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ESSENTIAL TRAININGS
FOR EARLY CHALLENGES

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PDGM—Essential trainings for early challenges

BY: JENNIFER PARK, AHCC/BMSC MEMBERSHIP COORDINATOR

Can you believe that we are already a few weeks into the new year? More importantly, we have now been under the new payment model, the Patient-Driven Groupings Model (PDGM), since January 1, 2020, and we all survived so far.

As we are still in the early days of PDGM, it is necessary to continue with training to keep your agency staff educated and up-to-date with the new requirements, in addition to keeping them engaged during these early challenging times as questions and issues arise. The agency managers should continue to support their employees by providing them with the essential tools they will need to get through these tough hurdles under PDGM. The better prepared and trained your agency employees are under PDGM, the higher your success rate will be. This will help keep the morale in the agency high and continue moving your staff in a positive and effective direction.

In this issue of the AHCC Journal, we bring you a collection of articles that take a closer look at the early challenges under PDGM and the essential training that you should provide for your staff. We hope that the information and tips in the articles will help your agency during this difficult and transitional period. Look for a Q&A on some coding questions along with the general updates from AHCC and our board. Also, look for the AHCC member profile and the AHCC Board member profile.

As we now are officially in 2020 and with PDGM in effect, we look forward to moving ahead with you during the next few months of more questions and answers, both positive and negative. We thank you for sharing new stories with us. We look forward to meeting more of our AHCC members and we hope you enjoy meeting your fellow members too. Please reach out to us at AHCCMembers@decisionhealth.com if you are interested in being featured in a future member profile.

As always, we love hearing from you with any ideas about how we can improve AHCC’s Quarterly Journal, suggestions for content we can offer on the AHCC website or any other thoughts you’d like to share. Please reach out to let us know what we can do for you.
Put your training to the test, mind the gaps and create new habits over time

BY: ROBERT MARKETTE JR., JD, CHC, HCS-C

Dear AHCC Member,

Welcome to the first issue of the AHCC Journal for 2020. We are now officially into life under PDGM and as home care coding and compliance professionals, our lives just got more complicated. The first quarter of 2020 promises to be busy, as we begin to wrestle with the challenges presented by a completely new payment system and the beginning of the RAP phase-out, all while addressing the numerous other compliance challenges we face on a regular basis.

As your Board, we hope to help equip you for what lies ahead in 2020. Our first step in that regard is the issue of the AHCC Journal you are holding in your hand. This issue focuses on PDGM and essential areas for training, so you are prepared for the early challenges. PDGM has been our future now for several years, and many of you may feel like you have been preparing for PDGM forever. Now that it is here, there may be a feeling that there is no more preparation. Now it is just day-to-day operations.

Check your connections

However, now is not the time to relax; rather, it is a time to see if your preparation worked and to respond to gaps you identify. Now is like the moment you turn the water back on after fixing a leak in your sink. You think you have done everything to be ready, but you don’t know for certain until the water starts to flow again. I remember installing a new deep-set sink in my kitchen. It required altering the pipes under the sink, because nothing lined up the same as the old sink. When I thought I was done and turned on the water, I discovered the drainpipes were not all connected as well as I thought. After several trips to the hardware store and several trials, I found a configuration of new pipes that got the water out of the sink and out of my house. However, before I was done, there were several times I unstopped the drain only to see the water come out of the pipe and go into the bucket I had placed strategically in my cabinet.

For home care coding and compliance specialists, 2020 may be a lot like my kitchen sink project. As you begin to operate under PDGM, you will start to put your operations through your new policies and procedures, just like water through a set of pipes. Just like pipes you think are watertight may start to leak, you may begin to identify similar gaps in your PDGM preparation. It shouldn’t surprise us if we identify gaps. PDGM preparations have a greater potential for gaps because you aren’t working with pipes, gaskets and washers. Your PDGM efforts involve people who have developed habits over years of operating under the old home health PPS system.

Identify the process gaps

As 2020 moves forward, your staff, from billers to coders to intake, will be working under many new policies and procedures. Like my deep-set sink needed new pipes to get the water out, PDGM requires many new processes. New processes can lead to mistakes. In other words, a compliance issue is not due to your policies failing to address the PDGM compliance issue. It’s due to an employee failing to follow the policy and procedure you have put into place. This failure can be the result of many factors.

One factor is time pressure. The new 30-day billing cycle will place much more pressure on your billing staff to get claims out the door. The RAP phase-out places even higher pressure on your agency’s cash flow. Billing staff may feel pressure...
to get claims submitted, which causes them to rush. In their haste, they may cut corners, or fall back into old practices. These mistakes will likely not be intentional but the result of staff rushing. There will, however, be cases where staff intentionally disregarded policies and procedures to meet internal claim submission deadlines.

**Build healthy new habits**

Another factor is, as noted above, habit. Habits can be hard to break. Under PDGM, a habit is like a piece of pipe you removed from under the sink that does not fit after you install the new deep-set sink. You can attempt to use the pipe, but as I learned, it will leak. Trying to use the old pipe in the new plumbing because it is right there, is like falling into old coding and billing habits that are not part of the new process. It happens because it is familiar, and the old method is deeply ingrained.

One habit that we’ve warned about is the use of specific codes that will not map to clinical groups. There are codes that home health coders have defaulted to for years. (We have all seen the “code lists” some people use, despite repeated warnings that it’s not a good idea.) When you have been coding a certain way for a long time, you may find yourself slipping back into those habits. This effort will also likely not be intentional, and in some cases, a coder might not even realize they did it until the internal pre-claim review returns the claim to them to recode.

Another area where compliance may break down involves staff who have new or broader responsibilities under PDGM. One example is intake staff. Intake staff members are likely tasked with more responsibility to identify whether a referral is institutional or community, early or late, etc., and to obtain documentation to support that determination. Your intake staff also had an increase in responsibility under the new CoPs. They may make mistakes from simply forgetting their new responsibilities. They may also face pushback from referral sources as they seek additional documentation and not be aware of the process they should follow to get assistance from the agency when needed.

Much like the old pipe that no longer fits must be replaced with a new pipe, new habits must replace old habits. Helping your employees build these new habits requires reinforcement. One key way to provide that reinforcement is through education. Educating and re-educating your staff will help them to unlearn “what they have always done.” You may have thought that you were done with PDGM training once you turned the calendar to 2020, but that is almost certainly not the case.

**How AHCC can help**

This issue of the AHCC Journal includes a number of articles that address critical areas for training. As your new processes begin to operate in the real world and you identify “leaks,” you will likely identify areas for additional training. If you are investigating a compliance issue and determine the cause was a failure to follow new policies and procedures you implemented for PDGM, you will provide additional training on the topic to your staff. Providing additional training on those new policies and procedures will help to reinforce the right way to do things and avoid future noncompliance.

