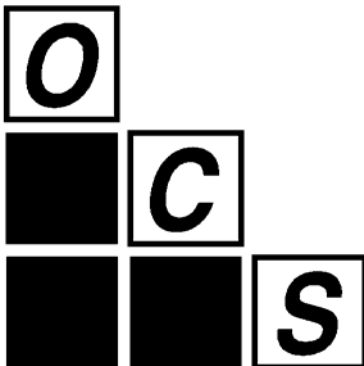


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**OCS' Clients PPS
Reference Handbook**



OUTCOME CONCEPT SYSTEMS®, INC

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Introduction

And then there was PPS...

As you may have noticed, there's been a small whirlwind of activity blowing through the Home Health industry. Yes, it's Prospective Payment System (PPS), and this fundamental change in reimbursement for Medicare patients has taken us all by storm.

The overhaul in the way that Medicare money is distributed is just one of the many changes that HHAs face under PPS. The overall mindset of the Home Health industry has shifted to focus on providing quality care with low resource expenditure. More tangibly, PPS has required changes to the OASIS data set and the assessment timing guidelines. All of these modifications translate to necessary changes in the way agencies manage their business, and as a result, they have additionally required changes in OCS' software and our client support.

This handbook is intended to be an **overview** of PPS, shedding light on questions like: What is PPS? How will it effect our clients? What software changes have resulted because of it? How can OCS help clients make an easy and successful transition? And what virtues of our product are even more beneficial to clients now that OASIS has become the driving factor behind Medicare reimbursement? Some information may be more interesting or pertinent than others. Use it as a reference if questions arise regarding PPS...

Prospective Payment System General Overview

Up until now, home health agencies have cared for their Medicare patients and then sent HCFA a bill for the cost of that care. The higher the cost of care, the more the agency was reimbursed. Patients with identical medical profiles (diagnosis, services and therapies required, level of functioning, etc.) could require dramatically different Medicare reimbursements, depending on which home health agency was caring for the patient.

The Home Health Prospective Payment System (HHPPS or just PPS) turns that system upside down and inside out.

Beginning October 1, 2000, Medicare will no longer reimburse agencies for the direct costs associated with a patient's care. Instead, Medicare will pay an agency a partial payment at the beginning of the episode of care, with full payment completed at the end of the episode, based upon the patient's anticipated resource needs.

To determine those anticipated needs, each patient will be scored at start of care (SOC) in three domains: clinical, functional, and service. The patient's status in each of those three domains will be evaluated by the answers to 20 OASIS (Outcome and ASsessment Information Set) questions. Those three status scores (clinical, functional and service) will be combined to place the patient in one of 80 Home Health Resource Groups (HHRGs).

The HHRG is used as a profile of a patient's clinical and functional needs, ultimately designed to help Medicare determine how much an agency will need to expend over 60 days (an episode) in order to care for that patient. Each HHRG is translated into a Case Weight. The Case Weight is multiplied by a base dollar amount and is paid to cover the costs of the anticipated resources needed for the patient's care based on the HHRG profile.

Now two separate agencies with patients who have identical profiles will receive the same amount of money from Medicare to care for those patients with one catch: the *wage index*. HCFA has taken into consideration that costs of care for identical patients in different parts of the country will vary according to salary differences. Therefore, part of the equation that determines final payment under PPS is the wage index for a given area.

The final figure that results from this master calculation is meant to cover all costs for a patient over a 60-day episode of care, including therapy, medical supplies, nursing services and personal care. The dollar amount is determined at the start of care, and because it is not earmarked for specific use, agencies can use the money as they see fit to care for the patient. The agency receives 60% of the entire reimbursement up-front, and the remaining 40% either when the patient is discharged or at the end of the 60-day episode, whichever comes first.

And then come the "what-ifs?"

What if the patient needs care for more than 60-days? If the patient is still on service when their 60-day episode comes to a close, the agency completes an OASIS recertification assessment. The recertification must be completed between days 56 and 60 of the first episode. It will be used to determine the patient's needs for the next 60 days of care, while simultaneously being used to generate a new HHRG and Case Weight for the patient. The only difference between the first and the second episode of care is that the agency will receive only 50% of the payment up-front. The remaining 50% will be paid when the patient is discharged or at the end of the episode. This process is repeated for as long as the patient is on service with the agency. HCFA expects that 70% of all patient cases will last for only one 60-day episode.

