OASIS C2: The Changing Face of OASIS in 2017
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Before We Get Started

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Vehicle for Change: IMPACT Act

- Bipartisan Bill passed September 18, 2014
- Signed into law by President Obama October 6, 2014
- Requires Standardized Patient Assessment Data across settings (SNF, LTAC, IRF, HHA)
  - Data Element Uniformity
  - Exchangeability of Data
  - Comparison of Quality and Data across Post-Acute Care (PAC) settings
  - Improved Discharge Planning
  - Coordinated Care
  - Quality Care and Improved Outcomes
Overview of Changes

- **OASIS-C2 Guidance Manual Effective January 1, 2017**

Overview of Changes

- Three New Standardized Items and Guidance
- Clarifications in response to questions submitted to the OASIS Help Desk.
- Response Specific Instructions (50 OASIS Items)
- Dash as Valid Response
- Formatting Changes
  - Roman to Arabic Numerals
  - “Enter Code” box versus check boxes
  - Boxes versus dashes _ _ _
Overview of Changes

- Renumbering of Select Items (PU, Heart, Drug regimen, Emergent care)
- New Skip Directions
- Revised Guidance for Look-Back Period for Five Items
- Reworking
  - “During past 14 days” changed to “within past 14 days”
  - “Previous OASIS” to “from most recent SOC/ROC assessment” [M1501, 1513, 2016, 2301, 2401]
  - For the OASIS, “Present on Admission” and “Present at SOC/ROC” have equivalent meanings
- Amendments to Accommodate Revised ICD-10 Codes
  - 7 digit codes
  - Removed reference to V and E codes

OASIS C2: New Items

- M1028: Active Diagnosis: PVD, Diabetes Mellitus
- New Impact Act Item
- M1060: Height and Weight
- GG0170C: Mobility-Lying to sitting on side of bed
- Application Example
  - Pressure Ulcer Stage: M1313a, M1313b, M1313c
  - Risk Adjustment
    - G0170C (Assistance)
    - M1620 (Bowel)
    - M1028 (Diabetes) M1060a(BMI)
    - M1060b (BMI)
OASIS C2 2107: Item Intent Changes

- Minor revisions to intent descriptions
  - M1306: Does patient have at least one unhealed PU
  - M1350: Does patient have skin lesion receiving intervention
  - M2001: Drug regimen review
  - M2003: Medication Follow-Up
  - M200: Medication Intervention

Dash is Valid

- A dash (–) can be a valid response
- Indicates no information available at time assessed
- Rarely used: Will impact outcome measure
- Usual occurrence unexpected transfer, discharge, death
  - M1028 (Active Dx)
  - M1060 (Height & Weight)
  - M1313 (Worsening Pressure Ulcer)
  - M2001 (Drug Regimen Review)
  - M2003 (Medication Follow-up)
  - M2005 (Medication Intervention)
  - GG0170C (Mobility)
**Item Number Changes**

- M1308 to M1311 Number of Unhealed Pressure Ulcers
- M1309 to M1313 Worsening Pressure Ulcer
- M1500 to M1501 Symptoms Heart Failure
- M1510 to M1511 Heart Failure Follow-Up
- M2000 to M2001 Drug Regimen Review
- M2002 to M2003 Medication Follow-Up
- M2004 to M2005 Medication Intervention
- M2015 to M2016 Patient/Caregiver Drug Education
- Note: Often when Item Text changes

**Minor Changes**

**M0030: Start of Care Date**
- Response Specific Instructions
  - Updated example to 2017
  - Deleted: For Medicare reimbursement, as explained in 42 CFR 409.46, a physician must specifically order that a particular covered service be furnished on the SOC date.