As you find yourself revisiting specific training areas over the next year, be patient. Remember that your staff has been working under the same basic payment system for more than 20 years. It will take time for PDGM compliance to become a habit. Furthermore, as we already see with the recent OASIS FAQs, the answers to some issues are changing, which means retraining staff as CMS changes its mind. These changes will make your life challenging, but as a home care coding and compliance professional, you are used to challenges. We have gotten through other changes, and we will get through this one together. AHCC, your fellow AHCC members and your AHCC Board are here to help you. Enjoy this issue! 🌼

Sincerely,
The AHCC Board

**ABOUT THE AUTHOR:**
Robert Markette, Jr., JD, CHC, HCS-C, Attorney with Hall, Render, Killian, Heath, & Lyman, P.C., is the Secretary of the AHCC Board.
AHCC BEST PRACTICE PAPERS

Our fourth-quarter Premium Members-only AHCC Best Practice paper focuses on best practices for coordination of care. The revised Conditions of Participation (CoP) include clear directives on care coordination and, if not followed, are increasingly resulting in deficiency citations.

Payment under the new Patient-Driven Groupings Model (PDGM) system will be dependent on appropriate, specific support for primary and secondary diagnoses. This will require close collaboration between physicians and interdisciplinary team members that manage a patient’s plan of care.

As the agency’s accountability for coordination of care is escalating, there are ways to improve coordination of care processes, such as setting up care teams focused on patient goals and correctly documenting all team interactions. You can also train your staff on efficient, collaborative practices and generally developing a care team mindset in the agency.


AHCC TALK

Each month members of the AHCC Board join us for AHCC Talk, a live discussion dedicated to helping home health and hospice providers run compliant and successful agencies. AHCC Talk aims to bring you closer to reliable experts in home health and hospice and to share the latest news and information from the industry and from the Association of Home Care Coding and Compliance (AHCC). In January 2020, we discussed the current issues in home care.

As we all know, the Patient-Driven Groupings Model (PDGM) went into effect on January 1, 2020. We have all been preparing for a while and wondering how things are going while moving into the early days with PDGM.

Robert Markette stated that it’s kind of eerie how quiet it’s been, since we expected the world to end on January 1st. Instead we’ve had a lot of conversations with clients, but every single conversation has been about something other than PDGM. Dee Kornetti believes that the home health industry is probably going to feel some of the biggest effects once these early trends in billing and reimbursements start coming through—we will see a lot more towards the end of the first quarter and into the second quarter. Both Robert and Dee agree that it is quiet for now.

More to come on PDGM and how it is impacting folks on future AHCC Talk calls.

Other issues discussed on this AHCC Talk included:

- Survey-related concerns,
- The old PPS systems are still being updated and are not ready, which affects the agencies and their working cash flows and that’s disconcerting overall,
The Department of Labor salary rule that went into effect January 1, 2020,

Changes in work, normal work flow, referrals and volume for therapists in home care.

We will definitely continue watching these issues as the year goes on.

Unfortunately, we had an issue with the AHCC Talk survey for this call and do not have the survey answers to share. We apologize for the technical issue. What issues are you most concerned about in 2020? We’d love to hear from you.

To join us for the next episode of AHCC Talk, register here: https://attendee.gotowebinar.com/register/6870114079026530819. To share your thoughts or suggestions for future episodes, email us at AHCCMembers@decisionhealth.com.

New on the AHCC website


AHCC Talk archive: Did you miss listening in to an episode of AHCC Talk? You can catch up with our recordings of past episodes here: https://ahcc.decisionhealth.com/Resources?resourceType=Free%20Webinars.


Tools: We’re always adding new tools to the AHCC website resources section. Here are some recent additions:

Don’t overlook maintenance therapy under PDGM—frequency isn’t the issue, patient need is

PDGM may mean more opportunity to keep patients from losing progress, but the key is documentation

BY: MEGAN PIELMEIER

Don’t lose sight of maintenance therapy in 2020, as the service continues to play an important role in the care your agency provides under Patient-Driven Groupings Model (PDGM). While the volume of therapy visits is no longer a factor in payment under PDGM, which took effect Jan. 1, all types of therapy still are necessary for many home health patients.

PDGM makes maintenance therapy possible

In fact, some industry experts contend PDGM lends itself to maintenance therapy and may even provide a bigger opportunity for maintenance therapy than existed under PPS.

“I think PDGM is set up for maintenance,” says Jennifer Sandel, owner of Home Care Service Solutions LLC in Battle Creek, Mich. If the patient has achieved great results with restorative therapy in the first 30-day period, it could be appropriate to shift to a focus on maintenance during the second 30-day period, Sandel says. You could do this to prevent the patient from losing progress, and to maintain current levels of function.

PDGM is set up for this, Sandel says. The new payment methodology no longer provides volume therapy incentive, basing reimbursement instead on a mix of patient characteristics such as primary
diagnosis, comorbidities, functional impairment level and admission source. Sandel has helped to implement an agency-wide progressive maintenance therapy program and is teaching clinicians how to document for this type of therapy, especially in PDGM.

**Maintenance therapy has been underused**

Agency provision of maintenance therapy has been rare in years past. Agencies used the physical therapy maintenance code (G0159) in 0.72% of home health episodes in 2017, compared to 0.94% in 2016, as shown by data from Minneapolis-based ABILITY Network Inc.

This trend continued even after the Center for Medicare Advocacy in Willimantic, Conn. fought a legal battle with CMS on behalf of Medicare beneficiaries. As a result, CMS agreed to provide education about maintenance therapy. CMS also agreed to update maintenance coverage in the Medicare Benefit Policy Manual.

In August 2017, CMS followed a federal judge’s order to launch a webpage full of resources to reinforce that maintenance therapy is covered under the Medicare benefit. The order fulfilled part of the *Jimmo v. Sebelius* case settlement agreement approved in Jan. 2013. However, even after these steps, some agencies remained hesitant to provide the service.

Some industry experts believe there was a disappointing underutilization of maintenance therapy under PPS and believe the service has the same role under PDGM as it should have had under PPS.

“I don’t think all agencies know about this,” Sandel says. For agencies that are aware that therapist assistants can now provide maintenance therapy, it’s a big deal. Some agencies are operating with two or three PTAs to every physical therapist, Sandel explains. This change can make staffing maintenance therapy easier.

“It will encourage the use of maintenance therapy. Before we didn’t have manpower to put people on maintenance,” Sandel says.

