Treating Joint Replacement Patients Post PPS Revision

By Shannon Ericson & Jeremy Pain
January 2008 revisions to the Home Health Prospective Payment System (HH PPS) not only revised the payment system, but also caused therapists to consider “revising” the manner in which they provided care to their patients – including joint replacement patients. What changes occurred with the PPS Refinement for therapists to consider readjusting their practice?

**Outcome and Assessment Information Set**

OASIS changes included the addition of M0110 (Episode Timing), and the replacement of M0245 and M0825 with M0246 (Case Mix Diagnoses), and M0826 (Therapy Need), respectively. Question M0110 added a new variable in determining case-mix points for an episode of care. An early episode, defined as the first or second adjacent episodes, will not earn as many case-mix points as a late episode, defined as the third or later adjacent episode.

**Diagnostic Categories and Coding**

Case-mix diagnoses expanded from four to 20 diagnostic categories. Additional secondary (other) diagnoses are now considered to garner case-mix points. Home health coders can now code according to the Official Guidelines for Coding and Reporting. V-codes capture case-mix points.

**Therapy Threshold**

In addition, and quite possibly the biggest change to occur, was the change in the therapy threshold and how the number of therapy visits effect the patient’s Home Health Resource Group (HHRG) and Health Insurance Prospective Payment System (HIPPS) codes and therefore, the ultimate episode payment. From Diagram 1, you can see that the number of therapy visits not only determines the Service Utilization score of the HHRG, but also determines in which one of the four equations the episode falls, thus effecting the episode payment.

Since January 1, 2008, 10 or more therapy visits for an episode of care is no longer the absolute threshold for additional case-mix points. That threshold has been graduated so that payment more accurately reflects the cost of treating

### Diagram 1: Case Mix Scoring

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1st &amp; 2nd Episodes</th>
<th>3rd + Episodes</th>
<th>All Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-13 Therapy Visits</td>
<td>14-19 Therapy Visits</td>
<td>0-13 Therapy Visits</td>
</tr>
<tr>
<td>Equation used to calculate points:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Clinical (sum of points)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>0-4</td>
<td>0-6</td>
<td>0-2</td>
</tr>
<tr>
<td>C2</td>
<td>5-8</td>
<td>7-14</td>
<td>3-5</td>
</tr>
<tr>
<td>C3</td>
<td>9+</td>
<td>15+</td>
<td>6+</td>
</tr>
<tr>
<td>Functional (sum of points)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F1</td>
<td>0-5</td>
<td>0-6</td>
<td>0-8</td>
</tr>
<tr>
<td>F2</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>F3</td>
<td>7+</td>
<td>8+</td>
<td>10+</td>
</tr>
<tr>
<td>Service Utilization (number of therapy visits)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1</td>
<td>0-5</td>
<td>14-15</td>
<td>0-5</td>
</tr>
<tr>
<td>S2</td>
<td>6</td>
<td>16-17</td>
<td>6</td>
</tr>
<tr>
<td>S3</td>
<td>7-9</td>
<td>18-19</td>
<td>7-9</td>
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<tr>
<td>S4</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>S5</td>
<td>11-13</td>
<td>11-13</td>
<td></td>
</tr>
</tbody>
</table>
a patient. The number of therapy visits is now a more integrated variable in determining case-mix points for an episode of care.

**Anticipated and Preliminary Findings**

It has been uncertain what the results of this change in the therapy variable of payment would be since 10 therapy visits had been such a driver in payment prior to the revisions. It had been surmised that therapy visits would decrease at least initially, until therapists and agencies developed a confidence in how the number of therapy visits would effect payment and outcomes. At the time of this presentation, it was too early to determine any definitive pattern. But preliminary results showed that: 1) the percentage of episodes with 10+ therapy visits decreased from 44 percent in December 2007, to 39 percent in March 2008*; 2) episodes with 10-13 therapy visits could be worth an average of $686 less in 2008 than in 2007*; 3) proprietary agencies increased their percentage of episodes with 14-19 therapy visit from 11 percent in 2007 to 13 percent in 2008*; and 4) nonprofit agencies decreased their percentage of episodes with 14-19 therapy visits (from 9 percent in 2007 to 7 percent in 2008), but increased their percentage of episodes with 6-9 therapy visits (from 13 percent in 2007 to 23 percent in 2008).* Some of these predictions were realized early on, but it is still too early to determine the lasting affects.

**An Agency’s Care of Patients with Joint Replacements**

In particular, it is of interest to know how the care of total hip and total knee replacement patients might be affected under this revised payment system, and how care may affect patient outcomes. While it is impossible for an article of this scope to report on national trends in therapy practice and effects on patient outcomes, it is within the scope to describe the considerations and changes one home health agency has made in the early months of the HH PPS revision to continue to provide quality care while operating with a profit.

At Home Care, Inc. in Oneonta, New York, has provided therapy care to patients since 1987, and has an average daily census of 6-7 therapy visits per therapist. Approximately 40 percent of their therapy cases are total hip and total knee replacement patients.