**M0032: Resumption of Care Date**
- Format change only

**M0066: Birthdate**
- Updated example to 2017

**M0069: Gender**
- Data Source
  - Added: If patient does not self-identify, referral information (including hospital or physician office record); observation
Minor Changes

**M0110: Episode Timing**
- Response Specific Instructions
  - “Enter” vs “Select”

**M0903: Date of Last (Most Recent) Home Visit**
- Response Specific Instructions
  - Report the date of the last visit made by the agency staff, whether or not it was included on the plan of care

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**M1011: Each Inpatient Diagnosis**
**M1017: Diagnoses Requiring Medical Treatment Regimen Change**
**M1600: Treated for UTI**
**M1700: Cognitive Functioning**
**M1710: When Confused**
**M1720: When Anxious**
- Response Specific Instructions
  - The term “past 14 days” is the two-week period immediately preceding the Start/Resumption of Care or M0090 date on Follow-up.
  - For purposes of counting the 14-day period (also for M1017)
    - Start of Care date is day 0
    - Day immediately prior to the Start of Care date is day 1.
Minor Changes

- M1018: Condition Prior to Regimen change...
  - Response Specific Instructions
    - Amended from Admission to Start of Care/Resumption of Care
    - Added 14 day count as on previous slide
- M1021/1023/1025 Primary Diagnosis
  - Response Specific Instructions
    - Minor edits
- M1034 Overall Status
  - “Select” changed to “Enter”

M0090: Date OASIS Completed

- Response Specific Instructions
  - Revised example date to 2017
  - Added
    - If agency policy allows assessments to be performed over more than one visit date, the last date is the appropriate date to record
    - If the clinician needs to follow-up, off site M0090 should reflect the date that last needed information is collected
    - If the original assessing clinician gathers additional information during the SOC 5-day assessment timeframe... date would be changed to reflect that
    - If an error is identified at any time, it should be corrected following the agency’s correction policy, M0090 would not necessarily be changed.
**M0104: Date of Referral**

- Response Specific Instructions
  - Revised Example Date to 2017
  - Added: A valid referral received when
    - Adequate information about a patient
    - Agency ensured that referring physician will provide the plan of care and ongoing orders.
  - Added: If hospitalist will not be providing an ongoing plan of care:
    Must contact an alternate, or attending physician for referral and/or further orders
  - Added: If start of care is delayed
    - Date of referral is date the agency received updated/revised information for services to begin
    - Excluding information from others, patient’s payer

**M1028: Active Diagnosis-Comorbidities & Co-existing Conditions**

- New Item
  - Identifies active diagnoses that are associated with a patient’s home health episode of care
- Time Points: SOC & ROC
- Identifies whether Diabetes and/or Peripheral Vascular Disease are:
  - Present
  - Active
- Item Rationale
  - Diagnoses influence functional outcomes or increase a patient’s risk for development or worsening of pressure ulcer(s).
  - Disease processes can have a significant adverse effect on an individual's health status and quality of life
NEW (M1028): Active Diagnoses-Comorbidities & Co-existing Conditions

- Check all that apply - See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.
  - 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
  - 2 - Diabetes Mellitus (DM)

- Active Diagnoses
  - Comorbidities
  - Co-existing Conditions

M1028: Active Diagnoses

- Response Specific Instructions
- Identify Diseases and Conditions
  - Verify by documentation in medical record sources
  - Clinician contact to confirm if no documentation
  - Determine if the diagnosis is active
    - e.g. Medications, glucose monitoring, peripheral pulses, wound care
M1060: Height & Weight

- New Item
- New Impact Item
- Time Points: SOC & ROC
- Purpose: Support calculation of the patient’s body mass index (BMI) using the patient’s height and weight
- Item Rationale
  - BMI is a guide for determining nutritional status
  - Weight measurement used in assessment of heart failure
  - Diminished nutritional and hydration status can lead to debility
  - Adversely affect wound healing and increase risk for the development of pressure ulcers

- Response Specific Instructions (Using rounding)
- Measure using Agency Policy/Procedures & Practice Standards
  - Height (in inches): Record most recent height measure since the most recent SOC/ROC
  - Weight (in pounds): Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)
• Response Specific Instructions Added
  – M1200: Vision
    • Physical deficits or impairments that limit the patient’s ability to use their existing vision in a functional way should be considered.
  – M1240: Has patient had formal pain assessment using validated standardized pain assessment
  – When a standardized, validated assessment has been conducted
    • Enter Response 1 or Response 2 based on the severity level that corresponds to the patient’s pain level, per the tool’s scoring instructions.
    • Enter Response 2 when the patient’s reported level of pain equates to a severe pain rating on the tool used.