Regardless of whether your agency increases the amount of maintenance therapy you provide, you shouldn’t reduce the total number of therapy therapist assistants by allowing them to perform maintenance therapy in the same way they are already allowed to perform restorative therapy under the home health benefit.

**TAs can help with services**

The final rule follows through on an American Physician Therapy Association (APTA)-supported proposal to allow physical therapist assistants (PTAs) and occupational therapist assistants (OTAs) to perform maintenance therapy services under a maintenance program established by a qualified therapist, as long as the services fall within scopes of practice in state licensure laws. In addition to supervising the services provided by the PTA or OTA, the qualified therapist still would be responsible for the initial assessment, plan of care, maintenance program development and modifications, and reassessment every 30 days.

"Some industry experts believe there was a disappointing underutilization of maintenance therapy under PPS and believe the service has the same role under PDGM as it should have had under PPS."
visits, Krafft says. Krafft is concerned that some agencies are trying to reduce therapy visits and mistakenly believe that taking such a step means the service becomes qualified maintenance therapy. The type of patients that agencies are getting now that PDGM is in effect, are the same as those they were receiving in 2019, Krafft notes.

The documentation must demonstrate that the provided services require skills of a therapist, and it must be reasonable for patients’ presentation or medical condition.

Top strategies for maintenance therapy implementation

- Develop your processes before taking your first patient. Make sure your clinicians know what they are doing, Sandel says. Your billing codes must be correct. Your agency should have everything in place before you take your first patient. This helps overcome the fear factor.

- Educate your clinicians about different types of therapy. Your clinicians must know the difference between what’s classified as restorative therapy for home care and what’s classified as maintenance, Sandel says. This distinction can be a challenge for some clinicians. Maintenance therapy works to maintain, prevent or slow unnecessary decline in a patient’s health and function. Your agency must start by teaching the basics.

- Properly identify your maintenance therapy patients. Your agency must make sure there is thorough staff education to ensure proper recognition of candidates for maintenance therapy, Krafft says. A lot of missteps can happen at the discharge planning stage, Krafft notes. The frequency is not what defines this type of therapy. It must be on the identified needs of the beneficiary and what resources will get them where they need to be.

- Write strong maintenance therapy documentation. Requirements of good maintenance therapy documentation include showing that the patient meets the eligibility requirements for being homebound and is under the prescription of a physician, says Diana Kornetti, owner/founder of Kornetti & Krafft Health Care Solutions in Fernandina Beach, Fla. The documentation must demonstrate that the provided services require skills of a therapist, and it must be reasonable for patients’ presentation or medical condition. The documentation has to illustrate that therapy is necessary to restore function or stabilize function for a maintenance course, Kornetti says. This could occur through slowing of the normal progression of a disease process (i.e., progressive neurological condition), or through skilled intervention centered around eliminating deterioration or decline that can commonly occur with chronic disease management, Kornetti says.

- Concentrate on quality assurance. Your agency must have a robust quality assurance department, Kornetti says. You should get a quality external audit to inform you of documentation problems you didn’t know about. It may confirm some of the things you thought or were seeing yourself.
FOCUS ON COMPLIANCE

Does CMS trust home health agencies to do the right thing when it comes to compliance?

A home health industry expert’s take on PDGM and major provisions in the final rule and whether CMS believes agencies can be counted on to behave

BY: KIRSTEN DIZE

Following a recent DecisionHealth webinar on the final changes to the Patient-Driven Groupings Model (PDGM) and other major provisions of the 2020 PPS final rule, agencies asked questions of industry expert Robert Markette, an attorney with Indianapolis-based Hall, Render, Killian, Heath & Lyman. Here are some of his answers.

Q What is your single-biggest takeaway from this year’s final rule?

A The cynic in me could say that CMS still doesn’t think very highly of home health compliance. Practically and realistically, my biggest takeaway is that they blinked on the behavioral assumptions.

They didn’t pull them all the way back, which I think is what we all wanted them to do, but when I read the rule, I went back and reread it to be sure they were really reducing that behavioral assumption amount. I anticipated the amount going up from the 8.01% they proposed in July.

The fact that CMS recognized that was a very large number was significant. CMS demonstrated some thoughtfulness. Their willingness to go back and look at other models where they’ve made assumptions, recognize that maybe they made some mistakes and apply what they’ve learned here were all very helpful.

I wish they would have done more to address the pretty clear impression they left on the industry as far as how we deal with compliance, and their discussions of low-utilization payment adjustments (LUPAs), for instance, because it’s troubling to me that CMS seems to take a pretty negative view of the way the industry might behave. It’s hard to understand how to operate in that environment because it feels like they’re always doubting us, but they changed, so I think that was a big one for us.

“CMS demonstrated some thoughtfulness. Their willingness to go back and look at other models where they’ve made assumptions, recognize that maybe they made some mistakes and apply what they’ve learned here were all very helpful.”

Q Are there any changes that you were hoping to see in this rule that were not included?

A I would have liked to see them drop behavioral assumptions completely. I would have liked to see them back away from the plan to eliminate RAPs (request for anticipated payment).

In my mind, their rationale for the RAP comes down to program integrity. I don’t like the idea of rolling out a regulatory requirement for program integrity purposes that punishes everybody. The examples that they gave were some serious bad actors, but they weren’t examples of providers who were trying to comply.
It seems that CMS noted a couple bad actors who engaged in rampant fraud, then decided to do away with the RAP entirely. It’s a little like saying, “Some people drive drunk so we’re just going to do away with cars. Everyone go back to riding horses.”

That doesn’t make any sense. They need to punish the wrongdoers.

I also think that you still need the RAP submitted, CMS needs this information, so it makes sense for us to submit it. That was my biggest disappointment. I really think that doing away with the RAP doesn’t really solve their problem.

It creates a huge financial problem for the industry at the exact same moment that PDGM is starting. Couldn’t this have waited a few years? CMS could have let us get through PDGM implementation, get settled into this new system then see what happened. To drop it all on us on Jan. 1 is disappointing.

Q: How can agencies prepare for the elimination of RAPs? Is it too soon to start preparing now? Is it at all possible CMS will pull back on this move?

A: At this point I don’t think there is any way CMS will pull back on the plan to phase out RAPs. They signaled their intentions very clearly last summer and in 2018 when they started asking for comments about it. I was surprised they proposed to wipe it out in just two years; I thought we might get a four- or five-year phase-in. I don’t think there’s any hope for it to change.

Is it too soon for agencies to change? I don’t think so. It’s very important now to look at cash-flow.