*Source: Outcome Concept Systems (OCS)*

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As leadership at At Home Care has reviewed its treatment of total joint replacement patients, it has reviewed all aspects of the home health experience – from admission to discharge and points in between – to make the experience as productive and quality driven as possible.

**OASIS Accuracy**

Equipping therapists with the knowledge and skill to provide a thorough and accurate OASIS evaluation has become a renewed emphasis of the agency. With the use of the OASIS NP tool, they have retrained new as well as experienced therapists and nurses on the proper completion of the OASIS assessment. They are aware that it is imperative that total joint patient assessments reflect the amount of skill that will be required to treat the patient during the episode.

In many cases, a therapist will be the primary resource assigned to the patient and who will complete the OASIS assessment at all time points. But at times, the nurse will be the resource assigned to the patient who will perform the OASIS assessment at the start of care, and possibly at other time points during the episode. It is in the latter cases that it is essential that the therapist(s) and the nurse communicate their findings with one another in an effective and timely manner. It is the experience of the agency that therapists discover functional deficits more readily than nurses. And in the end, when patient deficits are not recognized and documented at the start of care, the initial payment will not be maximized and true patient outcomes will not be recognized.

Because the nurse must complete the initial OASIS assessment within five days of the start of care, it is the goal of the therapists to contact the nurse within this time frame to share their findings. They discuss any discrepancies from the functional portion of the assessment as well as in the estimated number of therapy visits for the episode. As the assessing clinician, the nurse must make the final decision. It is the intention of the agency that this added communication will, in the end, provide a more accurate assessment.

**Coding**

While clinicians, both therapists and nurses, determine the diagnoses for which they are treating the patient — through evaluation and communication with the physician — At Home Care has hired a professional coder to assist in
sequencing the diagnosis list. Collaboration is required between the coder and the clinician(s) to accurately describe the patient condition and maximize the case-mix points for which the patient qualifies.

**Care Planning**

Care planning of the patient is initiated at the beginning of care after the initial assessment, and is updated throughout the episode according to the patient’s condition. Therapists not only address active range of motion and muscle strength, but also how these gains affect the patient’s function. Balance, aerobic capacity, edema control, pain management, and safety are areas that are frequently addressed in the patient’s care plan. While a patient’s gait and transfer quality will likely be addressed, it is emphasized that functional gait and transfers also be addressed in the care plan. Incision healing and home exercise program independence are also frequently considered as areas to be addressed in the care plan.

**Documentation**

Never has it been so important for therapists to thoroughly document the skill that they provide with each visit as to justify current and ongoing care. As is typical with many home health therapists, At Home Care has found that their therapists do not credit themselves with the skill that they provide. When a therapist does not fully document his or her care and the patient’s response to that care, the documentation does not support the skilled need for the visit. So they use their chart audit tool as one way to restructure therapists in what elements are necessary for quality documentation. They also use standardized therapy assessments such as the Timed Up and Go (TUG), Functional Reach, and Tinetti Balance and Gait Evaluation to document objective changes in the patient’s condition which in turn, assists in providing documentation that supports a skilled visit.

**Discipline Utilization**

Since the implementation of the HH PPS revisions, At Home Care has noticed an increase in the number of visits loaded at the front of the episode for their total joint replacement patients. Especially with physical therapy, they have noticed that a total knee patient will progress from three visits per week to two visits per week by week number two. Overall, the average number of therapy visits performed during an episode of care for total joint replacement patients ranges from six to 10. This is a decrease of approximately two visits per episode over the past 11 months.

It is an ongoing goal of the agency to adequately and appropriately use the skills of occupational therapists and speech therapists in patient care plans. When a patient has memory deficits, they encourage the case manager to consider obtaining a referral for speech therapy to provide memory strategies. When a patient requires instruction in bathing and shower and tub transfers, they encourage occupational therapists to provide services rather than the home health aide. By utilizing the skill of the occupational therapist, the patient is receiving skilled instruction and presumably demonstrating better outcomes in these tasks. Home health aide services are still utilized in collaboration with the occupational therapist, thus providing continuity of care to the patient.

**Discharge**

Most total hip and knee patients are discharged within three to five weeks of admission. This compares with five weeks and six weeks, respectively, one to two years ago. Additionally, an increased number of patients are being discharged to an outpatient clinic where further therapy is provided for the patient to meet their maximum potential.

**Outcomes**

At Home Care has found that even though there are a decreased number of visits, overall reimbursement hasn’t decreased as much as expected. This is likely due to the increased number of case mixes and improved code sequencing and OASIS accuracy. Total joint patients have shown improved functional gains with a lower number of visits per episode.

**Conclusion**

Improved staff training and education about the PPS refinements has proven to be an invaluable tool for this CHHA. Improved skilled nursing and therapy team communication has allowed for more accurate care planning of our total joint clients. With continued review and education of code sequencing and OASIS accuracy, surviving in this new reimbursement system for total joints is attainable.

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