purulent – thick or thin, opaque-tan to yellow
- Foul Purulent – thick opaque-yellow to green with offensive odor

Document Wound Odor

- Describe presence or absence of odor after cleansing the wound
- Descriptors include: strong, foul, pungent, fecal, musty, sweet, etc.

Describe Surrounding Tissue (Periwound)

- Describe the color, presence/lack of edema, tissue consistency (e.g. indurated (firm), boggy, etc.), temperature, etc.

Wound Terms

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Document Drainage Amount

- None – wound tissue dry
- Scant – wound tissue moist, no measurable drainage
- Minimal – wound tissue very moist, <25% of dressing saturated with drainage in a 24-hour period
- Moderate – wound tissue is wet, 25%-75% of dressing saturated with drainage in a 24-hour period
- Large – wound tissue is filled with fluid, >75% of dressing is saturated with drainage in a 24-hour period

Describe Wound Edges

- Definition – defined (well-demarcated) or undefined wound edges
- Attachment – attached or unattached wound edges
- Epibole – rolled wound edges
- Maceration – skin that is white and sometimes winkled and soft due to supersaturation
- Callused/Fibrotic – build-up of tissue at wound margin due to hyperkeratosis

Wound Terms

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Wound Bed Characteristics

- Non-Adherent – easily separated from the wound base
- Loosely Adherent – pulls away from the wound but is attached to wound base
- Firmly Adherent – does not pull away from the wound base

Tissue Amount

- Describe in percentages (e.g., 50% of wound bed is covered with loosely adherent yellow slough; 50% beefy, red granulation tissue).
- May also utilize the 'clock system' in describing ;location of necrotic tissue in the wound be.

Tissue Types

- Granulation – temporary structure composed of vascularized connective tissue that fills the wound void; may be red, pink, pale, or dusky red
- Slough – necrotic/avascular tissue that is yellow or tan in color and has a stringy or mucinous consistency
- Eschar – is described as thick, leathery, frequently black or brown in color, necrotic or devitalized tissue
- Epithelialization – process by which keratinocytes resurface the wound defect – can appear as deep pink, then progress to pearly pink; may form islands in the wound

Wound Terms

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Document Indicators of Infection

- Document fever, erythema (redness), increased drainage, odor, warmth, edema, elevated WBC, induration, pain, etc.

Document Complaint of Pain

- Document location, causative factors, intensity, quality, duration, alleviating factors, patterns, variations, interventions, etc.

Document Interventions to Promote Healing

- Examples include: dietary supplements, vitamins, lab tests, turning and repositioning schedules, support surfaces, padding, pillows, elevation, offloading, heel protection, incontinence management, skin care, barrier ointments, etc.

Document Conditions Which May Adversely Affect Healing

- Examples include: impaired mobility, nutritional status, abnormal labs, infections, deterioration of medical condition, non-compliance, etc.

Document Anticipated Wound Outcome

- Based on provider evaluation of co-morbid conditions, circulation, medication, and based on discussions and desires of the resident, advanced directors, anticipated life span, goals and wishes
- Is the wound good for healing, maintenance or palliative?

Wound Care Supplies

Wound care supplies that should be listed on the medication list includes:

- **Ointments**
- **Creams**
- **Wound Wash (NS, Wound Cleanser, etc.)**

ALL supplies used for wound care should be **listed under supplies on the plan on care** (excluding those on the medication list).

Wound care supplies used for each visit should be documented in the nurse's visit notes.

Example – SN changed dressing to left ankle DM ulcer-cleansed with NS, patted dry with 4x4 gauze (2), applied Med—Honey to wound bed, applied foam dressing, and secured with Coban.

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Documentation Tips

The most effective and efficient note documentation is done directly after the visit.

- Schedule visit to allow for 15-20 minutes to document before going to the next patient.
- Admissions – finished all your documentation within 48 hours. (This does take extra time). Ideally finishing the same day as the admission.
- Only used approved abbreviations (see your agency policy)
- Add details that paint a picture of the situation, so someone reading it could picture it in their head.

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Specificity of Orders

SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).

Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health patients under a home health plan of care. When a range of visit is ordered, the upper limit of the range is considered the specific frequency.

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Use of Oral (Verbal) Orders

When services are furnished based on a physician or allowed practitioner's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician or allowed practitioner before the HHA bills for the care in the same way as the plan of care.

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Chart Compliance

- F2F-MD visit note present, all elements met, appropriate timeframe (90 days before, 30 days after)
- Consent form completed and signed on SOC date
- 485/POC completed and signed by MD within 30 days
- Initial order/verbal order received-includes all disciplines providing services
- ICD 10 codes match summary and interventions. PDGM group matches our reason for care
- Patient summary clearly states why the patient is eligible for home health
- Was there improvement in bathing (M1830). If not was there anything more, we could have done to help the patient improve in this area?
- Was there improvement in medication management (M2020). If not was there anything more, we could have done to help the patient improve in this area?
- Timely initiation of care (either same day as M0102 or within 48 hours of M0104)
- Interventions show skill for each discipline (ensure to keep close eye on maintenance therapy patients)
- Was Med Reconciliation completed with each SOC, ROC, REC OASIS and any medication change?
- Oxygen listed on the medication profile if applicable
- All changes in the POC have a supplemental order and communication documentation with pt/caregivers
- Homebound status documented each visit
- Nursing frequent correct
- Inventions provided on visit notes match most recent orders
- Billable skill documented each visit
- Was the correct HCPCS code and location code selected for each visit note
- HHA frequency correct
- Aide supervisory done at least every 14 days
- LPN supervisory done at least every 14 days
- Care coordination documented at least every 60 days
- NOMNC completed-signed at least 48 hours prior to DC. HHCCN completed if reduced or terminated services while another service continued'
- Wound care/wound assessment documented
- If wound present was a picture obtained weekly
- Incident, infection, adverse event, compliant reported if applicable
- Documentation present of individualized emergency preparedness plan
- Physician was notified of any missed visits
- DC summary completed (includes all disciplines)

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Coordination & Care Planning

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42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care

Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. **The individualized plan of care must specify the care and services necessary to meet the patient-specific needs** as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.

