Oklahoma State Department of Health

# OASIS News You Can Use

## Five Star Rating System

INSIDE THIS ISSUE:



*Oklahoma State Department of Health*

***Quality Improvement & Evaluation Service***

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In January, 2017, CMS proposed changes to the Home Health Star Rating System.

There are two types of star ratings, and include:

**The Quality of Patient Care Star Rating** which is based on OASIS assessments and Medicare claims data. First published on HHC in July, 2015.

**Patient Survey Star Ratings** are based on the patient experience of care measures. These ratings were first published on HHC in January, 2016.

*Proposed* changes include:

Removal of "Influenza Immunization Received for Current Flu Season." The reason is the measure is influenced by factors outside the HHA's control that may vary by state

However, the measure will continue to report on HHC to encourage vaccination.

In addition to the removal of the above Influenza measure, CMS proposes to add "Emergency Department (ED) Use without Hospitalization." This rewards agencies that are successful in lowering ER use among their patients.

If these changes are made, CMS will finalize methodology and then post on HH Star Ratings web page. As early as April, 2017 preview reports could contain updated Quality of Patient Care (QoPC) ratings.

Preview reports are available to HHAs one quarter in advance of ratings displayed on HHC (i.e., 3 months lagged for OASIS and 6 months lagged for claims).

The Emergency Department Use measure is calculated by the **Numerator**: # home health stays where patient had an outpatient ED visit and no hospitalization in the 60 days following the start of the stay. Divided by the **Denominator:** # of home health stays in the 12-month observation period.

With the changes in these measures, the star ratings pretty much stay the same with 67% of HHAs having the same rating; 17.5% increase by half a star; 15.8% decrease by half a star. HHAs with fewer than 250 episodes per year the average QoPC Star Rating is relatively the same: 3.06 (with ER) versus 3.03 (current with Influenza measure). There was some concern over how the changes will impact the long-stay HHAs and it was identified the average QoPC star rating distribution would be 2.97% (ER) versus 2.9(current).

We hope that you will review information as it becomes available. Please send all questions and comments to HomeHealthQualityQuestions@cms.hhs.gov.

MLN Connects: Home Health Quality of Patient Care Star Ratings Update January 19, 2017

### QIES Help Desk Updates !!

Would you like to receive email notifications about important CMS and OASIS information? Go to: oasis.health.ok.gov and select "Get Updates". Or call our Help Desk at: **405- 271-5278.**

# Drug Regimen Review

During the November, 2017 Home Health Quality Reporting Program (QRP) requirements training, CMS instructed that the Drug Regimen Review was adopted as a patient assessment-based, cross-setting quality measure to meet the IMPACT Act requirements. Data collection for this measure began January 1, 2017 and will include OASIS-C2 items:

* M2001. Drug Regimen Review Item.
* M2003. Medication Follow-up Item.
* M2005. Medication Intervention Item.

The drug regimen review at M2001 has a very central role in the OASIS. There are multiple elements. In order to code that the drug regimen review has been completed all of the elements need to be assessed. In post-acute care, the drug-regimen review typically includes a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

Medications include prescribed and over the counter medicine, supplements and herbal remedies. They may be administered by any route (for example, oral, topical, inhalant, pump, injection, intravenous and via enteral tube). Excellent clinical judgment is necessary to identify any potential or existing clinically significant medication issue. For you to get "credit" for the Process QM, the physician or his designee must be notified by midnight of the next calendar day.

The following sources may be helpful in determining if any significant medication issues exist:

- Clinical record.
- Communication notes.
- Medication list.
- Physician's Drug Reference (PDR) or other clinical medication handbook or software.
- Several good online resources can be found in Chapter 5 of the OASIS manual.

An example of clinically significant medication issues may include: adverse reactions to medications, ineffective drug therapy (analgesic that does not reduce pain), side effects (potential bleeding from an anticoagulant), drug interactions (serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (generic name and brand name equivalent drugs are both prescribed), omissions (missing prescribed drugs), dosage errors (too high or too low), and nonadherence (regardless of whether it is intentional).

There may be times when portions of the drug regimen review are completed by staff other than the clinician completing the SOC/ROC OASIS. In that situation, the findings must be communicated to that clinician so that M2001 can be coded correctly. This type of collaboration does not violate the one clinician requirement. Agency policy and practice determines this process and how the documentation is completed. The M0090 date—the completion date —would be the date the two clinicians collaborated and the assessment was completed.