What if the patient's needs change during the episode, and the agency determines that it is going to cost more to care for the patient than first thought? If there is a change in the patient's status that was not anticipated in the original plan of care, then it is said that the patient has experienced a "significant change in condition" (SCIC). When a SCIC occurs, the agency completes a Follow Up Assessment (reason for assessment is 05, Other Follow Up). The data collected in this assessment is used to recalculate the patient's HHRG and Case Weight. The cost is pro-rated, based on when the change occurred during the episode. The agency will first receive a payment as determined by the original start of care assessment for the first part of the episode, followed by a payment based on the follow up assessment for the second part of the episode.

What if the patient's care only lasts 42 days? If the patient's care takes fewer than the 60 days allotted, then the agency still receives the full payment for the full 60-day episode. The exception to this rule is if the patient is discharged, but then readmitted into home care before the original 60 days are over. When this occurs the agency will receive a partial episode payment (PEP) for the first episode of care. The agency will receive a pro-rated portion of the full reimbursement of the short episode.

What if the patient's care lasts only a couple of days—does the agency still receive the full 60-day payment? If the patient requires fewer than 5 visits then the episode of care is considered a low utilization episode (LUPA). LUPA's are paid for on a per-visit basis.

In summary, agencies will now be paid a prospective dollar amount, which they are allowed to use as they see fit. It no longer means that more visits mean more revenue—they mean more cost. Because of this change, agencies will start to look at efficient and effective ways of caring for patients without spending more than necessary.

Tips and Tricks

The following ideas provide some suggested ways to help OCS' clients increase the efficiency of OASIS data collection under PPS, while simultaneously making it more accurate and less painful.

Using Reports to Increase OASIS Efficiency

The collection of OASIS assessments in a timely and accurate manner has never had such a material affect on your agency. The fact is that under PPS, the codes used to determine your reimbursement are derived directly from your OASIS assessments. This puts extra pressure on clinicians and agency staff to make sure that assessments are completed and corrected efficiently.

It is essential to establish agency-specific processes to effectively handle the completion and submission of OASIS assessments. In addition, reports can provide an objective tool to monitor, analyze, and improve your agency's performance in collecting and encoding OASIS data. The following few tips will help you started:

- Make sure that you are getting the most out of your OCS-OASIS Verification Report. This report clearly lists the OASIS questions that are causing errors, as well as the problems with the data that prevent the record from being locked. Use this report to alert clinicians to errors within their assessments and to clearly communicate what items need to be corrected.
- Occasionally review random Verification Reports to look for consistent errors.
 - ◆ Is there a question that data entry personnel frequently leave blank because it is "hidden" in your printed forms?
 - ◆ Are valid ICD-9 codes being used? Would your agency staff benefit from an in-service training on coding?
 - ◆ Are there certain questions that tend to trip-up clinicians? Why do they cause more problems than other questions? Is it something that can be addressed with cross-discipline training?
- Use the OCS-OASIS Recert Reminder Report to keep on top of patient recertifications that need to be completed. Remember that these assessments impact your agency's revenue almost as much as start of care assessments. The Recert Reminder Report contains all the necessary information to help your administrative and clinical staff schedule visits for completing recertification assessments.
- Run the Unverified Assessment Report on a daily basis to see which assessments within your software are not yet locked. This will help to stay on top of unverified assessments and make sure that they get corrected quickly. Sort the report by "due lock date" to list the assessments that are closest to being out of compliance at the top of the report.
- The Unverified Assessment Report can also help you keep an eye out for consistent problems. For example: Are the majority of the errors unanswered questions or are they logical errors? Do some clinicians seem to have assessments appearing more frequently on this report than others?

OASIS Changes

The implementation of PPS for home health means that payments for Medicare (traditional fee-for-service) patients will be determined by the answers to 20 questions in the OASIS assessment. The anticipated payment for the episode of care will be calculated at start of care, recertification, and when the patient experiences a significant change in condition (SCIC). An OASIS assessment is collected at those points in care, and, based on that assessment, an HHRG is calculated. Next, the anticipated resource use and dollar cost is determined according to the data in the assessment.

Several changes, which are outlined in detail below, have been made to the OASIS data set, which will accommodate the need to use the assessments to generate the HHRGs. Revisions include text changes to the questions, a new question added to the data set, and a few other modifications. Agencies will need to modify their OASIS forms in order to meet these requirements. And, of course, along with a change in forms, comes the obligatory change in software.

The new version of OCS-OASIS (2.6.102) includes the necessary changes to the OASIS assessments.