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484.60(a) Standard: Plan of Care

484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. 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 modifications to the original plan.

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484.60(a)(2) Individualized Plan of Care Must Include

- 484.60(a)(2)(i) All pertinent diagnoses
- 484.60(a)(2)(ii) The patient's mental, psychosocial, and cognitive status
- 484.60(a)(2)(iii) The types of services, supplies, and equipment required
- 484.60(a)(2)(iv) The frequency and duration of visits to be made
- 484.60(a)(2)(v) Prognosis
- 484.60(a)(2)(vi) Rehabilitation potential
- 484.60(a)(2)(vii) Functional limitations
- 484.60(a)(2)(viii) Activities permitted
- 484.60(a)(2)(ix) Nutritional requirements
- 484.60(a)(2)(x) All medications and treatment
- 484.60(a)(2)(xi) Safety measures to protect against injury
- 484.60(a)(2)(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors
- 484.60(a)(2)(xiii) Patient and caregiver education and training to facilitate timely discharge
- 484.60(a)(2)(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
- 484.60(a)(2)(xv) Information related to any advanced directives
- 484.60(a)(2)(xvi) Any additional items the HHA or physician may choose to include
- 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care

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Items Required on the POC Aren't Listed in Some EMR's

Examples:

- Risk of hospitalization
- Advanced directives
- Attestation to the F2F date by the certifying physician

Ensure your EMR has all required elements for the POC or ensure they are added on each POC.

Should you include a patient admission summary on the POC?

YES!

- Our signed POC is supplemental documentation to support the F2F.
- A patient summary that lists the reason the patient is requiring home health justifies the skilled need for home health. Sometimes the Physician's F2F visit doesn't always have enough detail to support home health services.

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Medicare Benefit Policy Manual – Chapter 7 – Home Health Services

Supporting Documentation Requirements (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21

- While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician or allowed practitioner, acute/post-acute care facility, and/or HHA.

Medicare Benefit Policy Manual – Chapter 7 – Home Health Services – Content of the Plan of Care

Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21

The HHA must be acting upon a physician or allowed practitioner plan of care that meets the requirements of this section for HHA services to be covered. For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician or allowed practitioner after any needed consultation with the qualified therapist.
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments.
- The plan must include the expected duration of therapy services.
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

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Plan of Care Template

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐ M ☐ F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures

16. Nutritional Req.	17. Allergies

18.A. Functional Limitations

1 ☐ Amputation	5 ☐ Paralysis	9 ☐ Legally Blind
2 ☐ Bowel/Bladder (Incontinance)	6 ☐ Endurance	A ☐ Dyspnea With Minimal Exertion
3 ☐ Contracture	7 ☐ Ambulation	B ☐ Other (Specify)
4 ☐ Hearing	8 ☐ Speech	

18.B. Activities Permitted

1 ☐ Complete Bedrest	6 ☐ Partial Weight Bearing	A ☐ Wheelchair
2 ☐ Bedrest BRP	7 ☐ Independent At Home	B ☐ Walker
3 ☐ Up As Tolerated	8 ☐ Crutches	C ☐ No Restrictions
4 ☐ Transfer Bed/Chair	9 ☐ Cane	D ☐ Other (Specify)
5 ☐ Exercises Prescribed		

19. Mental Status							
	1 ☐ Oriented	3 ☐ Forgetful	5 ☐ Disoriented	7 ☐ Agitated
	2 ☐ Comatose	4 ☐ Depressed	6 ☐ Lethargic	8 ☐ Other

20. Prognosis	1 ☐ Poor	2 ☐ Guarded	3 ☐ Fair	4 ☐ Good	5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

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Plan of Care Template

22. Goals/Rehabilitation Potential/Discharge Plans	
23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date of HHA Received Signed POT
24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

I certify/ recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred 12/1/2021 within timeframe requirements and it is related to the primary reason the patient requires home health services.	**Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.**

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Proper Care Planning Starts with Admission

OASIS-E includes the following sections:

Section	Title	Section	Title
A	Administrative Information • Patient Tracking	H	Bowel and Bladder
B	Hearing, Speech, and Vision	I	Active Diagnoses
C	Cognitive Patterns	J	Health Conditions
D	Mood	K	Swallowing/Nutritional Status
E	Behavior	M	Skin Conditions
F	Preferences for Customary Routine Activities	N	Medications
G	Functional Status	O	Special Treatments, Procedures and Programs
GG	Functional Status: Functional Abilities and Goals	Q	Participation in Assessment and Goal Setting

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Why Home Health? Why Now? What Services?

- Summary: Patient is an 84-year-old female patient of Dr's Cody Coyote MD, and David Dennis MD. Following a colonoscopy patient was found to have a rectosigmoid junction tumor. Patient was admitted to the hospital on 06/20/2023 to undergo a laparoscopic low anterior resection with diverting ileostomy. Patient is being admitted to home health for: SN to instruct on care of ostomy, change in diet and comorbidities. PT, OT, and HHA were all offered and refused. Comorbidities: Rectal carcinoma, Rectal bleeding, CKD 3, CHF, HTN, COPD, and constipation. Patient lives in own home with 2 adult sons and a daughter who lives close by who can help with her ADL and IADL cares. Patient requires assistance with bathing but will bathe when her daughter is present and able to help her.
- The clinician verified the plan of care with Dr David Dennis on 06/26/2023 at 16:52. The plan of care was approved. Patient's personal healthcare goal: to have ostomy reversed.

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Let's Set Up a Plan of Care

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Remember PIG

P - Problem

I – Intervention

G - Goal

What are we seeing the patient for? What other diagnoses could put the patient back in the hospital?

- Aftercare for surgery
- New ileostomy
- CHF/HTN
- COPD
- CKD
- Constipation (already has constipation and on opioid after surgery)
- Pain
- Medication error/side effects

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Set Up Your Interventions:

Myth – All diagnoses need an intervention

- Aftercare for surgery
- New ileostomy
- CHF/HTN
- COPD
- CKD
- Constipation (already has constipation and on opioid after surgery)
- Pain
- Medication error/side effects (always a factor if on any medications)
- Wound complications

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Don’t Forget

SOC/ROC assess for fall risk, depression, pain, risk for pressure ulcers, and pressure ulcers. You will get to answer this question on discharge.

