The Home Health Guide to Medicare Service Delivery

2017 Edition

J'non Griffin, RN, MHA, WCC, HCS-D, COS-C, HCS-H

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J'non Griffin, RN, MHA, HCS-D, COS-C, HCS-H, Reviewer
Tami Swartz, Editor
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HCPro
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Brentwood, TN 37027
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Fax: 800-785-9212
Email: *customerservice@hcpro.com*

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Foreword

Every year, home health agencies are required to comply with more regulations intended to create a more patient-centered, outcomes-driven care model. This year, our industry faces additional cuts in payment, the continuation of ACOs, moratoriums in certain geographic areas, bundled payments, pre-claim review, and new *Conditions of Participation*, while continuing to raise standards for the quality of care. Medicare home health has significantly changed over the past few years, and with the new *Conditions of Participation*, even more will be required of agencies. Many processes in the agency will have to be restructured, with the first major update in the *Conditions of Participation* in almost 20 years. Some of the biggest challenges include a new QAPI program, additional patient rights, and coordination of care between disciplines and across the patient's providers. During this time of change, we will need resources to provide training, support, and oversight. Instead of additional resources, home health agencies will be reimbursed less and still face stiff civil monetary penalties for noncompliance with the *Conditions of Participation*.

Compliance with all the regulations is critical to your agency's future success. To meet these challenges, your agency must implement a three-point strategy for the delivery of Medicare services:

- Knowledge and Empowerment: First, staff must know the requirements for service delivery. Educate all staff members about the regulations and recent changes, so they have a working knowledge of the requirements.
- Culture of Compliance: Second, staff must deliver services according to the regulations. The agency must implement a system of checks and balances to ensure appropriate service delivery.
- Proof in Documentation: Third, all staff members must document appropriately. Effective documentation shows that the patient met the requirements, the services were appropriate, and the patient responded or demonstrated progress.

The Home Health Guide to Medicare Service Delivery serves as a training tool and resource to assist you in implementing this three-point strategy. Because scrutiny is increasing, agencies must be in a perpetual state of survey readiness and compliance, and it is our hope that this guide will assist you in meeting that goal.

1. **The Basics of Medicare Service Delivery** presents the fundamentals of Medicare coverage criteria and the *Conditions of Participation*.
2. **The Prospective Payment System** gives an overview of critical concepts, including the Home Health Resource Group (HHRG), consolidated billing requirements, and clinical issues with an impact on billing, including the new way to bill disposable negative pressure wound therapy.
3. **All About the OASIS** discusses the fundamentals of the OASIS and assessments.
4. **Compliance and Care Delivery** highlights issues related to visits, physician orders, and start of care, recertification, and discharge.
5. **Documentation Essentials** looks at documentation fundamentals, the clinical record, diagnoses, and the plan of care. This includes a section related to the 485 and elements of content.

SECTION 1

SERVICES

The Basics of Medicare Service Delivery

The Process of Skilled Service Delivery
Medicare Coverage Criteria
Medicare Noncoverage and Beneficiary Notices
Overview of the *Conditions of Participation*
Understanding the New *Conditions of Participation*

Introduction

This section, "The Basics of Medicare Service Delivery," presents the fundamentals you need in order to deliver appropriate services to your patients and produce documentation that justifies the services provided and promotes appropriate payment.

The Process of Skilled Service Delivery: Homecare providers must follow an organized process in service delivery. This chapter focuses on the basics of care delivery and documentation.

Medicare Coverage Criteria: This chapter highlights key elements in the delivery of Medicare services in the Prospective Payment System (PPS) and discusses the requirements for each of the Medicare-covered disciplines (skilled nursing, therapies, medical social services, and home health aide). The requirements for coverage are found in the *Medicare Benefit Policy Manual,* which is CMS Publication 100-2, Chapter 7, and, for payment, in CMS Publication 100-4, Chapter 10. It is imperative that all home health clinicians and leadership are familiar with these guidelines, as they are the judge of whether the patient meets the Medicare criteria or not. Think of this like that benefit booklet that you receive when you sign up for an insurance plan.

It is necessary, but difficult, to stay up to date with all of the changes to the rules and guidelines from Medicare. HCPro has paid extra attention to those changes and included all of the changes for 2017 in *The Home Health Guide to Medicare Service Delivery*. The final rule to update the PPS payment rate, effective January 1, 2017, incorporated payment updates and changes to our case-mix system. We will provide guidance regarding the mandated Advance Beneficiary Notice (ABN) and the Home Health Change in Care Notice (HHCCN) forms with hints on successfully training staff to use them.