New Question

A new question was added to the OASIS data set. This new question will be used to determine if the patient falls into the “high therapy” category. A patient who is expected to have a high therapy need will have a much higher rate of payment.

The new question is numbered M0825, and it is to be included in assessments used at Start of Care, Resumption of Care, Recertification, and Follow Up. The text of the question reads:

(M0825) Therapy Need: Does the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

0 – No

1 – Yes

NA – Not applicable

Question Metamorphosis

The question regarding the patient’s recent discharge from an inpatient facility, M0170, has been discontinued and replaced with an only slightly different version of the same question numbered M0175. The difference between the two question is in the answer options. M0170 has one answer option for patients who have been discharged from a nursing home; M0175 breaks the choices down to Skilled Nursing Facility and Other Nursing Home.

This question will be included in the Start of Care, Resumption of Care, Recertification and Follow Up assessments. The question and answer text reads:

(M0175) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply)**

0 – Hospital

1 – Rehabilitation Facility

2 – Skilled nursing facility

4 – Other nursing home

5 – Other (specify) _____

NA – Patient was not discharged from an inpatient facility **[If NA, go to M0200]**

Expanded Question Locations

There are three questions that, until now, have only been used on Start of Care and Resumption of Care assessments. But they are questions that are used to determine the HHRG and Case Weight not only at SOC and ROC, but also at recertification and follow up. Now those three questions, M0230—Primary Diagnosis, M0240—Secondary Diagnosis, and M0390—Vision, can be found both on the two follow up assessments in addition to their original locations.

Until now the question regarding the payment source for the patient's care, M0150, has been found on all assessments other than the two transfer assessments, the death assessment and the assessment for a patient discharged with no further visits after start of care. In order to more easily and accurately implement the masking of private pay data on all assessment types, and in order to effectively track a patient's payment source across the entire episode of care, this question is now included in all assessment types.

Expanded Answer Locations

The question M0220, regarding conditions prior to medical or treatment regimen change or inpatient stay, had different answer options depending on the type of assessment in the 1098 version of the OASIS data set. For the 0800 version, the answer options NA and UK have been added to the recertification and follow up assessments.

Text Changes

The question M0550, regarding a patient's ostomy, has been changed on all assessment types. These are text changes only. The new text reads:

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

0 - Patient does not have an ostomy for bowel elimination.

1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.

2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Recertification Timing

Under the former OASIS regulations, recertifications were required at two-month intervals. A patient who is admitted on the fifteenth of May, for example, was required to have a recertification completed no later than the fifteenth of July. An agency has a five day window prior to (and including) the recertification date to complete the assessment.

With the new OASIS regulations under PPS, recertifications are due every 60 days. The 5-day window is still the allowed time frame for completing the paperwork. The example admission date of May 15 will now translate to a recertification date of July 14.

When to Use Which Assessments

In the big scheme of things, the use of various assessment types has not changed very much. However, there are a few circumstances in which things have changed and in which using the proper assessment type becomes very important.

Under the new version of OASIS, those requirements still stand, unless a ROC is accompanied by a significant change in condition. If a resumption of care occurs during the recertification window, and the patient experienced a significant change in condition, then the agency must complete **both** a ROC assessment and a Recertification assessment. The below chart lists the various situations and the appropriate assessments to use at each time.

Point in Care	Assessment type to be completed
Recertification	Recertification (RFA 04)
Resumption of Care after inpatient stay (ROC)	ROC (RFA 03)
Significant Change in Condition (SCIC)	Other Follow Up (RFA 05)
ROC during the recert window	ROC (RFA 03)
ROC accompanied by a SCIC	ROC (RFA 03)
ROC during the recert window accompanied by a SCIC	ROC (RFA 03) and Recertification (RFA 04)

New Verifications

As you know, OCS has updated the OCS-OASIS software to be compliant with the new rules and data set in place for the home health Prospective Payment System. As part of the update, you will see changes to the way in which OASIS data is collected, in addition to enhancements to the data entry module and new reporting features. In addition to the above, there are also a few enhancements that are not so visible. For example, we have added new verifications to improve data integrity and prevent inaccuracies in the OASIS data which ultimately drives our clients' Medicare payments.