M2401. Intervention Synopsis
At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Mark only one box in each row.)

Plan/Intervention	No	Yes	Not Applicable	
	↓Check only one box in each row↓			
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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Example Interventions:

SN Interventions

Clinician to assess pain every visit. Clinician to educate patient/caregiver on **pain management** including pharmacological and non-pharmacological methods.

Clinical to teach **pressure ulcer prevention** including position changes at least every 2 hours, pressure relieving equipment, and susceptible areas that are most at risk.

Clinician to educate patient/caregiver on **fall prevention** measures using home health admission booklet (preventing falls-proper footwear, clear pathways, removing/securing throw rugs, cords/wires, proper lighting assistive device(s))
Clinician to educate patient/caregiver to report any falls/injuries
Clinician to assess for exacerbations of all diagnoses, provide education and report to the physician as needed
Clinician to develop individualized symptom assessment **emergency plan** with patient found in the admission booklet to identify symptoms early and help prevent rehospitalization.
SN to perform inspection of patient's lower extremities every visit and report any alteration to skin integrity to physician.

Clinician to educate patient and caregiver on high-risk opioid **medication:** hydrocodone/acetaminophen surgical pain users, why it is high risk: Opioids are highly addictive, a growing problem throughout the United States. Overdose can cause respiratory depression. Specific teaching Opioids are safest when used for three or few days to manage acute pain, such as pain that follows surgery or a bone fracture. If opioids are needed for acute pain, work with the doctor to take the lowest dose possible, for the shortest time needed, exactly as prescribed. Report signs and symptoms: Drowsiness, dizziness, nausea, vomiting, respiratory depression, constipation. Do NOT take alcohol, clinician to review and education on all **medications.** Clinician to assess for and education on any new medications.

SN to instruct on **CHF** including s/s of exacerbation to report including increased weight gain, difficulty breathing, increased edema, chest pain, rapid or irregular heartbeat, fatigue and weakness.
SN to education on **constipation** prevention including medication intervention, increasing fluid and dietary fiber, have prune or prune juice on hand, etc.

Visit 1: SN to provide **Ostomy education** to patient/caregiver using P-H education pathway about ostomies, home safety measures, safety outside of the home, care team, infection control
Visit 2: SN to provide ostomy education to patient/caregiver using P-H education pathway ostomy pouch, changing pouch, cleaning pouch, peristomal skin care
Visit 3: SN to provide ostomy education to patient/caregiver using P-H education pathway exercise needs, suggested dietary modifications
Visit 4: SN to provide ostomy education to patient/caregiver using P-H education pathway irrigating colostomy concerns and adjusting to having an ostomy signs, symptoms and problems, dehydration, blockage, stents, UTI, stoma infections when to call the doctor
SN to assess sites for any s/s of infection including drainage, swelling or pain greater than 5/10 at sites. SN to report any changes to MD.
SN to instruct patient and caregivers on s/s of infection, including drainage, swelling or pain greater than 5/10 at sites and to report any changes to SN or MD.

Selecting Goals:

Myth – All interventions need a goal

- Focus on the most important items
- Ensure we have at least one patient specific goal (per COP's)
- Must be time specific (discourage "by end of cert"), use months or weeks
- Use short term and long-term goals
- All interventions listed on the POC must be addressed, so don't overdo it with a 100 interventions

Goal Examples:

SN Goals
Patient's **pain** will be managed throughout the episode (goal term: short, target date: 8/24/23)
The patient will be free from **falls** and hospitalizations during the certification period (Goal term: long, target date: 8/24/23)
All comorbidities will be managed throughout the episode comorbidities including CHF, CKD 3, HTN, COPD (Goal term: short, target date 8/24/23)
Patient/caregiver will verbalize understanding and demonstrate teach back on how to properly take all medications (Goal term: short, target date: 7/15/23)
Patient/caregiver will be able to verbalize understanding of ostomy management and symptoms to report (Goal term: long, target date: 8/24/23)
Surgical sites at right lower quadrant, umbilicus, left upper quadrant and lateral to umbilicus to heal with out complications within 3 weeks. (Goal term: short, target date: 7/5/23)

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Plan of Care Updates

Patient changes need an order to update the POC (examples):

- Medication changes
- UA order for s/s of UTI
- MD requested blood draw
- Increased or decreased visits
- DC Home Health services
- Wound dressing steps changed
- Adding additional services

*Patient must be informed of all changed and agree to the changes

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Coordination

Interpretive Guidelines 484.75(b)(1)

- The term ‘interdisciplinary’ refers to an approach to healthcare that includes a range of health service workers. ‘Ongoing interdisciplinary assessment’ is the continual involvement of all skilled professional staff involved in a patient’s plan of care from the initial assessment through discharge, which should include periodic discussion among the team regarding the patient’s health status and recommendations for the plan of care.
- An interdisciplinary approach recognizes the contributions of various health care disciplines (MDs, RNs, LPN/LVN, PT, OT, SLP, MSW, HH aids) and their interactions with each other to meet the patient’s needs.
- 484.80(g)(1) Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with **written patient care instructions** for a home health aide **prepared by the registered nurse or other appropriate skilled professional** (that is, physical therapist, speech-language pathologist, or occupational therapist)
- 484.80(g)(2) A home health aide provides services that are:
    - (i) Ordered by the physician
    - (ii) Included in the plan of care
    - (iii) Permitted to be performed under state law
    - (iv) Consistent with the home health aide training
- Home Health aides must be members of the interdisciplinary team, must report changes in the patient’s condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA’s policies and procedures.

Home Health Aide Care Plan

The reason for the visits by the home health aide must be to **provide hands-on personal care** of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

Personal Care Means;

- Bathing, dressing, grooming, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens to an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care; and
- Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

Home Health Aides are not able to determine if a patient needs a certain task completed. Don't use 'PRN' on the Aide Care Plans.