• Change from Roman to Arabic Numbers
• Item Intent
  – Prior: Presence or absence of Unstageable or unhealed Stage II or higher pressure ulcers only
  – Now: Presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers only
M1306: Does Patient Have Unhealed Pressure Ulcer

- New Item Text
- Response Specific Instructions Extensive
  - Home Health agencies may adopt the NEW NPUAP guidelines
  - CMS definitions do not perfectly align with each stage
  - When discrepancies exist providers should rely on the CMS OASIS instructions.
- Terminology “healed” vs. “unhealed” ulcers can refer to whether the ulcer is “closed” vs. “open”.
- Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI) not be considered healed
- Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.

M1307: Oldest Stage 2 Pressure Ulcer

- Item Text/Item Intent:
  - Identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed)
  - Assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and
  - Identify patients who develop Stage 2 pressure ulcers while under the care of the agency.
- New Response Options
  - Roman to Arabic
    - The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)
      - 1 Was present at the most recent SOC/ROC assessment
      - 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:
        - NA No Stage 2 pressure ulcers are present at discharge
    - Additional extensive Response Specific Instructions
M1311: Current Number of Unhealed Pressure Ulcers at Each Stage

- For Determining “Present on Admission”
- New Item Numbers
- New Item Text and Responses
- Dash Valid
- New Skip Directions (M1311)
- Identifies number of:
  - Stage 2 or higher pressure ulcers at each stage present at the time of assessment.
  - Stage 1 pressure ulcers and ulcers that have healed are not reported in this item.

M1311: Number of Unhealed Pressure Ulcers

- Extensive Response Specific Instructions
  - Terminology referring to “healed” vs. “unhealed” ulcers refers to whether the ulcer is “closed” vs. “open”
  - Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed
  - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed
M1313: Worsening in Pressure Ulcer Status since SOC/ROC

- New Item Text
- New Item Number
- New Response Options
- New Impact Act Item
- Dash Valid
- Extensive New Response Specific Instructions
- TIME POINTS ITEM(S) COMPLETED - Discharge

M1313: Worsening Pressure Ulcer

- Revised “d. Unstageable” to:
  - d. Unstageable: Known or likely but Unstageable due to non-removable dressing.
  - e. Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar
  - f. Unstageable: Suspected deep tissue injury in evolution. ITEM
M1320: Status of Most Problematic Pressure Ulcer

- Response Specific Instructions Changed
  - “Healed” vs. “unhealed” ulcers refers to whether the ulcer is “closed” vs. “open”.
  - Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin) not be considered healed.
  - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
    - Determine which pressure ulcer(s) are observable
    - Determine which observable pressure ulcer is most problematic
    - Utilize the WOCN Society’s Guidance on OASIS to determine status of the most problematic observable pressure ulcer

- Data Sources
  - Added reference WOCN guidance

M1320 & M1322

M1322: Current Number of Stage 1 Pressure Ulcers

- Extensive Response Specific Instructions
  - Sentence added to address dark skin tones
    - Terminology referring to “healed” vs. “unhealed” ulcers refers to whether the ulcer is “closed” vs. “open”.
    - Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed
    - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed
    - Determine which observable pressure ulcer is most problematic
M1324: Stage Most Problematic Stageable Unhealed Pressure Ulcer

- Response options changed
  - 1 Stage 1
  - 2 Stage 2
  - 3 Stage 3
  - 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers

- Response Specific Instructions
  - Terminology referring to “healed” vs. “unhealed” ulcers
  - Determine which pressure ulcer(s) are stageable or unstageable.
  - Determine which stageable pressure ulcer is the most problematic.

