Medicare pays for three services for the care of wounds:

1. Performing actual hands-on care to the wound – wounds must require complex wound care
2. Teaching the caregiver and/or patient how to care for the wound
3. Assessing the wound when medically necessary
   - Wound should be significant enough to have risks
   - Other disease processes may increase risk of complications, like diabetes, peripheral vascular disease

When documenting:
- Include type of wound (and cause, if applicable), location, size, color, drainage and any undermining.
- Use a wound care flow sheet for capturing details.
- Use objective terms, e.g. “2 cm of bloody drainage on pad,” rather than “moderate.”
- If unsure of etiology of wound, ask physician.
- Be consistent in documenting etiology of wound – pressure ulcer, stasis, diabetic ulcer.
- Remember wounds are documented in the OASIS, visit notes and POC – consistent documentation of the type of wound from clinician to clinician is essential.
- If possible, have the same clinician measure the wound each time for consistency.

For further information, see the Medicare Benefit Policy Manual, CMS Publication 100-2, Chapter 7, Section 40.1.2.8
Sometimes the case manager may note conditions that would be better treated by a physical or occupational therapist or a speech-language pathologist. The case manager has a responsibility to assess the situation for the physician, and to notify the physician if the patient would benefit from additional services in the home and obtain an order for at least a therapy evaluation visit.

Indicators of potential need for therapy services include:

**PHYSICAL THERAPY**

- Deficits in the mobility questions on the OASIS assessment
- Recent change in the patient’s mobility
- Gait or transfers appear unsafe or laborious
- Poor compliance with a home exercise program because it has become too difficult
- An assistive device is not being used correctly or does not seem to “fit” patient’s needs
- Falls or near-falls
- Pain that affects mobility
- Accessibility issues in the home

**OCCUPATIONAL THERAPY**

- Deficits in the ADL or IADL questions on the OASIS assessment
- Recent decline in the patient’s self-care ability
- Increasing difficulty managing household tasks
- Avoidance of bathing in the tub or shower, or recent preference for robes and leisure wear rather than normally worn clothing
- Poor endurance for ADLs and IADLs
- Recent visual deficits that affect ADL performance
- Multiple home safety hazards, especially in the bathroom or kitchen
- Psychiatric problems affecting ADL/IADL performance
SPEECH-LANGUAGE THERAPY

- Deficits in communicative and cognitive questions on the OASIS assessment
- Recent cognitive/memory changes impacting safety of ADLs or IADLs
- Difficulty with or avoidance of written materials – lists, phone numbers, checkbook, etc.
- Subtle signs of aspiration risk such as pocketing of food, drooling, “gurgly” voice after eating, frequent coughing while eating
- Decrease in voice volume
- Avoidance of conversation
There are specific times that OASIS assessments must be completed:

- **Admission**: complete a start of care (SOC) OASIS within **5 days**
- **Recertification**: complete a follow-up OASIS within the **5 days prior** to new recertification (**days 56 – 60**)
- **Resumption of care (ROC)**, after an inpatient stay: complete a ROC OASIS within **2 days** of the resumption of care
- **Transfer** to an inpatient facility: complete a transfer OASIS within **2 days**
- **Discharge** or death: complete the discharge OASIS within **2 days**
- When a **significant change** is noted: complete a follow-up OASIS within **2 days** of identification of the change. Your agency is responsible for defining a “significant change.”
- If the patient is **in the hospital** on **day 60** of an episode, the patient must be discharged, and a discharge OASIS completed
- If the patient is **in the hospital** and returns home on **day 57**, during the **5-day** window for the recertification assessment:
  - Complete a ROC OASIS, and waive the follow-up assessment for recertification
  - Project therapy need (M2200) for the next 60-day episode of care

If an OASIS is inadvertently missed, it should be completed as soon as the omission is discovered.

For additional details, Chapter 4 of the OASIS Implementation Guide addresses when the OASIS needs to be completed, and who should complete it. The manual is found at: www.cms.hhs.gov/HomeHealthQualityInitiatives/14_HHQIOASISUserManual.asp
This M item asks “Is this PPS episode considered ‘early’ or ‘late’?” Remember, CMS defines “early” as the first or second adjacent episode of home health care provided. “Late” is considered the third or greater adjacent episode of care.

Helpful hints to more clearly define:

1. “Adjacent” is considered “continuous”, or with 60 days or less break in care.
2. A 60-day break is considered by the end of the prior 60-day episode date, or the “to-date” on the final claim. This date may be later than the last visit the patient received.
3. The adjacent care is only referring to prior traditional Medicare PPS episodes. Care provided under another payer, or a managed care Medicare plan is not considered when determining if an episode is “early” or “late.”
The primary diagnosis is the unresolved condition, supported by physician documentation, which is most related to the current home health plan of care. It is not necessarily the same as the inpatient hospital diagnosis.

The primary diagnosis should be the one which:

- Represents the most acute condition
- Requires the most intensive skilled services (i.e. nursing or therapies)
- Relates most closely to the interventions to be rendered
- Reflects the main reason for providing home care

There are multiple groups of diagnoses that contribute points toward reimbursement. These are called “case mix” or payment diagnoses. Some of these diagnoses contribute points whether they are primary or other (secondary) diagnoses, some when used as primary diagnoses and some only when used in combination with other diagnoses or certain OASIS items.

Diagnosis case-mix group examples include:

- Diabetes
- Blindness
- Pulmonary
- Gait
- Gastrointestinal disorders
- Neurological disorders
- Orthopedic disorders
- Skin disorders
- Heart disease and hypertension