**Score 9 – NA - When the patient is not taking any medications.**

**Score 0 - No Response When:**

1. The patient's list of medications from the inpatient facility discharge instructions matches the patient's medication list.
2. The assessment shows that diagnoses or symptoms for which the patient is taking medications are adequately controlled.
3. The patient has all their prescribed medication.
4. The patient has a plan for taking the medications safely and timely.
5. The patient is not showing any signs/symptoms of an adverse medication reaction.

**Code 1 - Yes - Issues found during review** If any of the above are NOT true, And if:

1. Patient takes multiple OTC medications (including herbals) that could interact with prescribed medications.
2. Patient has medications prescribed by multiple physicians or obtained from multiple pharmacies which increases the risk of drug interactions.

Keep in mind that the situations listed should meet a level of clini-

## M2001 Continued

cal significance that warrants the immediate attention of the physician for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance not requiring immediate attention is not considered a clinically significant medication issue.

**Coding a dash (–).**

This indicates that no information is available or an item could not be assessed. This usually occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly. **CMS expects dash use to be a rare occurrence.**

### What is the difference?

**Adverse drug reaction** (ADR) may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

**Side Effect** is often used interchangeably with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

# Assessment Tips
# M2020: Management of Oral Meds

M2020 is assessing the patient's ability to take oral medications reliably and safely. The key to this item is assessing the patient's ability, and not their actual performance. Whether or not the patient is willing or compliant is not assessed here.

These items address the patient's ability to safely take *oral* medications. The clinician is looking at the patients current health status, the activities he or she is permitted to do, and the patient's environment. The patient needs to be viewed from a holistic perspective when assessing ability to perform medication management. A patient's ability may be temporarily or permanently limited by physical impairments, emotional, cognitive, behavioral impairments, sensory impairments, environmental barriers.

Ask the patient to show you how he/she takes his/her medication. Observe the patient preparing and gathering medication supplies or moving to the area where the medications are normally kept. Is the process organized? Did the patient have help to prepare the medications? Are there compliance aids being used?

Next, have the patient describe how he or she would proceed with taking his or her medications. Is the patient able to tell you the correct dose and schedule of the medication? Ask the patient to demonstrate opening the medicine bottles or pill box. Does the patient open the lid, select the correct dose and close the lid before moving on to the next medication? Does the patient reliably take the medication as prescribed? Select one medication with a known start date and count the pills to verify compliance.

When coding M2020 if the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

Medication management is a key patient safety issue and clinicians must assess this area carefully.

**MARK YOUR CALENDAR**

Look for our upcoming 2017 OASIS trainings at

***oasis.health.ok.gov***

Sign up for OASIS trainings using our QR Code:

# Future Potential Monetary Adjustments

**Denial of Home Health Payments when required patient assessment is not received.** Effective April 3, 2017. Change Request (CR)9585 directs MACs to automate the denial of Home Health Payment System claims when condition of payment for submitting patient assessment data has not been met. Make sure that your billing staff is aware of this change. Per the Code of Federal Regulations (CFR) at **42 CFR 484.210(e)**, submission of an Outcome and Assessment Information Set (OASIS) assessment for all Home Health (HH) episodes of care is a condition of payment. If the OASIS is not found during medical review of an HHA claim, the claim is denied. The Office of Inspector General (OIG) has recommended that Medicare strengthen its enforcement of OASIS as a condition of payment . (While the regulation requires the assessment to be submitted within 30 days, the **initial implementation** of this edit will allow 40 days.)

In denying the claim, Medicare will supply the following remittance messages: Group Code of CO, and a claim adjustment Reason Code of 272.

# Change and Popular Q&A

Beginning April 2017, and quarterly thereafter, our department will begin contacting agencies regarding excessive fatal records appearing on the validation reports. The purpose is to help with your claim processing as stated above. This will also assist with the Conditions of Participation. Your agency's Fatal records need to be resolved initially by day 40 in order to avoid possible claim denials

**Q9. Who can perform the comprehensive assessment when RN and PT are both ordered at SOC?**

A9. According to the comprehensive assessment regulation, when both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

Reference Category 2,

Question 9,

CMS Q&A's.

## Automation Tip

Remember to occasionally pull CASPER reports in order to compare to software generated reports. CASPER reports are housed with CMS and are incorporated in with the QM's and survey process. What appears on the CASPER reports are a result of OASIS submitted and accepted records that can be different than what appears on your software generated reports.


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