Home Health Aides should report to the case manager any concerns regarding the patient, refusal of any services ordered, and any follow up on possible care plan changes needed.

The Home Health Aide should be involved in IDT.

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Example of a Home Health Aide Care Plan

Vital Sign Notification

BP Systolic	> 160	< 90	Pulse	> 100	< 50	Respiration	> 28	< 12
BP Diastolic	> 90	< 60	Temperature	> 101	< 96	✓ No Bowel Movement in 3 Days		
Foley:			Weight Gain or Loss					

Vital Signs	Frequency
Blood Pressure	every visit
Pulse	every visit
Respiration	every visit
Temperature	every visit
Weight	

Elimination	Frequency
Assist w/ Bed Pan	
Assist w/ Bedside Commode	
Catheter Care	
Empty Ostomy Bag	
Incontinent Care	every visit
Record Bowel Movement	

Activity	Frequency
Assist in Ambulation	every visit
Assist in Transfer	every visit
Range of Motion	
Turn or Position	

Household	Frequency
Change Linen	
Light Housekeeping	every visit
Make Bed	

Personal Care	Frequency
Assist to Dress	every visit
Back Rub/Massage	
Check Pressure Areas	every visit
Comb Hair	
Complete Bath	
Foot Care	
Nail Care	
Oral Hygiene Denture Care	every visit
Partial Bath/Sponge	
Pericare	every visit
Shampoo Hair	
Shave	every visit
Skin Care	every visit
Tub	
Shower	every visit
Universal Precautions	every visit

Additional Comment

CM: Melissa Feser, please perform VS every visit.

Supervision

484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services, a **registered nurse** or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in 484.80(g), **must make an onsite visit to the patient's home no less frequently than every 14 days.** The home health aide does not have to be present during the visit.

- If an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional, then the supervising individual must make an on-site visit to the location where the patient is receiving care in order to observe the assess aide while he or she is performing care.
- A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

484.80(h)(4) Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to:

(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family

(iii) Demonstrating competency with assigned tasks

(iv) Complying with infection prevention and control policies and procedures

(v) Reporting changes in the patient's condition

(vi) Honoring patient rights

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PDGM Payment, Including LUPAS

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What is PDGM?

Patient Driven Grouping Model

Home Health Payment Program

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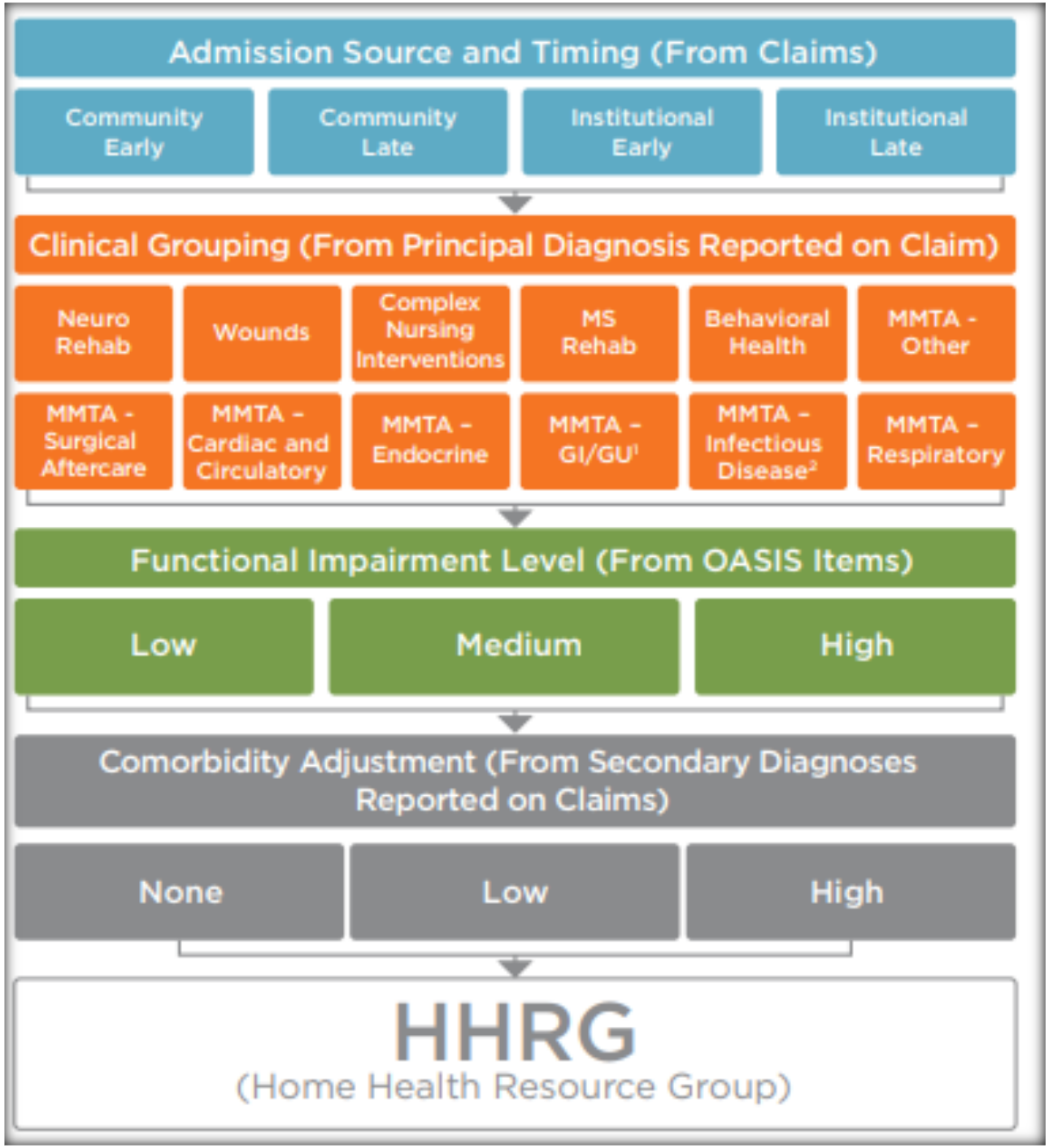