The Conditions of Participation: These regulations apply to all patients in a Medicare-certified homecare agency. Agencies are basically saying "I agree to abide by these conditions in order to participate in the Medicare program." Learn about important concepts and certification issues that have an impact on care delivery and documentation. This chapter focuses on the new regulations released in 2017 and the top-cited regulations, although they are all important. We have also included a section dedicated to and provided tools to ensure your agency is ready when that surveyor shows up at your front door.

Chapter 1: The Process of Skilled Service Delivery

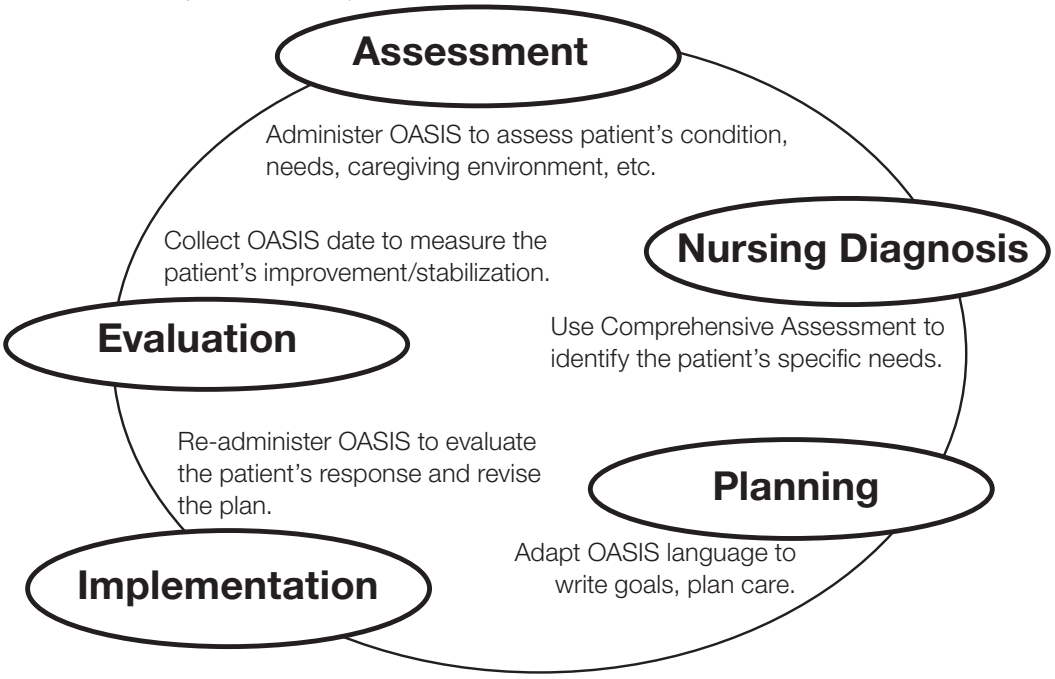
You are about to take a trip. You know there will be detours along the way, and traveling conditions may change without notice. Your time and resources are limited. But you have to make it to your destination on time and using the right route. What will you do? You develop a plan and you use a map.

Caring for the homecare patient in the PPS is similar to taking a trip. Care delivery often involves spur-of-the-moment revision and working with other caregivers and family members. Service delivery must be flexible, coordinated, efficient, and effective. Medicare certification rules require that the care provided meets the patient's individual needs. As homecare providers move further into the PPS and its past and almost-certain future revisions, Medicare will look more closely at patients' achievement of outcomes, provider compliance, and homecare revenue and expenses.

To accomplish all these objectives, care delivery must follow a systematic process. Because there are no travel agencies to help the homecare patient, it's up to you to develop and follow a process for the delivery of skilled services. With an organized process, you can react to changes and modify care without losing sight of the end results.

The process of care delivery is an organized, systematic method of providing individualized care that focuses on identifying and treating the patient's unique responses to actual or potential alterations in health. The steps in the process are interrelated, interdependent, and recurrent. Each step assists the staff member in fulfilling the requirements for service, providing appropriate care, and recognizing the crucial elements of documentation.

Figure 1: *The Process of Care Delivery*



Assessment

The American Nurses Association Standards of Clinical Practice define assessment as "a systematic, dynamic process by which the nurse, through interaction with the patient, significant others, and healthcare providers, collects and analyzes data about the patient." Assessment, the first step in the process of care delivery, establishes a database to help you monitor and evaluate the patient's condition. From a *coverage* perspective, the data substantiate that the patient meets the requirements for service initially and on an ongoing basis. Assessment is also the most frequently utilized qualifying skilled service by nursing in home health.