Most of the new verifications are to be expected and will likely slip by unnoticed (i.e. requiring the newly added questions to be answered). Some verifications were user requested, and very subtle, (i.e. not allowing spaces or dashes in the patient Medicare numbers). However, two of the new verifications are significant enough, and different enough, that they are worth mentioning individually. The following describes in more detail:

New verification #1: Diagnosis codes

When HCFA originally announced which primary diagnosis codes would determine point values in the clinical dimension of the PPS scoring, it was pointed out by an observant agency or two that they had listed codes that are not considered valid as primary diagnoses. So, the list changed and the diagnosis scoring was changed to give points for some secondary diagnoses. At the same time, a list of invalid codes, which would lead to a number in the HIPPS code indicating invalid clinical data, was produced.

In order to avoid our clients having to submit invalid data or incomplete HIPPS codes due to "bad" diagnosis codes, OCS built in primary diagnosis and secondary diagnosis verifications that check the validity of the ICD-9 codes entered into the software. These verifications will make sure that all primary diagnoses entered are valid as primary and that full codes are used when required.

This could pose a problem when it comes to verifying assessments and fixing invalid codes for any agency that is not stringent about coding accuracy. Invalid codes are not especially common: in our benchmark database warehouse less than 1% of 175,000 SOC diagnoses were invalid. However, less than 30% of the SOC assessments in that same set of data were worth clinical points under PPS.

The moral of the story? This may be a good time for clients to review the ICD-9-CM coding guidelines to make sure that they are using the most accurate codes.

The new diagnosis verifications will look like this:

- ◆ M0230 Primary diagnosis entered (M0230) is not a valid primary diagnosis code. This ICD-9 can only be used as a secondary diagnosis code.
- ◆ M0230 Primary Diagnosis (M0230) is incomplete; this ICD-9 is a diagnosis code requiring a fourth and/or fifth digit.
- ◆ M0230 Primary Diagnosis (M0230) is incomplete; this ICD-9 is a diagnosis code requiring a fifth digit.
- ◆ M0230 Primary diagnosis entered (M0230) is not a valid primary diagnosis code and is not complete. This ICD-9 can only be used as a secondary diagnosis code and requires a fourth and/or fifth digit.
- ◆ M0240 Secondary Diagnosis (M0240-1) is incomplete; this ICD-9 is a diagnosis code requiring a fourth and/or fifth digit.
- ◆ M0240 Secondary Diagnosis (M0240-1) is incomplete; this ICD-9 is a diagnosis code requiring a fifth digit.

New verification #2:

A new question added to the OASIS data set for PPS is M0825, the question regarding a patient's need for therapy. The question text reads:

(M0825) Therapy Need: Does the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

A new verification has been added to this question to ensure that the correct answer option is being selected based off of the patient's payment source.

The therapy question must be answered "yes" or "no" for Medicare patients in order to determine the HHRG and Case Weight for that patient's episode of care. In the new version of OCS-OASIS, this rule is enforced with a verification check. If the answer to M0150 (payment source) is 1 – Medicare, traditional fee-for-service, and the answer to M0825 is NA, then a verification error will result and the assessment will not lock.

There is only one exception: if the reason for assessment is resumption of care after an inpatient stay and there has been no significant change in condition, then the appropriate answer to M0825 for a Medicare patient is NA. If the payment source is Medicare, the assessment type is 03, ROC, and M0825 is answered NA, then a warning message will be produced by the OCS verifications. The warning will not prevent the assessment from locking, but it will notify the user that if the patient experienced a SCIC, then the answer to M0825 needs to be yes or no in order for the payment to be modified accordingly.

On the other hand, if the payment source is not Medicare—traditional fee-for-service, then the only valid response to M0825 at any point in care is NA. M0825 refers specifically to the **Medicare payment period** and the **Medicare therapy threshold**. As such, the question is only applicable to Medicare patients. The valid answer to the question for any non-Medicare patient is NA—Not Applicable. Any other answer will produce a verification error and will prevent the assessment from locking.

This verification also serves as a safety net, ensuring that agencies enter the accurate payment source into the assessment. The HIPPS code submitted as part of the RAP (Request for Anticipated Payment) will be compared to the HIPPS code generated by analyzing the raw OASIS data submitted to the state. If the payment source is not marked as Medicare, then there exists some risk that the assessment will not be submitted to the state correctly. This could result in payment problems down the line.

HIPPS Code and OASIS Claim Matching Key

We all know that select pieces of information from the OASIS data set will be used to determine a patient's anticipated resource use throughout an episode of care. That determination is based on how sick they are **clinically**, their level of **functioning**, and what type of **services** they both required in the past and will need in the future. Based on the patients' scores in each of these three domains, they will be assigned to resource groups (HHRGs) with corresponding Case Weights. This information will ultimately be used to determine the anticipated payment for the episode of care.