HHRG Broken Down Into

Oasis

- Admission Source/Timing: Community or Institutional (Early or Late)
  - M100 – on OASIS
- Functional Impairment Level (Low, Medium, High)
  - ADL Questions on the OASIS

Diagnosis Coding

- Clinical Grouping (Principal Diagnosis)
  - M1021
- Comorbidity Adjustment from Secondary Diagnoses (none, Low, High)
  - M1023

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M1000: Inpatient Facilities

M1000. From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days?	
↓ Check all that apply	
☐	1. **Long-term nursing facility (NF)**
☐	2. **Skilled nursing facility (SNF/TCU)**
☐	3. **Short-stay acute hospital (IPPS)**
☐	4. **Long-term care hospital (LTCH)**
☐	5. **Inpatient rehabilitation hospital or unit (IRF)**
☐	6. **Psychiatric hospital or unit**
☐	7. **Other (specify)**
☐	NA **Patient was not discharged from an inpatient facility** → *Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC*

M1021/M1023: Primary Diagnosis/Other Diagnoses

M1021. Primary Diagnosis & M1023. Other Diagnoses	
Column 1	**Column 2**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses

M1021. Primary Diagnosis	
a. _____	V, W, X, Y codes NOT allowed a. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

M1023. Other Diagnoses	
b. _____	All ICD-10-CM codes allowed b. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
c. _____	c. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
e. _____	e. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
f. _____	f. ☐☐☐.☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

Early Versus Late

PDGM Payment:

- Early period of care – First 30 days
- Late period of care – Second or later 30-day period

OASIS M0110:

- Early – Patient's first and second episode of care (60-day episodes)
- Late – Third or later episode of care in the current sequence of adjacent payment episodes

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Primary Diagnosis Determines Clinical Group

TABLE 1: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

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PDGM Acceptable

Not ALL ICD-10 diagnoses codes can be used as primary diagnosis. Face to Face Encounter must directly address the primary reason for home health (primary diagnosis)

Some Examples

Sometimes clarification from the provider is needed to be able to get a valid ICD-10 code

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Appropriate PDGM diagnoses	Not appropriate PDGM diagnoses
**MUST SPECIFY SITE • Rheumatoid arthritis defined joints • Primary OA per joint • Primary Generalized osteoarthritis • Polyarthritis • Gout – (drug induced or idiopathic) • Aftercare joint replacement • Fractures • Spondylolysis • Spondylolisthesis • Ankylosing spondylitis • Osteomyelitis • Discitis • Lumbago with sciatica • Collapsed vertebrae • Cervicalgia • Lumbar radiculopathy • Lumbar, thoracic, cervical stenosis • Muscle wasting and atrophy • Sarcopenia • Rhabdomyolysis • Osteoporosis • Lymphedema • Dysphagia • COPD • Pneumonia • COVID • Hereditary/Idiopathic neuropathy G60.9 • Benign paroxysmal vertigo (add specific side) • Open wounds • Lacerations • Surgical wound complications • Surgical wound infections • Sepsis • Chronic Kidney disease stages 1-4 • Malnutrition	• Any R codes which are symptom codes except dysphagia R13.10 • Vascular Dementia F01.50 • Rheumatoid arthritis unspecified M06.9 • Osteoarthritis unspecified M19.90 • Muscle weakness M62.81 • Altered gait R26.89 • Repeated falls R29.6 • Pain in knee, shoulder, hip, back unspecified • Pain unspecified R52 • Low back pain M54.50 • Dorsalgia M54.9 • Unsteadiness on feet R26.81 • Dysarthria (not related to CVA) R47.1 • Spinal stenosis unspecified M48.00 • Weakness R53.1 • Abdominal pain R10.9 • Edema R60.0 • Shortness of breath R06.02 • Dyspnea R06.00 • Polyneuropathy G62.9 • Age-related physical debility R54 • Diarrhea R19.7 • Fecal incontinence R25.9 • Abrasions • Hypotension unspecified I95.9 • Vertigo R42 • Altered mental status R41.82 • Post COVID condition U09.9 • Bacteremia • Chronic Kidney disease stages 5,6 • Anorexia R63.0 • Failure to thrive R62.7

Order of Clinical Groups per Payment

- **Wounds –** highest payer (don't be deceived, you are still paying for wound supplies
- **Neuro Rehab** - Stroke, Alzheimer's Parkinson's MS, etc.
- **Musculoskeletal Rehab** – Joint replacements, OA, etc.
- **MMTA's** – HTN, DM, MI, body system surgical patients, etc.
- **Complex Nursing** – Attention to codes, catheter, IV, etc.
- **Behavioral Health** – Dementia, Depression, etc.

Each Clinical Group has different thresholds that have to met the Functional Impairment Levels

Clinical Group	Level of Impairment	Points (2023)
MMTA - Other	Low	**0-32**
	Medium	**33-43**
	High	**44+**
Behavioral Health	Low	**0-31**
	Medium	**32-43**
	High	**44+**
Complex Nursing Interventions	Low	**0-33**
	Medium	**34-54**
	High	**55+**
Musculoskeletal Rehabilitation	Low	**0-33**
	Medium	**34-45**
	High	**46+**
Neuro Rehabilitation	Low	**0-35**
	Medium	**36-51**
	High	**52+**
Wound	Low	**0-33**
	Medium	**34-51**
	High	**52+**
MMTA - Surgical Aftercare	Low	**0-33**
	Medium	**34-43**
	High	**44+**
MMTA - Cardiac and Circulatory	Low	**0-31**
	Medium	**32-43**
	High	**44+**
MMTA - Endocrine	Low	**0-30**
	Medium	**31-43**
	High	**44+**
MMTA - Gastrointestinal tract and Genitourinary system	Low	**0-33**
	Medium	**34-49**
	High	**50+**
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	Low	**0-33**
	Medium	**34-45**
	High	**46+**
MMTA - Respiratory	Low	**0-33**
	Medium	**34-46**
	High	**47+**

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Functional Impairment Levels are based on these point (Medicare is adjusting these again for this year.)