The comprehensive assessment must include the OASIS data for Medicare and Medicaid patients. The OASIS assessments at the start of care and recertification also provide a basis for the increase or decrease to the 60-day standard payment. This is performed by the Medicare Prospective Payment System by establishing a Home Health Resource Group (HHRG), the case-mix adjuster that determines payment for each payment episode.

Lastly, the assessment is key in a home health agency's quality data. The Outcome-Based Quality Improvement (OBQI) and the Process-Based Quality Improvement (PBQI) (and their publically reported subsets) are driven by the OASIS data—measuring changes from the start of care (SOC) or resumption of care (ROC) to transfer or discharge.

Staff collect data through assessment at three important times during the care delivery process:

1. The initial comprehensive assessment provides data about the patient's needs, condition, caregiving environment, etc., to help you plan appropriate care. This information also establishes a baseline for future evaluation of the effectiveness of care (outcomes). This first visit most likely contains two mandated components. First, the "initial assessment" (484.55a) is simply an assessment of the patient's immediate care needs and whether to assess if the patient meets the Medicare guidelines for coverage. This is the standard that must be met within 48 hours of referral, or 48 hours from the patient's return home from an inpatient setting, or on the specific day (if applicable) that the physician ordered home health to begin. Most of the time, the clinician will move seamlessly into the comprehensive assessment (484.55b) after completing this high level initial assessment. The comprehensive assessment must be completed within five days after the start of care, per federal regulation, and must be conducted by one clinician.
2. Ongoing assessment while providing care evaluates the patient's condition and response to care and can lead to revisions in the plan.
3. Assessment of the patient's condition at the time of discharge provides insight into the patient's progress and response to care, as well as the effectiveness of care.

The *Conditions of Participation* require the agency to incorporate agency- and discipline-specific elements with Outcome and Assessment Information Set (OASIS) data elements to form a comprehensive assessment. Staff must complete a comprehensive assessment at specified times, including start of care, transfer to an inpatient facility, resumption of care, follow-up (major decline or improvement in health status and recertification), and discharge.

Key points to assess include the patient's level of knowledge, resources, functional limitations, physical status, principal diagnosis, history of illness, pertinent medical history, body systems, weight, vital signs, allergies, personal and social history, and home condition and environment. Evaluate family and caregiver abilities and limitations.

Collect both objective and subjective data. Look at how well the patient is meeting basic requirements (respiration, safety, rest, etc.), as well as illness-imposed requirements (medications, diet, dressings). Determine that patients in the PPS meet Medicare coverage criteria. Evaluate and interpret data to identify a direction for care delivery.

> *The patient is on a therapeutic diet. Does he know what foods to eat? Is he able to obtain the food? Can he measure and prepare the food? Is he motivated to adhere to the diet?*

Record assessment data according to agency policy. Communicate significant findings to other members of the team.

Needs Identification

Use assessment data to identify applicable nursing diagnoses, needs, and problems. The nursing diagnosis is a clinical judgment about the individual, family, or community's behavior or physical response to actual or potential health problems or life processes. By clustering the patient's signs and symptoms and related etiology or contributing factors into a meaningful area of concern, the nursing diagnosis identifies problems that are amenable to resolution by means of nursing actions.

There are three components to a nursing diagnosis. The name of the nursing diagnosis refers to the human response. Related factors are situational, physiological, psychosocial, spiritual, or maturational considerations that can cause or contribute to the health problem. Document these as "R/T" (related to). The defining characteristics are observable cues or inferences that cluster as manifestations of a nursing diagnosis. These signs and symptoms are evidence that the nursing diagnosis applies to the patient. Document these "as evidenced by." If these signs and symptoms are recorded in the assessment notes, it is not necessary to include them in the documentation of the nursing diagnosis.

> *The patient had a hip arthroplasty. One nursing diagnosis would be impaired physical mobility R/T pain, as evidenced by decreased ability to ambulate and transfer.*

Use nursing diagnoses as the basis of care planning. The nursing diagnosis itself drives the patient's goal or expected outcome. The goal shows resolution or elimination of the problem. The related factors direct the selection of interventions. Interventions should prevent, reduce, control, or eliminate the factors that contribute to or cause the problem. The more specific the etiology and contributing factors, the more specialized the interventions can be.

> The nursing diagnosis identifies the problem: *Impaired skin integrity on buttocks.*
>
> Related factors direct interventions: *Paraplegia with long periods of sitting in wheelchair.*
>
> The expected outcome shows resolution of problem: *Demonstrate measures to prevent/minimize skin breakdown.*
>
> Interventions control or eliminate related factors: *Assess skin condition. Change posi-*

tion in chair every hour. Massage bony prominences three to four times a day. Teach techniques to improve nutrition and hydration.