Look at how quickly your agency is getting RAPs out the door, how a reduction to a 20% RAP amount will impact cash flow, how all of that will impact the ability to make payroll and what steps can be taken to minimize any negative impact. Consider a line of credit to fund payroll or set aside money to cover a potential disruption to cash flow.

Q: Do you think it’s likely CMS will make any adjustments to the list of acceptable primary diagnosis codes outside of the rulemaking process?

A: I don’t think so because they seem to be somewhat reluctant to do it within the rulemaking process. I think we could see changes through notice and comment rulemaking as we go forward.

An exception might be if we get into 2020 and suddenly a large number of otherwise eligible patients are rejected for care in the system because of a code, and there isn’t necessarily a “more proper code.”

In that case, I think CMS might look at it, determine it’s not proper to have a code change, create an eligibility change and make an adjustment. Barring something like that, I think any changes will come through rulemaking.

Q: It’s getting closer to the end of the value-based purchasing pilot program and CMS made some small tweaks in this final rule. What is the likelihood that value-based purchasing will be rolled out nationwide? Is it possible that program will be discontinued?

A: I’ve not heard a lot from CMS, but my opinion—and I don’t think I’m alone in this—has been for a long time that value-based purchasing is coming to the entire industry, nationwide. CMS has been very fond of value-based purchasing as a model for other provider types for a long time now.

They want to move toward value-based purchasing and away from fee-for-service type models. I think it’s likely they wrap up the value-based purchasing pilot, take some time to digest what they’ve learned, then roll it out nationally.

I will add that I am not always the best at predicting the future, but value-based purchasing seems to fit right in that sweet spot of things CMS is really interested in and believes are the future of Medicare.

NOTE:
For more on PDGM and the final rule, purchase the on-demand recording of this webinar, “Get Ready for PDGM and All Changes Finalized in the 2020 Payment Rule.” Order your copy at https://store.decisionhealth.com/2020-pdgm-payment-rule.
FOCUS ON OASIS

Keep tabs on CMS’ January quarterly OASIS Q&As for direction on PDGM, function items

As we sort through implementation of PDGM, CMS’ guidance on common scenarios will determine how you handle OASIS items

BY: KIRSTEN DIZE

When your clinicians respond to M0104 (Date of referral) they should enter the date your agency received a valid referral, and must keep in mind that a valid referral doesn’t necessarily require a primary diagnosis eligible for reimbursement under the Patient-Driven Groupings Model (PDGM).

This is just one piece of guidance CMS included in its quarterly OASIS Q&As published to the CMS website Jan. 21. The latest release of OASIS Q&As delves into issues around PDGM as well as M items capturing activities of daily living (ADLs) and GG items capturing mobility and self-care. In the response to Question 3, CMS explains that your referral is valid when your agency receives adequate information about the patient, including name, address, contact information, diagnosis and/or general home care needs and assurance that the referring physician or another physician will provide the plan of care and ongoing orders.

Start with the valid diagnosis date

In the scenario outlined in Question 3, the agency receives a complete referral from a physician at an inpatient facility on Jan. 1, 2020, and the patient is discharged to home health that day. The diagnosis provided on the referral doesn’t fall into a PDGM clinical grouping, so intake staff calls to get a more specific diagnosis. The agency gets the more specific diagnosis on Jan. 4, 2020, and starts care on Jan. 5, 2020. CMS explains that the agency received adequate information, including a relevant diagnosis and had a valid referral on Jan. 1, 2020, so that is the correct admission date to enter on M0104.

“The assessment process, along with collaboration with the physician, may lead to identification of additional diagnoses for care planning and/or reimbursement purposes,” CMS explains in the response.

Don’t let details delay care

Delays in getting care started immediately after receiving and accepting a referral could result in timely initiation of care issues, lapses in patient care, loss of referrals and CMS scrutiny, notes Arlynn Hansell, owner of Therapy and More, LLC in Cincinnati.

“You’ve got to get it clarified, but get your clinician out there and get that patient started,” Hansell
says. “We have a valid referral; we just need to get a diagnosis that will play nice in the sandbox.” Absence of a diagnosis code that qualifies for payment doesn’t mean that patient doesn’t need care, Hansell adds. “We just need a valid diagnosis, so that’s our problem not the patient’s,” Hansell says.

CMS will likely take note of gaps in care and may flag that as a problem. “If you’re waiting around for a valid diagnosis four days later, you’re now several days out from discharge and that’s a problem. That’s starting to look suspicious and they’re going to look into those,” Hansell says.

If, however, the referral has no diagnosis at all, the referral is not considered complete. You can enter the date that a physician provides a diagnosis in M0104, Hansell says.

**PDGM is challenging agency methods**

Questions 3 is a prime example of challenges and shifts happening in the early days of PDGM, says Karen Tibbs, quality and education manager with Wayne, Pa.-based McBee Associates. “That just proves the impact of PDGM and these clinical groupings, just from that question being asked and that answer being published,” Tibbs says. “PDGM is impacting every part of what agencies are doing now, and agencies are evidently looking at that intake process and trying to figure out what is the best way to manage this.”

Some agencies are considering whether to accept a referral at all if it doesn’t have a valid primary diagnosis eligible for payment under PDGM, Tibbs says. Several McBee agency clients require review of initial precoding, face-to-face documentation or initial diagnosis to determine if there is a likelihood a valid primary diagnosis can be identified.

“Agencies are looking at that intake process to feel out what’s the best way to do that, and this is another indication that agencies are kind of scrambling,” Tibbs says.

**Is PDGM about patients or payments?**

This issue could “definitely” cause access-to-care issues for patients, according to Tibbs. “It’s just the nature of the beast. If you aren’t going to get paid for that patient, you can’t afford to take that patient in,” Tibbs says. “Some will do it pro bono, but that’s not going to be the norm. You can’t shut down because then you’ll help no one.”

**Be aware of these additional updates**

- **Remember that PDGM isn’t OASIS guidance.** In the response to Question 4, CMS notes that CMS will no longer use M0110 (Episode timing) in calculating case-mix or payment. Other payers such as Medicare Advantage might use this data in their payment model, however. You may respond to M0110 with “NA—Not applicable” for assessments where data is not required for the patient’s payer, according to CMS. “For the next year, we may still have to do that for other payer sources, but it may trickle off,” Tibbs says. Otherwise, instructions found within the OASIS guidance manual are not changing. “Keep your guidance separate when you’re thinking about M0110. PDGM is not OASIS guidance, it is payment. Don’t let your brain meld the two together,” Hansell says.