M1322 & M1324

M1322: Surgical Wound
M1324: Status Surgical Wound

- Response Specific Instructions Changes (minor)
  - Deleted: Openings in the skin adjacent to the incision line caused by the removal of staples or sutures are not to be considered as part of the surgical wound
M1350: Does Patient Have Skin Lesion Receiving Intervention

- Item Intent only changed
  - Identifies the presence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.

M1501 & M1511: Symptoms in Heart Failure/Heart Failure Follow-up

- Item Intent
  - Wording from most recent OASIS to SOC/ROC assessment
- Item Number
- Skip Directions
- Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment.
M1501: Symptoms in Heart Failure Patient

- **Response Specific Instructions**
  - **Item details:** if patient has been diagnosed with heart failure
    - Enter Response 0, 1 or 2 (No, Yes, Not assessed) if diagnosis of heart failure, regardless of whether the diagnosis is documented elsewhere
    - Enter "NA" if the patient does not have a diagnosis of heart failure
    - If response “1 – Yes” to report symptoms associated with heart failure even if other co-morbidities that also could produce
  - Consider any new or ongoing heart failure symptoms (reported or observed) that occurred at the time of or at any time since the most recent SOC/ROC.

M1740 & M1745

- **M1740: Cognitive Behavior and Psychiatric Symptoms**
  - **Response Specific Instructions Added**
    - Behaviors reported could be identified by a formal diagnosis and/or determined by the assessing clinician to be associated with a significant neurological, developmental, behavioral and/or psychiatric disorder
  - **M1745: Frequency of Disruptive Behavior Symptoms**
    - **Response Specific Instructions Added**
      - Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders, identified either by diagnosis and/or based on the assessing clinician’s clinical judgment
• **M1820: Current Ability to Dress Lower**
  
  — **Response Specific Instructions**
  
  • Replaced “Pick” with “Enter”
  
  • In cases where a patient’s ability is different for various dressing lower body tasks, *enter the response that best describes the patient’s level of ability to perform the majority of dressing lower body tasks*
  
  • Deleted “underline” to “safety”
  
  • If the patient *requires standby assistance (a "spotter")* to dress safely or verbal cueing/reminders, enter Response 2

• **M1840: Toilet Transfer**
  
  — **Response Specific Instructions**
  
  • Removed underline “safely”
  
  • Added guidance to use in absence of a toilet in the home based on ability to use commode, bedpan, urinal

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**GG0170C: Mobility-Lying to Sitting on Side of Bed**

• **New Item**

• **New Impact Act Item**

• **Item Rationale**

  — Mobility limitations can adversely affect wound healing and increase risk for the development of pressure ulcers.

• **Includes**

  — Admission Performance
  
  — Discharge Goal

• **Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
### GG0170C: Mobility-Lying to Sitting on Side of Bed

- **Item Intent**
  - Identifies the patient’s need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **Code the patient’s usual performance at the SOC/ROC using the 6-point scale**
  - 06 = Independent performs without any human assistance
  - 01 = Dependent caregiver must provide ALL of the effort

### M1900: Prior functioning ADL/IADL

- **Format of Responses Changed**
- **Options Changed**
- **Text Same**
- **Response Specific Instructions**
  - For each functional area, Enter a response versus Select
M1900: Prior Functioning ADL/IADL

- Prior Functioning ADL/IADL
  - Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Enter Code

  - Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene
    Enter Code
    0 Independent
    1 Needed Some Help
    2 Dependent

M2001, M2003 & M2005

M2001: Drug Regimen Review
M2003: Medication Follow-up
M2005: Medication Intervention

- New Impact Act Item
- Item Number
- Item Text
- Response Options (except M2003)
- Dash is Valid
- Changed Description
M2001: Drug Regimen Review