Oasis Question	Responses	Points
M1800: Grooming	2 or 3	3
M1810- Upper Body Dressing	2 or 3	5
M1820- Lower Body Dressing	2 3	4 12
M1830- Bathing	2 3 or 4 5 or 6	2 10 17
M1840- Toilet Transferring	2, 3, or 4	6
M1850- Transferring	1 2, 3, 4, or 5	3 6
M1860- Ambulation/Locomotion	2 3 4, 5, or 6	6 5 20
M1033- Risk for Hospitalization	Four or more items marked (excluding 8, 9, or 10)	10

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Example of HIPPS Code Broken Down

HIPPS code of 2FC31

- '2' indicates Institutional Early (1-early community, 3-late community, 4-late institutional)
- 'F' the first letter is the clinical group (Behavioral Health)
- 'C' is high functional level (A-low & B-medium)
- '3' high comorbidity adjustment (1-none, 2-low)
- '1' all HIPPS codes end with a '1'

Second Letter in the HIPPS – Clinical Group

A – MMTA – Other
B – Neuro
C – Wound
D – Complex
E – MS Rehab
F – Behavioral Health
G – MMTA Surgical Aftercare
H – MMTA Cardiac
I – MMTA Endocrine
J – MMTA GI/GU
K – MMTA Infectious Disease
L – MMTA Respiratory

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What's a LUPA

L – Low
U – Utilization
P - Payment
A - Adjustment

The LUPA threshold **varies for a 30-day period of care depending on the payment group** to which it is assigned. For each payment group, the 10th percentile value of visits is used to create a payment group-specific LUPA threshold with a minimum threshold of at least 2 visits for each group.

A 30-day period with visits less than the LUPA threshold for the payment group is paid the national **per visit amount by discipline** adjusted by the appropriate wage index based on the site of service of the beneficiary. Such periods that do not meet the LUPA threshold for the payment group **are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full 30-day period payment amount.**

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LUPA Versus HIPPS Payment

CGS LUPA Calculator: https://www.cgsmedicare.com/medicare_dynamic/j15/lupa/lupa_threshold.aspx

Year of Service: 2023

HIPPS: 1CB31

Search >>

Visit threshold = 4

1st 30-Day Billing Period

01/03/2023 - 02/01/2023

Payment Group Details

Primary Diagnosis Code:	I872 - Venous insufficiency (chronic) (peripheral)
Admission Source & Timing:	Community Early
Clinical Group & Level:	Wound - Medium
Comorbidity Adjustment:	2
LUPA Level:	4
HIPPS Code:	1CB31

HH Discipline	CY 2022 Per-Visit Payment Amount	CY 2023 Wage Index Budget Neutrality Factor	CY 2023 HH Payment Update	CY 2023 Per-Visit Payment Amount
Home Health Aide	$71.04	1.0007	1.040	$73.93
Medical Social Services	$251.48	1.0007	1.040	$261.72
Occupational Therapy	$172.67	1.0007	1.040	$179.70
Physical Therapy	$171.49	1.0007	1.040	$178.47
Skilled Nursing	$156.90	1.0007	1.040	$163.29
Speech-Language Pathology	$186.41	1.0007	1.040	$194.00

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Ways to Help Prevent LUPAS

- Know what the threshold is for your patients.
- Schedule out more than enough visits per 30-day episode
- Add in home health aide visits (ex. Long term catheter patient's)
- Prevent hospitalizations – eats away at your 30-day period
- Plan ahead – if patient has a surgery that is scheduled assess the visits scheduled before hand (patient could end up having surgery and having to stay at the hospital and then transfer to a rehab facility before coming home)

Medicare expects that the LUPA percentage for agencies will be around 10%.

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HHVBP (Home Health Value Based Purchasing)

HHCAHPS 30%

OASIS Based Measures 35%

Claims Based Measures 35%

The Expanded HHVBP Model

The HHVBP Model was designed to support greater quality and efficiency of care among Medicare-certified Hoe Health Agencies (HHAs) nationally. Under the model, Medicare payments made to HHAs are dependent on the HHA's performance on specified quality measures relative to their peers. The HHVBP Model was first tested among HHAs in nine states from January 1, 2016, to December 31, 2021. National expansion began on January 1, 2022. Calendar Year2022 is pre-implementation year.

The first full performance year for the expanded HHVBP model is CY 2023.

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Agencies to Compete Nationally (No Longer State Level) Within Two Size-Based Cohorts

- Large agencies (cohort) – those that are required to submit an HHCAHPS survey in the performance year (7,084 agencies)
- Small agencies (cohort) – groups of competing agencies that are exempt from submitting the HHCAHPS survey (485 agencies)

Small cohort are agencies that are exempt from HHCAHPS submission due to fewer than 40 surveys in the reporting year and these benchmarks are not calculated for these agencies.

VBP Metrics

The metrics that calculate the Value Based are based on the SOC or ROC, whichever is most recent as well as the final OASIS (either Discharge or Transfer).

CMS will calculate hospitalization measures from claims.

HHVBP Measures

Measure
OASIS-based Measures
Discharged to Community
Improvement in Dyspnea
Improvement in Management of Oral Medications
Total Normalized Composite (TNC) Change in Mobility [e]
Total Normalized Composite (TNC) Change in Self-Care [f]
Claims-based Measures
Acute Care Hospitalizations
Emergency Department Use Without Hospitalization
HHCAHPS Survey-based Measure Components
Care of Patients
Communications Between Providers and Patients
Specific Care Issues
Overall Rating of Home Health Care
Willingness to Recommend the Agency