- **For wheelchair use, go with the most recent guidance.** In Question 19, CMS explains that clinicians should enter “1—Yes” on GG0170Q (Mobility, Does patient use wheelchair and/or scooter) if the patient uses a wheelchair infrequently, for instance when the patient visits the cardiologist because of the distance from the car to the office. This is the case even though the OASIS guidance manual states that if the patient is ambulatory and not learning how to mobilize in a wheelchair “for community mobility outside the home (for instance to a physician appointment or to dialysis), enter code 0—No.” You must abide by the most recent guidance provided by CMS, Hansell says. The most recent guidance is found in the Q&As.

**RELATED LINK:** View the January 2020 Q&As at http://bit.ly/2tvO7ea.
CMS proposes changes to OASIS in spades—27 new items on the heels of PDGM

A draft of the already named OASIS-E is expected in early 2020

“Big changes are coming to the OASIS in 2021, and CMS expects a draft of the revised assessment in early 2020, according to the 2020 PPS final rule. CMS released an OASIS-D to OASIS-E crosswalk with its 2020 PPS proposed rule, indicating the revised assessment already has its name. The revised assessment adds 27 new items—or standardized patient assessment data elements (SPADEs)—at various timepoints, according to the final rule and corresponding supplemental documents. “I think that’s what we’re going to be talking about a lot next year,” says Diane Link, president of Link Healthcare Advantage in Littlestown, Pa. “We need to get ready for the next big thing, and that’s SPADEs.” The new items will capture information on cognitive function and mental status; special services, treatments and interventions; medical condition and comorbidities; impairments; and social determinants of health. The changes are designed to comply with the IMPACT Act, which calls for...
standardization across four post-acute settings including home health. New cognitive items are expected to be the most challenging, adding at least 10 minutes to the admission assessment, Link predicts.

**Expect more stress as changes come fast**

The changes come hard on the heels of recent OASIS changes as well as a new payment model. OASIS-D took effect Jan. 1, 2019, OASIS-D1, along with the Patient-Driven Groupings Model (PDGM) were implemented on Jan. 1, 2020. Implementing OASIS-E on Jan. 1, 2021 doesn’t leave much time to acclimate to these substantial changes.

“It kind of scares me. And to come right on top of PDGM, that’s crazy,” Link says. One commenter even recommended CMS wait five years before making additional changes to the OASIS. In response, CMS said in the final rule that “The timeline outlined is intended to give providers sufficient time to become familiar with the new measures and participate in trainings and other stakeholder engagement initiatives prior to submitting data on the measures.”

Since the proposed rule was introduced in July, Arlynn Hansell, owner of Therapy and More, LLC in Cincinnati, has led trainings and let providers know OASIS-E is likely on the way. The warning has been met with shock, and most agencies aren’t thinking about preparations for these coming OASIS changes.

“I’m sure it’s on the minds of some specialists, but the focus right now is PDGM, because OASIS isn’t taking effect this January,” says Bill Dombi, president of the National Association for Home Care & Hospice (NAHC) in Washington, D.C. The timing is further complicated by the fact that many clinicians are still struggling with GG items capturing mobility and self-care that were introduced as part of OASIS-D, Link says.

**CMS gives the rundown**

CMS plans to implement the following items and changes on Jan. 1, 2021:

- **A1005 (Ethnicity) and A1010 (Race).** These items will replace M1040 (Race/ethnicity), according to CMS’ combined change table.
- **A1110 (Language).** This is a new item to indicate preferred language and whether the patient needs or wants an interpreter.
- **A1250 (Transportation).** This is a new item to indicate whether lack of transportation has kept a patient from medical appointments, meetings, work or from getting to things necessary for daily living.

> Since the proposed rule was introduced in July, Arlynn Hansell, owner of Therapy and More, LLC in Cincinnati, has led trainings and let providers know OASIS-E is likely on the way.

- **A2121 (Provision of current reconciled medication list to subsequent provider).** This is a new item, with two versions collected at different timepoints. A2121A will be collected at discharge and A2121B at transfer. Additional transfer of information items will also be added. Those items are: A2122 (Provision of current reconciled medication list to patient at discharge) and A2123 (Route of current reconciled medication list transmission).
- **B0200 (Hearing).** This is a new item designed to assess ability to hear and can include ability with a hearing aid if it is normally used.
- **B1000 (Vision).** This item replaces M1200 (Vision), which will be voluntary at follow-up as part of OASIS-D1 in 2020 and removed from follow-up in 2021.
- **B1300 (Health literacy).** This is a new item to address patients’ social determinants of health. It will assess how often patients need...
help when reading instructions or other written material from doctors or the pharmacy.

- **C0100 (Should brief interview for mental status (C0200-C0500) be conducted).** This item is one of the new cognitive items. If clinicians determine this interview appropriate, they will complete the corresponding interview items. The Brief Interview for Mental Status (BIMS) includes C0200 (Repetition of three words); C0300 (Temporal orientation (orientation to year, month, and day)); and C0400 (Recall; and C0500 (BIMS summary score)).

- **C1310 (Signs and symptoms of delirium (from CAM©).** This is another new item that involves assessment of a patient’s cognitive ability. It utilizes the Confusion Assessment Method.

- **D0700 (Social isolation).** This is a new item designed to assess how often patients feel lonely or isolated from the people around them.

- **D0150 (Patient mood interview (PHQ-2 to 9).** This item will replace M1730 (Depression screening) and involves several parts.

- **D0160 (Total severity score).** This is a new item that joins with D0150 in adding PHQ-2 to 9 to the OASIS.

- **M1242 (Pain interfering) has been finalized for removal.** J0510 (Pain effect on sleep), J0520 (Pain interference with therapy activities) and J0530 (Pain interference with day-to-day activities) are new items being added to the OASIS to assess pain.

- **K0520 (Nutritional approaches).** This is a new item that will involve checking all that apply. Some responses to this item replace responses “2—Parenteral nutrition” and “3—Enteral nutrition” on M1030 (Therapies).

- **N0415 (High-risk drug classes: Use and indication).** This is a new item that involves selecting whether the patient is taking medications in included drug classes.

- **O0110 (Special treatments, procedures and programs).** This is a new item that involves checking all of the provided treatments that apply. 🧹
Effective strategies for compliant diabetes coding under PDGM

Getting your patient the right care is your first concern—but no one wants to risk compliance issues or leave money on the table either.

BY: MEGAN HERR

Under PDGM, your primary code choice ultimately determines your patient’s clinical grouping placement—which helps determine the reimbursement amount your agency receives for services.

When it comes to coding for diabetes, not all codes in the category fall into the same clinical group. If you choose the wrong diabetes code, it could mean your place the home health episode into an incorrect clinical grouping, which is a compliance issue. It could also mean you leave rightful reimbursement on the table.