Although the use of nursing care plans is not mandated, they are a tried and true method of needs identification and the process of planning nursing care.

For therapy and medical social services, identify the patient's need for services, following the basic concepts employed in the use of nursing diagnoses. State the need or problem in terms of functional limitations, identifying the impact of the problem on the patient's life. Include related medical or physical factors to establish the medical necessity of the interventions. Identify an expected outcome to show resolution or improvement. And define interventions.

Need: *Patient cannot stand.*

Related factors: *Decreased range of motion (ROM) in knee joints, related to osteoarthritis.*

Expected outcome: *Patient can rise from chair without assistance.*

Interventions: *Active ROM exercises to knee. Develop and implement home program. Teach wife how to perform exercises.*

After you completely identify the patient's need or problem, focus documentation on the specific problem, as well as the patient's response.

Planning

Planning, also called the mapping step, is the process by which staff determine how they will provide care in an organized, individualized, and outcome-oriented manner. Include the patient in the planning process, keeping in mind his or her specific limitations and situation, to develop a plan that encourages the patient's participation. An outcome-oriented care plan shows that you believe you can meet the patient's needs in the home environment.

The process of care planning involves four substeps: identifying priorities of care, establishing expected outcomes, determining interventions, and writing the care plan.

Priorities of care

When the patient has multiple problems, establish priorities of care to identify areas of first intervention. Look closely at what you can accomplish within the homecare framework, given the patient's resources, abilities, motivation, and support. Assign highest priority to the most urgent problems—those that threaten the patient's safety or ability to remain in the home. Consider comorbidities that will affect the plan of care.

Goals

A goal, or expected outcome, details the results you expect after the patient receives the care. It is a prediction of a change in the patient's status as a result of care delivery and it drives the selection of interventions. Choose interventions designed to help the patient achieve the goal. Expected outcomes also serve to measure the success or appropriateness of the plan.

"The patient cannot ambulate. The expected outcome is for the patient to walk independently with a walker. The therapist will teach the patient ambulation techniques and use of the walker. At the time of discharge, the therapist will evaluate the patient's progress toward achieving the goal."

Write goals that are realistic, attainable, specific, and quantifiable. The goal should explain how the patient will progress or respond, not how the nurse will intervene.

The planning process focuses on two types of expected outcomes. Long-term expected outcomes are broad statements representing the patient's maximal gain, which will take more time to accomplish. For many homecare patients, a long-term goal most closely resembles a discharge plan, which is written in Locator 22, Goals, Rehabilitation Potential, and Discharge Plans, on the plan of care.

"Patient can demonstrate wound care technique."

A short-term expected outcome is the heart of the care delivery process. Derived from the long-term expected outcome or patient need, it reflects the ability of the patient to improve or stabilize in the immediate future. Short-term goals are usually incorporated into a discipline-specific care plan. Include a target date for achievement or review of the goal.

"Demonstrate aseptic technique in wound care by August 7."

If you break the goals into components or smaller parts, you will be able to demonstrate and document smaller increments of progress. For example, the following statement reflects an expected outcome that is very general and difficult to measure:

"Will comply with diet."

By breaking this goal into its components, you can measure progress more readily.

"Demonstrate use of food exchange lists in planning meals."

Follow these steps to write effective goal statements.

- Make the patient the subject of the statement. This shows that the patient has some accountability or responsibility in care planning and also reflects the patient's participation in the process.
- Begin with an action verb. An action verb describes something you can see or hear. Examples include ambulate, explain, and perform.
- Include specific content. Describe the response or behavior you expect the patient to achieve in terms of when, how well, where, and/or how much, as appropriate. Focus on knowledge, skill, presence or absence of symptoms, or physiological findings. Make the language measurable. See Section 5.
- Include a time frame or target date. This holds you accountable for action or review by a particular date. Fit the timetable to the tasks, level of intended achievement, the patient's abilities, and your schedule.

With Medicare service delivery, outcomes play a huge role and may very well someday be relative to payment. CMS has formulated outcome measures, many of which are publicly reported. When delivering care, agencies should consider these outcome measures, depicted in Section 2.