But how exactly does all of this work with billing? It's all connected together through the HIPPS code and OASIS Claim Matching Key. These two fields, generated in the OASIS software, are entered into the billing software and used in the request for anticipated payment (RAP) to tell the fiscal intermediary how much money the agency will receive for that patient.

HIPPS Code

The HIPPS Code is simply a five-character representation of the HHRG/Case Weight and the quality of the OASIS assessment used to calculate the HHRG. The first character of the code is always the letter "H," characters 2, 3 and 4 relate to the clinical, functional and service scores, respectively and the fifth character speaks to the integrity of the OASIS data.

The chart, Fig. 1, is used to translate the HHRG into the appropriate HIPPS code. The next chart, Fig. 2, demonstrates how the fifth character is determined.

Example:

An assessment with an HHRG of C2F3S1 and no invalid data would have a HIPPS code of HCHK1.

Fig. 1

Character	HHRG Value	HIPPS Value
2	C0	A
	C1	B
	C2	C
	C3	D
3	F0	E
	F1	F
	F2	G
	F3	H
	F4	I
4	S0	J
	S1	K
	S2	L
	S3	M

Fig. 2

Fifth Character Value	Represents
1	No incomplete or invalid data
2	Invalid data, clinical domain
3	Invalid data, functional domain
4	Invalid data, service domain
5	Invalid data, clinical and functional domains
6	Invalid data, functional and service domains
7	Invalid data, clinical and service domains
8	Invalid data, all three domains

The Fifth Character

The “fifth character”, the numeric code that exists to indicate incomplete or invalid data, has caused a stir in the industry. This code has inspired articles with titles such as “PPS instructions to MIS vendors reveal 8 red flags that could trigger review” ([...home health line](#)) and “New PPS Coding Forces HHAs to Report Own OASIS Errors” ([Eli’s Home Care Week](#)). It has been called a “HCFA ‘big-brother’ tactic” and some publications have led readers to believe that it might have an impact on the payment they receive under PPS.

The Truth: Whether the code might trigger a medical review or audit remains to be seen. For now it is known that the last digit of the HIPPS code will not impact an agency’s payment. Payment is determined by the Case Weight for a patient’s assessment, which is dependent upon the HHRG, and therefore not affected by the HIPPS code fifth digit. Because the fifth digit indicates incomplete diagnosis codes, illogical answers or unanswered questions, however, the number at the end of the HIPPS code may indicate that there are problems with the data. Problems with the data could have an impact on the HHRG calculation, and therefore could in turn impact Case Weight and payment.

Example:

The following two cases demonstrate how the invalid data could, or could not, impact payment.

Case 1:

Primary diagnosis for a patient is 320.0 but it was incorrectly entered into the OASIS software as 320. The ICD-9 code 320 is invalid, because it requires a fourth or fifth digit by ICD-9 CM coding rules. No clinical points are given for the diagnosis. The number 2 is added to the end of the HIPPS code to indicate invalid clinical data.

If the code had been entered correctly as 320.0, then 20 points would have been assigned to the clinical score for the assessment (for a neurological primary diagnosis) and the clinical domain would have been one or two levels higher for the assessment guaranteeing a higher Case Weight.

Case 2:

It is not anticipated that the patient will need more than ten hours of therapy. Instead of answering the therapy question (M0825) no, it is accidentally left blank. No points are added to the service domain for therapy and the last digit of the HIPPS code becomes 4 to indicate invalid service domain data.

If the therapy question had been answered “no,” the last digit of the HIPPS code would have been a 1, but there would be no change in the HHRG, case weight or amount of payment.

The fifth digit of the HIPPS code currently alerts an agency to problems within their data that may negatively impact their payment. Instead of waiting to present errors in the form of an ambiguous number at the end of the HIPPS code, OCS has developed checks within the OCS-OASIS verification process that will not allow agencies to lock invalid data into an assessment. If any incomplete or invalid data is entered into the OCS-OASIS software, a verification error and report will be produced and the record will not be locked. Only locked assessments will be assigned an HHRG, Case Weight and HIPPS code. This quality check ensures that our clients have the most

accurate OASIS data possible, which ultimately helps our clients receive appropriate reimbursement under PPS.