The most commonly coded primary diagnosis in both the wound and endocrine clinical groups was a diabetes code, according to data from Santa Barbara, Calif.-based Strategic Healthcare Programs (SHP).

Focus on the actual focus of care

The biggest challenge, now that PDGM is in effect, is for agencies who don’t put their emphasis on doing it right, says J’non Griffin, owner of Home Health Solutions in Carbon Hill, Ala.

Consider why the patient is receiving home health services, when you decide which code to place in the primary spot.

“Everybody is so focused right now on how much they’re going to be paid—and I get it—it’s a big change; but, they’re forgetting that they need to keep in mind what the actual focus of care is,” says Griffin. “If they’re doing it wrong and ADRs come, they’re going to get creamed if the focus of care they coded is not the actual focus of care.”

Mind those coding conventions

Keep coding conventions and guidelines in mind when you’re coding for diabetes. Industry experts say that while home health practitioners commonly diagnose diabetes mellitus, agencies commonly miscoded diagnoses because they failed to assign the combination codes for diabetes mellitus with associated manifestations.

According to coding conventions, you should interpret the subterm “with” or “in” within the Alphabet Index as a link between diabetes and any of the conditions listed under the indentation under the word “with” or “in.”
The convention goes on to state, “these conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions.”

Look at all of the patient’s comorbidities and then use coding knowledge to decide if there is an assumed relationship between the diabetes and any of the other comorbidities according to the coding conventions, says coding expert Jennifer Warfeld.

For example, if a patient has diabetes and kidney disease, you can capture this through coding diabetic kidney disease.

“Oftentimes, I’ll see coders assign E11.9 (Type 2 diabetes mellitus without complications), which means the patient has diabetes but doesn’t have any other complications that can be related to the diabetes. But then I’ll see the patient also has kidney disease,” Warfeld says. “Well, there is an automatic assumption between diabetes and kidney disease so you can’t say that a patient has diabetes with no complications and then say they have kidney disease. You have to make that relationship.”

Ask for the details you need

When you’re unsure whether a comorbidity is related to the diabetes and whether to code it using a diabetes combination code, query for further information, Warfeld recommends. A wound is a good example.

“If a patient has a foot wound and the doctor just says they have a wound on their right foot, you will want to verify with the provider whether or not that wound is a diabetic wound,” Warfeld says. Your failure to make that connection is a coding error and you place that episode into an incorrect, lower-paying clinical grouping.

“If you’re looking at a patient with a pressure ulcer and diabetes, and there is clear indication from the physician that that the ulcer is from pressure, you could put the ulcer as primary and the diabetes as secondary,” Warfeld says. Your appropriate coding choice places that episode into the wound category clinical grouping.

“However, when the documentation indicates, for example, a foot ulcer that is related to the diabetes then you don’t have a choice, the diabetes code has to come before the ulcer,” Warfeld explains. This code order places the patient into the endocrine clinical grouping.

“If the ulcer is just stated as a pressure ulcer and that’s your focus of care, then yes, that can be primary,” Warfeld says. “But when your referral is for a diabetic ulcer of the right foot then you don’t have a choice in how you code that. The diabetes has to come before the ulcer code.”

More diabetes coding tips

▪ If the diabetes is documented as uncontrolled, classify it by the type and whether it is hyperglycemia or hypoglycemia. But, be sure to query if the existing documentation is unclear because no default code exists for “uncontrolled diabetes.”

▪ Unless the doctor specifies that diabetes and one of the associated manifestations are unrelated, always assume they are connected and code them together.

▪ The “with” convention doesn’t apply to “not elsewhere classified (NEC)” index entries that cover broad categories of conditions. Don’t assume a causal relationship when the diabetic complication is “NEC” unless linked by the physician in the documentation.

▪ When locating the code in the tabular list, check for guidance or instructions within the code section, the category and within any chapter guidelines. Doing so will ensure you don’t miss any steps.

▪ Only use code Z79.84 (Long term (current) use of oral hypoglycemic drugs) to indicate the use of oral anti-glycemic when the patient does not also take insulin. If the patient is treated with oral medications and insulin, only assign Z79.4 (Long term (current) use of insulin).

▪ Don’t assign Z79.4 if insulin is given temporarily to bring a Type 2 patient’s blood sugar under control during an encounter.
FOCUS ON CODING

Struggling with condition changes and therapy use in early days of PDGM? You aren’t alone.

As we officially transition to the Patient-Driven Groupings Model (PDGM), CMS will likely need to provide more guidance to handle additional queries.

BY: KIRSTEN DIZE

Like other agencies across the nation, you probably have questions about how to best handle some changes as you deal with PDGM. But some industry experts say the real test will come in response to the first round of claims submitted in late January.

“Agencies are still in a watch-and-wait kind of mode and looking at their cash flow,” says Bill Dombi, president of the National Association of Home Care and Hospice (NAHC) in Washington, D.C. Even so, experts have been flooded with a wide range of questions as agencies find their way during the early days of the new model.

More information is required

Questions include how should you handle patient change in condition and focus of care during the first 30-day episode, whether or not you should discharge and readmit a patient that goes to the hospital, and how should you handle patients who were in the middle of a PPS episode at the start of the new year, says J’non Griffin, owner of Home Health Solutions LLC in Carbon Hill, Ala.

“There are a lot of last-minute questions—operational kinds of things—like whether the RAP holds for new providers to companies that have gone through a change of ownership. There are questions of diagnostic codes and questionable encounters,” Dombi says.

Other new requirements that took effect Jan. 1 are further complicating agencies’ transition, says Arlene Maxim, a home health and hospice expert with A.D. Maxim Holdings based in Troy, Mich. Requirements to use SSN-free Medicare numbers on claims, OASIS-D1 and a new internet-based system—iQIES—to submit OASIS data all took effect the same day. The combination “is playing havoc” on agencies, Maxim says.

Therapy plans are mixed under PDGM

Agencies and experts alike are closely watching therapy under PDGM. “A number of companies are
indicating they are taking it day to day with therapy instead of having a knee-jerk reaction. Others have already reduced their therapy staff,” Dombi says. Some agencies are using outsourced therapy to control costs.

Overall, reactions to the new model and use of therapy are varied. “The wise move that we are seeing is that companies are not just reacting in an arbitrary way,” Dombi says.

**PDPM should not predict PDGM’s future**

After the October rollout of the new Patient-Driven Payment Model (PDPM) for skilled nursing facilities (SNFs), reports surfaced of significant layoffs and reduced hours for physical therapists and physical therapist assistants.

The SNF model bears several similarities to PDGM, with both models designed to align payment with patient characteristics, conditions and needs, while eliminating the connection between reimbursement and the volume of therapy services provided.