• Item Response
  – 0 No - No issues found during review [Go to M2010 ]
  – 1 Yes - Issues found during review
  – 9 NA - Patient is not taking any medications [Go to M2040]

• Examples Taken Out of Item Stem
  • “Not Assessed” is No Longer an Option
  • Definitions added: Medication Interaction & Adverse Drug Reaction
  • Slight change in wording response options (“problems” to “issues”)
  • Intent: Removal of “This item captures information for calculation of a process measure to identify best practices related to medications.”
  • Extensive additions, revisions to Response Specific Instructions

M2003: Medication Follow-up

• Item Text
  – Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

• Item Intent
  – Identifies if potential clinically significant medication issues identified through a medication review were addressed with the physician (or physician-designee) by midnight of the next calendar day following their identification.
  – Removed reference to “calculate process measure..” language
**M2003: Medication Follow-up**

- **Definition Added: Contact with Physician**
  - Communication to physician or designee by phone, voicemail, electronic means, fax, other
  - Appropriately conveys message
  - Direct to/from physician or physician designee
  - Indirectly through physician’s office staff on behalf of physician/designee

- **Response Specific Instructions**
  - Extensive changes/additions
    - What, When to report
    - Response guidance based on physician recommendations

**M2005: Medication Intervention**

- **Item Number**
- **Item Intent**
  - Since previous assessment amended to previous SOC/ROC were addressed with the physician or physician designee
  - Removed “used to calculate process measures”

- **Item Text**
  - Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

- **Item Response**
  - 0 No
  - 1 Yes
  - 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- **Extensive additions, revisions to Response Specific Instructions**
M2016: Patient/Caregiver Drug Education Intervention

- Item Number
- Item Text
  - (Episode timing) Patient/Caregiver Drug Education
  - At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
- Response Specific Instructions Added
  - Drug education interventions for M2016 should address all medications the patient is taking, prescribed and over-the-counter, by any route
  - Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider

M2020 & M2030: Management of Oral & Injectable Medications

- Response Specific Instructions
- All “Select” responses changed to “enter” responses
- M2020
  - Only medications whose route of administration is p.o. should be considered for this item. Medications are considered to be p.o. if they are placed in the mouth and swallowed, with absorption occurring through the gastrointestinal system. Medications administered by other routes, including sublingual, buccal, swish and expectorate, or administered per gastrostomy (or other) tube are not to be considered for this item.
- M2020 & M2030 (added)
  - For a patient residing in an assisted living facility where the facility holds and administers medications, M2020 should continue to report the patient’s ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Report ability based on assessment of the patient’s vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, despite the facility’s requirement.
M2040: Prior Medication Management

- Item Text Change
  - Item options reformatted but text has not changed
- Enter code versus Check response
- Response Specific Response: change from “Select” to “Enter”

M2102: Types and Sources of Assistance

- Item Text Response: options reformatted but text not changed
  - Enter Code
- Response Specific Instructions
  - “Select” changed to “Enter”
  - Added “Non-agency” before caregiver as appropriate
M2200: Therapy Need

- Response Specific Instructions
  - “Report” and “Answer” changed to “Enter”
  - Deleted related CoP number (Possible final rule)
  - Deleted Underline to “are ordered”

M2301: Emergent Care

- Item Number
- Enter Code
- Item Text
  - Previous OASIS assessment to most recent SOC/ROC
  - Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
- Skip directions
- Response Specific Instructions
  - “Select” replace by “Enter”
M2310: Reason for Emergent Care

- Response Specific Instructions
  - Changed “does not address” to “excludes”
  - Deleted Doctor’s Office “scheduled less than 24 hours”

M2401: Intervention Synopsis

- Item Number
- Item Text
- Response Options
  - Changed wording from “previous OASIS assessment” to “most recent SOC/ROC assessment”
  - Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?
  - Change NA response column for rows b, c, d, and e from last OASIS to most recent SOC/ROC assessment
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