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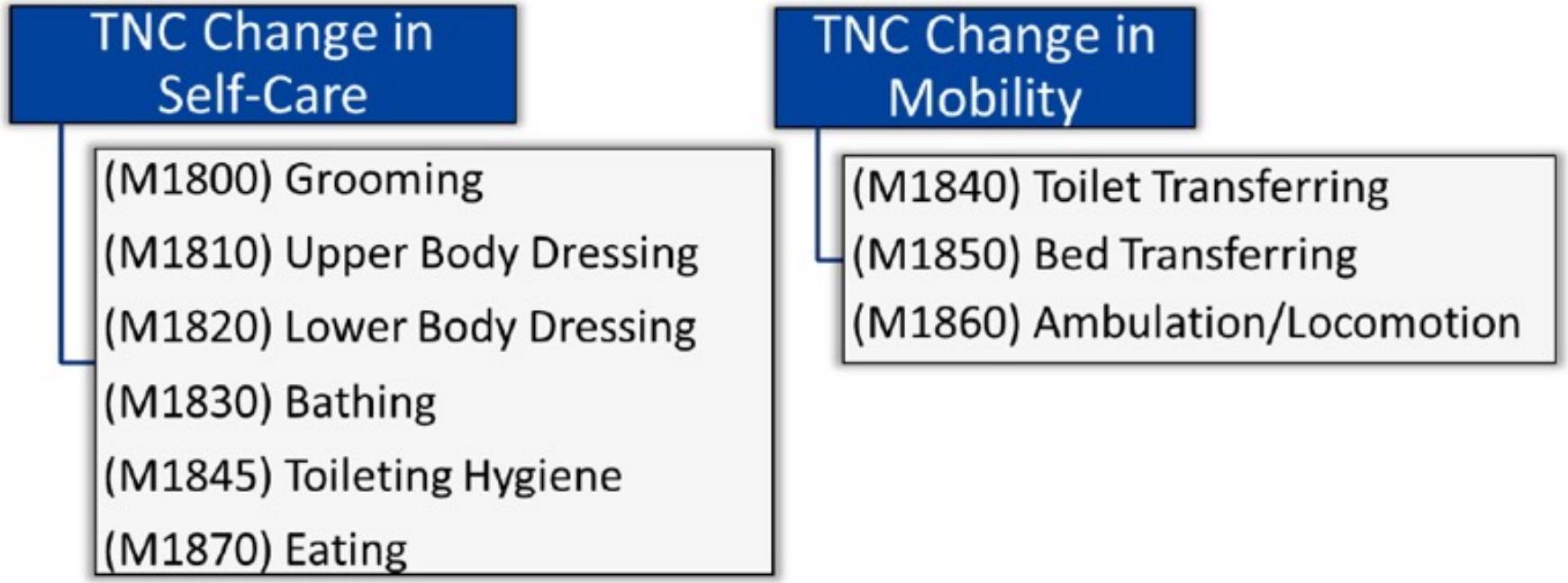
OASIS ADL Items



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HHVBP Items

HHCAHPS Survey-based* Component Name/ Short Name and Component Question	Type	NQF ID	Data Source	Link to Component Specs/Response Categories
Care of Patients/Professional Care	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2062
Q9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?				Never, Sometimes, Usually, Always
Q16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?				Never, Sometimes, Usually, Always
Q19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?				Never, Sometimes, Usually, Always
Q24. In the last 2 months of care, did you have any problems with the care you got through this agency?				Yes, No
Communications between Providers and Patients/Communication	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2580
Q2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?				Yes, No
Q15. In the past 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?				Never, Sometimes, Usually, Always
Q17. In the past 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?				Never, Sometimes, Usually, Always
Q18. In the past 2 months of care, how often did home health providers from this agency listen carefully to you?				Never, Sometimes, Usually, Always
Q22. In the past 2 months of care, when you contacted this agency's office did you get the help or advice you needed?				Yes, No
Q23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed?				Same day; 1 to 5 days; 6 to 14 days; More than 14 days
Specific Care Issues/Team Discussion	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2582
Q3. When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?				Yes, No
Q4. When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription medicines you are taking?				Yes, No
Q5. When you started getting home health care from this agency, did someone from the agency ask to see all the prescription medicines you were taking?				Yes, No
Q10. In the past 2 months of care, did you and a home health provider from this agency talk about pain?				Yes, No
Q12. In the past 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?				Yes, No
Q13. In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?				Yes, No
Q14. In the last 2 months of care, did home health providers from this agency talk with you about the **important side effects** of these medicines?				Yes, No

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Payments & Billing

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Nursing G Billing Codes

G0162

- RN (only) for management and evaluation of POC

G0493

- RN for the observation and assessment of the patient's condition

G0494

- LPN for observation and assessment of the patient's condition

G0495

- LRN training and/or education of a patient or family member

G0496

- LPN training and/or education of a patient or family member

Telemedicine (Non-Billable)

HCPCS	Description	REV Code
G0320	Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system.	042x, 043x, 044x, 055x, 056x, and 057x
G0321	Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system.	
*G0322	The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring) Report the use of remote patient monitoring that spans a number of days as a single line item showing the start date of monitoring and the number of days of monitoring in the units field.	

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What is YOUR Responsibility

- Any OASIS has to be completed, exported, and received (not rejected).
- Complete ALL visit documentation timely. Several agencies have a 2-day requirement from the visit date. (Per company policy)
- Orders written for any frequency changes or updates in the POC.
- Finished all required paperwork for SOC/ROC/Recert/Transfer/DC
- If insurance requires Pre-Auth – Ask for visits before they run out and get your verification specialist to request more visits.
- Make corrections promptly when QA/Biller asks.
- Ensure supervision visits has been completed within the required time frame.

Do you want to get paid?

An agency can't bill until all the chart documentation has been completed and verified that it is billable.

Holding up the billing process could lose potential revenue, increase the time before the agency gets paid, decrease your accuracy of chart documentation (it's not fresh in your mind a week later).