Home health experts warned at the time that you shouldn’t follow the lead of SNFs and should avoid significantly changing your therapy utilization immediately after Jan. 1. By doing so, you could invite more CMS scrutiny.

**Take these steps to mitigate PDGM confusion:**

- **Individualize care plans and decisions.** According to the revised Home Health Conditions of Participation (CoPs), you must base the frequency and duration of therapy visits listed on the plan of care on the patient’s individual needs [§484.60(a)(2); G574]. What works for one patient may not work for another. There must be a conversation about what is being done with the patient.

- **Implement a process for patient change in condition.** Your efforts will help ensure proper payment throughout a 60-day episode of care. If the patient’s condition or focus of care changes in the middle of a 60-day episode of care, it can also impact payment. If it’s a true, unexpected significant change in condition (SCIC), clinicians should complete the “other follow-up” OASIS assessment, also known as RFA 5, according to the OASIS guidance manual. In situations that don’t involve a significant change, such as anticipated changes in focus of care after a wound heals, your agency can simply update the primary diagnosis on the claim, without completing another OASIS, Griffin says. You do need to communicate the changes between the clinician, clinical manager, coder and biller to ensure appropriate case management, coding and payment.

- **Determine whether discharge or transfer is more appropriate.** When a patient is readmitted to the hospital, your agency may have a choice of whether to discharge or transfer the patient, Griffin says. If the readmission is not within 14 days of the next 30-day home health period, you could discharge the patient then readmit, Griffin explains. While this action would result in partial episode payment (PEP), it would also result in an institutional, late admission for the next payment period. If you choose to do a resumption of care (ROC)—and it’s within 14 days before the next 30-day payment period—it would result in a community, late designation for the next payment period. If a patient is readmitted to the hospital outside the 14 days of the next 30-day payment period, you can discharge the patient if you don’t expect that patient to return to home health. If you expect the patient to return within that 30-day period, it would make sense to conduct a transfer instead.

- **Review CMS PDGM resources.** CMS has a PDGM landing page with resources including the 2020 PPS final rule, the interactive grouper tool, a breakdown of case-mix weights, change requests and recordings of provider calls. View those resources at [https://go.cms.gov/2tvXNVw](https://go.cms.gov/2tvXNVw).
Alert physicians to PDGM documentation requirements to speed up order turnaround

When you make your referring physicians and their staff aware of the shorter deadlines and how they can help, you’ll make your job easier in the process.

BY: MEGAN PIEMEIER

Your agency should partner with physicians to educate them about the Patient-Driven Groupings Model (PDGM) and the documentation you need. Doing so will make the process smoother, as you’ll be able to work more collaboratively with physicians.

If you haven’t already, your agency should start by making physicians aware of the changes to the way your agency will be paid under PDGM, including needed coding specificity, says Diane Link, owner of Link Healthcare Advantage in Littlestown, Pa. Physicians will need this background to better understand why your agency is querying about diagnoses that you didn’t query about under the previous model, Link says.

“PDGM is more about collaborative care and coordination. We need to make sure [physicians] are still referring, and to keep them happy,” Link says. Referral sources will likely be more patient with your agency if they know why you’re suddenly asking for more information.

CMS is going to look for documentation to support a primary diagnosis, especially if a physician first provides a primary diagnosis that is no longer valid under PDGM, says Mary Carr, vice president.
of regulatory affairs for the National Association of Home Care & Hospice (NAHC) in Washington, D.C.

Make the right connections
Your agency also must get all documentation signed by the physician and returned more quickly to meet the faster turnaround time required by the 30-day PDGM payment periods. You need physician cooperation to submit claims timely, so you must educate physicians on PDGM timing requirements.

Internally, your agency should assign someone to do physician follow-up, so that it is done consistently and remains a priority.

“We can’t wait for 28 days to get something signed,” Link says. First, it’s important for your agency to make sure they are communicating with the right physician, Link says. It’s a waste of everyone’s time to send a request for signature to the wrong physician, and such an error can delay your claims.

Follow orders full circle
To facilitate a faster process, find out how physicians want to receive orders, Link says. Determine if fax, email or a portal is the preferred method then use that method for communication.

Your agency also should set up a follow-up schedule. If the physician doesn’t get back to you with documentation within 30 days, it will be a problem. Take a customer-friendly approach to following up, Link recommends. Internally, your agency should assign someone to do physician follow-up, so that it is done consistently and remains a priority. Some agencies utilize order management and referral tracking software to make this process run smoothly, Link adds.

Try these tips to improve physician communication

- **Adopt a proactive approach.** Your agency must be proactive when working with referral sources, Carr says. Under PDGM, the billing cycle is cut in half and CMS is scrutinizing claims, so don’t wait for physicians to come to you. Reach out to referral sources to set the tone and develop a positive relationship with the physician.

- **Schedule a one-on-one meeting with the physician.** You can discuss changes in the industry to improve your partnership and better help patients. Ask about the best time to follow up with the physician and the preferred method of communication to demonstrate that you’re willing to adapt for the physician. Getting this kind of time with the physician can be tough, however, so you may have to meet with the office manager and leave behind some reference information for the physician. Make an effort to befriend office staff, because they can help get things in front of the physician, Link adds.

- **Decide who should educate physicians about PDGM.** Select the staff member to conduct physician education based on who has the best relationship with the physician, Link stresses. “A lot of times it is that marketeer because they are stopping by and dropping things off. A clinical person could come along. You might want to send along someone who has the coding guidelines and what you need to code,” Link says.
ASK AHCC

AHCC Q&A

Do you have a question for AHCC? We’re here to help you find the answers you need. Please send your questions in to us at AHCCMembers@decisionhealth.com.

Q Regarding laparoscopic surgeries, one of our coders says she was told to never code aftercare when a surgery was performed laparoscopically. I am trying to find something to show otherwise. Any advice?

A Aftercare codes may be used when there has been initial treatment of a disease and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. Official Guidelines Section I.C.21.7—If the procedure (laparoscopic surgery) has resolved the original condition, then aftercare codes are appropriate to use.

Q If H&P has documented BPH only on a male patient, and the home health agency nurse has checked urinary incontinence on the Oasis-D “Elimination” page, may coders assume a relationship and code this as a BPH with LUTS?

A The coder may NOT assume or code urinary incontinence if the physician has not documented the diagnosis in the referral, or if the clinician has not documented physician confirmation obtained following the SOC visit. If the patient has reported incontinence, and the clinician has identified this in the OASIS, the physician verification must be documented in order for the coder to include the diagnosis in the sequencing.