Interventions

Work with the patient and significant others to design approaches and interventions specific to the patient's problem, need, or nursing diagnosis and that are acceptable to the patient. Approaches must be realistic and reasonable, given the situation. Specify who will do what and when, and show cooperation among the caregivers. Include the patient in the selection of interventions and individualize them to fit the unique situation. Correlate interventions with the medical plan of care, incorporating agency policy, procedure, and standards of care. Use a blend of assessment, teaching, and hands-on procedures. Incorporate Medicare skilled services, reflecting phraseology like that used in the now-retired CMS treatment codes. **Refer to Appendix B.**

> *"R.N. to do pressure ulcer care daily and teach procedure to wife."*
>
> *"Ultrasound by P.T. three times a week."*
>
> *"Complete bed, bath, personal care by aide twice a week."*

Because of the evidence-based practices/interventions noted in OASIS-C1, Outcome-Based Quality Improvement (OBQI), and Process-Based Quality Improvement (PBQI) measurements, there are additional interventions that your home health agency may choose to implement for your patients, and to obtain "credit" for these practices in the publically reported measures. These practices promote the delivery of consistent, high-quality care designed to improve patient outcomes. The development of best practices is specific to an agency. The practices must fit within the agency's policies and procedures and meet the needs of its patients, physicians, and staff. In a later section, we will discuss best practices and process measures in detail.

Care plan

Every home health patient has a plan of care (POC) ordered by the physician. Certified agencies have specific required information for this POC, such as diagnosis, rehabilitation potential, interventions, goals, and medications. A discipline-specific care plan directs the specific interventions and facilitates communication with other team members. It serves as the written map to guide care delivery and documentation and facilitate coordination of services. Discipline-specific care plans are not mandatory, so many agencies do not use them. However, as agencies move into outcome management, OBQI, PBQI, and value-based purchasing, the value of a written care plan (or its derivatives, such as clinical paths) will become more obvious.

A care plan validates that staff addressed all patient needs, revised the plan to reflect changes in the patient's situation, and carried out all tasks and that the patient participated in the process. **See Section 5.**

Alternatives to care plans include care maps, teaching plans, protocols, and disease management tools, to name a few. The value in these care planning tools comes from standardization. The tool lays out a path for care delivery for a patient in a given situation with particular needs. Following

this path minimizes the possibility of errors and omissions and promotes consistent care. The Home Health Quality Improvement (HHQI) organization is a federally funded program that serves as a great resource as it supplies evidence-based education and work plans for disease processes. When using standardized care plans, etc., agencies must not ignore the very important component of individualizing those plans based on each patient's unique needs.

Implementation

Once you have identified the patient's needs and developed a plan, implementation puts the plan into action. It is the organization and actual delivery of care that are crucial to achieving outcomes. During care delivery, assess the patient and determine priorities of care. Coordinate services; communicate care with other members of the team, the physician, the patient, and family or caregivers; and follow established policy and procedure. Supervise staff according to established protocol.

Evaluation

The American Nurses Association defines evaluation as the process of determining both the patient's progress toward the attainment of goals and the effectiveness of the nursing care. Throughout care delivery, staff collect and record data on the patient's condition and response and modify the plan as needed. In this final step, compare the patient's health condition and level of functioning to the identified expected outcomes.

Evaluate two critical components. Look first at changes in the patient and how those changes affect ongoing care: Collect data to assess the patient's response, performance, or progress, comparing them to the expected outcome criteria. Identify any changes in condition or needs. How has the patient progressed toward achieving the goals? What improvements or changes in behavior do you notice?

Record responses precisely, concisely, and objectively.

> *"Compliant with medication regimen. Edema resolved."*

Document even the smallest changes or increments of progress, and compare them to the baseline.

> *The original goal was for the patient to ambulate independently. At the time of evaluation, the patient can transfer but not ambulate independently.*

In documenting the evaluation of patient progress, instead of emphasizing the perceived failure, note the positive gains in comparative language.

> *"On admission, patient could not ambulate or stand. Can now transfer independently."*

Then look at the appropriateness of the plan. Evaluation determines whether the needs or nursing diagnoses were correct, whether the outcomes were reasonable and realistic, whether the interventions were appropriate, and the impact of the total plan on the patient. If, upon evaluation, the patient's needs have changed or interventions are ineffective or require updating, the plan of care should be revised accordingly.

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Reviewed by
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Updated to reflect the 2017 home health PPS final rule, new *Conditions of Participation*, and OASIS-C2, ***The Home Health Guide to Medicare Service Delivery, 2017 Edition,*** offers a one-stop solution for home health professionals who are looking for answers to their Medicare compliance questions.

This book also enables agencies to ensure services are delivered according to current Medicare regulations and helps staff understand how to produce patient care documentation that supports compliance and proper payment claims.

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an *H3*.Group brand
100 Winners Circle, Suite 300
Brentwood, TN 37027
www.hcmarketplace.com

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