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Billing Audit Form

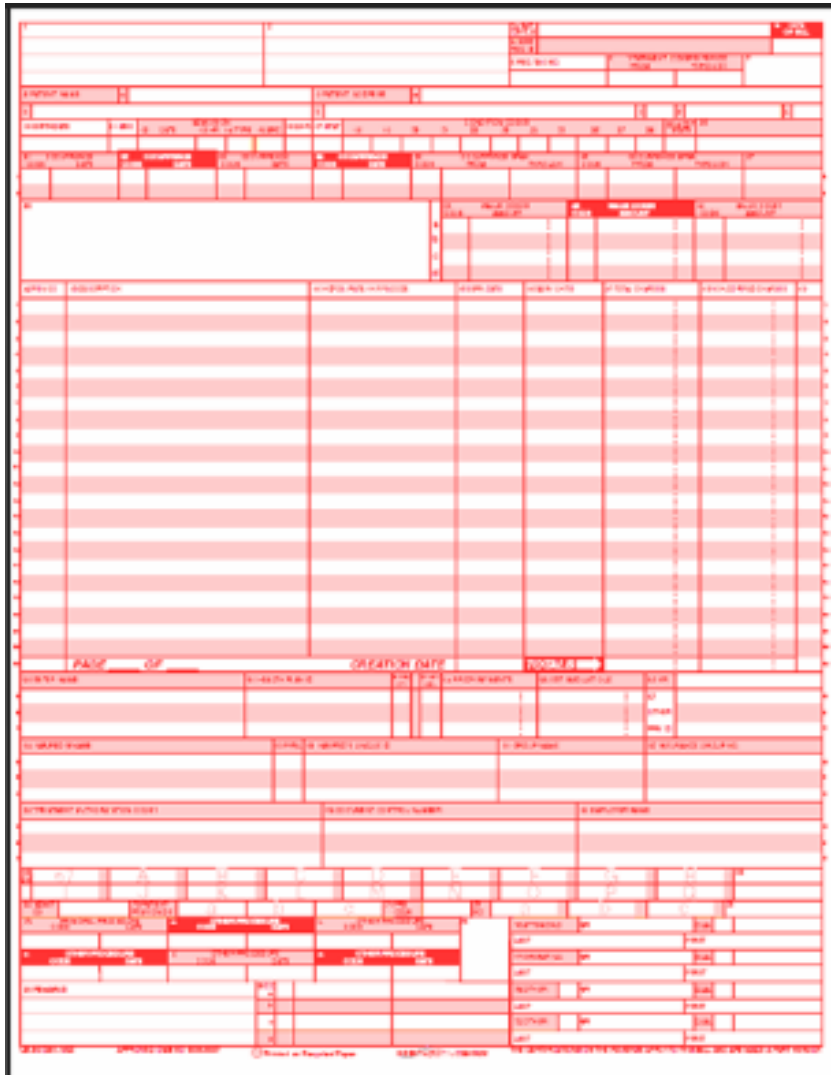
	Verify dates on episode and admission are accurate (View -> Episode dates)
	Verify all visits in billing period are completed and billable
	Verify frequency and duration for all disciplines is correct and has matching orders
	Supervisory visits Q14d (HHA, LPN, PTA, COTA)
	Therapy re-eval 1Q30d
	Verify 485 is present, correct, signed and dated by MD
	Verify all other orders are compliant/uploaded/signed and dated
	Verify F2F is attached and compliant
	Look at the patient's insurance profile and verify the address (including zip code), DOB and policy (MBI #) are present. SSN needs to be all in or totally blank
	Verify Prior Auth was obtained, is active and uploaded
	Reconcile orphaned documents (View > Reconcile Authorization) (non-Medicare)
	Verify all OASIS in this billing period have the status of "Exported" (Recert OASIS is in the episode previous of what you are billing)
	DC ONLY: Verify DC paperwork is complete (DC OASIS, DC summary for each discipline, HHCCN and NOMNC per guidelines, HEP)
	DC ONLY: Verify DC summaries are completed/ faxed to MD

Home Health Billing

NOA – Notice of Admission must be submitted for all Medicare SOC's with 5 days (primary diagnosis on NOA, doesn't have to match the primary diagnosis on the claim)

Billed in 30-day episodes (Claim is called UB04)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0023	HH PPS	2EB21	02/25/2023	30.000		
0421	VISIT CHARGE	G0151	02/27/2023	4.000	155 00	
0421	VISIT CHARGE	G0157	03/03/2023	3.000	116 25	
0421	VISIT CHARGE	G0157	03/07/2023	3.000	116 25	
0421	VISIT CHARGE	G0157	03/08/2023	2.000	77 50	
0421	VISIT CHARGE	G0157	03/10/2023	2.000	77 50	
0421	VISIT CHARGE	G0157	03/14/2023	3.000	116 25	
0431	VISIT CHARGE	G0152	03/01/2023	4.000	156 00	
0551	VISIT CHARGE	G0299	03/18/2023	3.000	112 50	
0551	VISIT CHARGE	G0493	02/25/2023	6.000	225 00	
0551	VISIT CHARGE	Q5001	02/25/2023	1.000	01	



Payment

Under PDGM Payment

- Once you have hit the LUPA threshold, you are paid the same amount no matter how many visits you made (unless an outlier).
- More visits isn't always better. Make your visits count.
- Second 30-day episode is paid significantly lower than the first 30-day period.

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OASIS Items

Star Measures:

M0102/M0104 – Timely Initiation of Care

M1400 – Improvement in Shortness of Breath

M1830 – Improvement in Bathing

M1850 – Improvement in Bed Transferring

M1860 – Improvement in Ambulation

M2020 – Improvement in Management of Oral Medications

Acute Care Hospitalization (claims-based)

HHVBP Items:

M1400 – Improvement in Shortness of Breath

M1800 – Grooming

M1810 – Current Ability to Dress Upper Body

M1820 – Current Ability to Dress Lower Body

M1830 – Improvement in Bathing

M1840 – Toilet Transferring

M1845 – Toileting Hygiene

M1850 – Improvement in Bed Transferring

M1860 – Improvement in Ambulation

M1870 – Feeding or Eating

M2020 – Improvement in Management of Oral Medications

PDGM Items:

M1033 – Risk for Hospitalization

M1800 – Grooming

M1810 – Current Ability to Dress Upper Body

M1820 – Current Ability to Dress Lower Body

M1830 – Bathing

M1840 – Toileting Transferring

M1850 – Bed Transferring

M1860 – Ambulation and Locomotion

Diagnosis codes – for the claim, usually pulled from the OASIS to the claim. Primary determines clinical group, comorbidity adjustment-secondary codes

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Questions?

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Thank You

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Celeste Miller RN, BS, HCS-D, COS-C
Administrator
Celeste@OracleBCC.com
Office: 435-200-5084