Q H&P noted BPH and a foley catheter change, urinary retention was not in H&P, but the home health agency nurse has checked urinary retention on the OASIS-D “Elimination” page. May coders assume a relationship and code this as a BPH with LUTS?

A Again, no. No assumption may be made without the physician documentation of the diagnosis of urinary retention.

Q Would I code a trauma wound to the location of a DM ulcer along with the codes for DM ulcer? Or just the DM ulcer?

A If the trauma wound is located around the area of the DM ulcer, and you have two distinct lesions, you may use all 3 codes—the trauma wound, DM with ulcer, and the ulcer location/ severity code. If the trauma wound is located within the DM ulcer area, confirm with the physician which wound you are addressing. An ulcer and a trauma wound are distinctly different lesions with different treatments and healing processes. If the DM ulcer is deteriorating due to an injury/trauma to the area, you continue to have a DM ulcer. Physician verification is required so you can code specifically.

Q Do symptoms need to be confirmed with an MD before they can be coded?

A Yes. All diagnoses must be supported in physician documentation—even symptom codes.
Meet AHCC Board Member
Diana L. Kornetti, PT, MA, HCS-D, HCS-C
Owner/Founder Kornetti & Krafft Health Care Solutions

What did you do before entering home health or hospice?
I taught in a PTA program in Central Florida and served as the Rehab Program Manager for a local community hospital in Central Florida.

How long have you been in home health or hospice?
25 years

Why did you get into this line of work?
I became interested in what home care offered early in my career as a therapist providing patient care. Having about 10 years of clinical experience in hospitals, inpatient rehab facilities and outpatient clinics, I felt I could impact patient’s only to the extent that they were able to identify their needs when they came to see me (or I them, in their hospital room!). With my passion for treating older adults (geriatric population) my whole career until this point, and having a parent with physical disabilities while growing up, I understood there was so much more I would be able to address by seeing patients one at a time, in the environment where they need to function safety . . . their home. Therapy has always been, in my 35-year career, a business of numbers, and I wanted to make a difference in the lives of the people I treated, on an individual basis. I couldn’t do that as successfully in a clinic situation treating 2-3 people per hour, simulating situations that they encountered in their personal living space at home. I decided to make the full-time switch to home-based physical therapy and have never regretted it!

What has been your biggest challenge?
Getting “up to speed” as a contracting PT with all the regulations and survey requirements—orientation was non-existent for a contracted therapist!
What has been your biggest reward?

Quickly being identified as a leader and then being asked to provide contracted services to multiple agencies in my area … this led to starting a contracted therapy company providing PT, OT and SLP services to over 15 agencies in the Northern and Central Florida area.

How has the field changed since you began working in home health or hospice?

Greater regulations; improved accountability through enhanced interoperability and data analysis. “Real-time dashboards” for data analysis and trending just didn’t exist back then.

How has BMSC certification helped in your professional career?

I became a better comprehensive assessment clinician/initial therapy evaluator once I understood coding and case-mix assignments. I asked better questions of both the patient/their family/CG and physicians, and my assessments provided a clear rationale outlining causative factors for patient impairments and supported skilled need for care.

What do you like most about serving on the AHCC board?

The ability to interact with individuals throughout the country and facilitate programming/education that immediately translates into daily practice improvements.

What piece of advice would you offer to someone new to home health or hospice?

Read the regulations, survey requirements and understand you have guidance outlined by your professional license to be accountable and responsible to ensure that you meet requirements for third-party payers. KNOW THEM!

If you could have any other job, what would it be?

I have the job I envisioned, along with business partners Cindy Krafft and Sherry Teague, in Kornetti & Krafft Health Care Solutions. I am excited about the future of home care and the role of therapy in shaping the narrative as we look to a unified payer model for post-acute care providers in 2023 and beyond!

What was your first job?

I was a waitress at a Friendly’s Ice Cream Store in my hometown of Trenton, NJ.

A few of your favorite things:

My family—four siblings, and 11 nieces and nephews; my family—wife Sherry and our dogs, Beaux, Gator, Chiqui, Sissy and Trixie; Gator Football (GO GATOR!); and friend vacations!

Vacation spots: Florida Keys (friend vacations!), Hawaii, and I’m going this Spring on a cruise of the Inner Passage of Alaska!

Hobby: Gardening—I like to get my hands in the dirt and watch things grow & blossom.

Non-alcoholic beverage: Diet Coke, but I am slowly converting to a water aficionado.

Foods: Mexican—a supporter of Taco Tuesdays!

Activity: Walking, especially sightseeing on vacation and on the beaches of Northeast Florida! 💚
I’m currently the Vice President of Education and Control Standards for Quality in Real Time (QIRT). In this position I am responsible for the education of staff, as well as clients. I am also responsible for the quality of the coding and OASIS reviews we complete. I additionally develop client and agency education and educational materials for the industry.

Q What did you do before entering home health or hospice?

A I was a registered nurse in the hospital, specializing in Interventional Radiology and Medical Surgical Nursing.

Q How long have you been in home health or hospice?

A 16 years

Q Why did you get into this line of work?

A I laugh—at the time I had a small daughter and I thought it would be an easy job making home visits. I quickly found out how challenging home nursing was. It’s just you out there and you need to be sharper and more informed than other nursing settings.
What has been your biggest challenge?

I’d say just keeping my knowledgebase up with the frequent industry changes.

What has been your biggest reward?

Helping others deliver the best care they can to their patients through education and training.

How has the field changed since you began working in home health or hospice?

We have seen OASIS to OASIS B thru OASIS D1, and now OASIS E is on the horizon. We have seen ICD 9 to ICD 10, PPS to PDGM and all the changes and final payment rules in between. The changes keep coming and a little faster now.

How has BMSC certification helped in your professional career?

It has helped be recognized as a professional in the industry. I know that my company doesn’t even consider job candidates without certification.

What do you like most about being an AHCC member?

I think it’s wonderful having the educational support, as well as the advocacy of the AHCC behind us. Having other members we can network with as well has been beneficial. I love the new AHCC website.

If you have attended, how many Coding Summits or Compliance Summits have you been to? What are your favorite memories?

Wow, I’ve lost track, 9 or 10 I believe. My favorite memory was probably the Elvis impersonator at lunch at Summit to unveil the following year’s location.

What piece of advice would you offer to someone new to home health or hospice?

Be flexible with change.

If you could have any other job, what would it be?

Nothing comes to mind.

What was your first job?

I worked at the cafeteria in a K-mart department store.

A few of your favorite things:

Vacation spots: Tybee Island, Georgia/Savannah

Hobby: Kayaking

Non-alcoholic beverage: Raspberry tea

Foods: Peanut butter

Activity: Cardio-drumming