OASIS Claim Matching Key

The OASIS Claim Matching Key identifies which one of a patient's assessments was used to calculate the corresponding HHRG, Case Weight and HIPPS code. It is a combination of the patient's start of care date, the date the assessment was completed, and the type of assessment in the form: YYYYMMDDYYYYMMDD99.

Example

The OASIS Claim Matching key for a recertification assessment (RFA 04) completed on 11/15/2000 on a patient who has a start of care of 9/17/00 would read 200009172000111504.

How the HIPPS Code and OASIS Claim Matching Key are used

The HIPPS Code and OASIS Claim Matching Key are included in the request for anticipated payment (RAP), which determines Medicare billing under PPS. The HIPPS Code is submitted as the representation of the HHRG, Case Weight and ultimately the payment amount. When a Medicare OASIS assessment is submitted to the state with a HIPPS Code, HCFA's software will use the data in the record to recalculate the HIPPS Code and validate its accuracy. If the code submitted in the export file and HCFA's version don't match, a warning error message is produced. The OASIS Claim Matching Key is used to match up the HIPPS Code that is submitted in the RAP to the HIPPS Code generated by HCFA's software for the same assessment to confirm that the code on the RAP is correct.

Timeliness, One Client's Experience . . .

As if there aren't enough pressures and paperwork for home health clinicians already, starting October 1, clinicians must also face the fact that their OASIS assessments will now directly drive Medicare payment. A request for payment cannot be generated and submitted with a patient's HIPPS code, and the HIPPS code can't be generated without the complete set of OASIS data. Now more than ever, getting assessments collected and entered on time must be a primary focus of an agency and its administrative staff.

Debra Campbell of Angel Home Health and Hospice in Franklin, North Carolina, recently learned that her agency's rate of late lock dates on OASIS assessments is around 3%. This was very exciting news, especially considering that the national average is around 16%. That's no small accomplishment, considering that Angel Home Health and Hospice is an agency that completes somewhere in the neighborhood of 75,000 visits per year.

What is their secret? How do they keep up with everything? Debra shared their process and policies to help other agencies get control of late locking assessments.

- Clinicians have had in-service training to improve the quality of data collection and minimize errors
- All assessments are dropped off in a central location— an "assessment drop box"
- Data entry personnel empty drop boxes several times a day
- Data is promptly entered into the OCS-OASIS software
- When errors occur upon verifying the assessment, verification reports are generated and placed with the original assessment in clinicians' boxes
- On a daily basis, clinicians pick up error reports and drop off newly completed assessments
- Clinicians are responsible for quickly correcting errors and returning both the original assessment and the verification report with corrected items checked off

Debra claims to have no great insight or special secrets. She believes that the key to success is setting forth the expectation that clinicians will complete their assessments quickly. In her own words, "they just know that they have to do it." And they do.

Other ideas for accurate and timely OASIS assessment completion:

- Set clear expectations early
- Educate clinicians about the importance of OASIS assessments and how they drive payment—late and incomplete assessments are a detriment to the agency's success.
- Consider tying accuracy and/or timeliness to pay, bonuses or performance review
- Review your assessment forms for areas that are unclear. Forms will need to be redone to accommodate the new OASIS format anyway. Take this opportunity to evaluate how well the forms currently work and identify what could be changed to make them easier to complete. Are clinicians consistently missing one or two questions? Are those questions "hiding" within the documentation?

Transition Timing

Day by day the implementation date for PPS draws closer and the “to do list” does not seem to shrink proportionally. After all the forecasting, education and preparation, it comes down to transitioning to PPS by implementing new assessment forms, installing new software and changing the way agencies bill Medicare. The timing of this transition will pose many challenges, making advance planning and preparation essential.

The goal of the information included below is designed to serve several purposes: to ensure that you are aware of the transition challenges you will face over the next several weeks; to explain how the OCS-OASIS software update fits into the process; to clear up confusion on timelines; and to provide some recommendations on the best way to go about implementation. The primary focus is on minimizing both the amount of necessary work and the room for error.

Regulatory Requirements: OASIS Data Set

PPS begins for all Medicare certified home health agencies October 1, 2000. In order to prepare for that date, changes are being made to the way in which information is collected. The OASIS data set has been revised by HCFA to contain all of the information necessary to determine which of the 80 home health resource groups each patient falls into at start of care, resumption of care, recertification, or when the patient has a significant change in condition. This revised version of the data set does not have a set “start date;” instead, HCFA has set up a one-month time frame for agencies to shift from the old version of the assessments to the new version.

The new version, OASIS B-1 (0800), **must** be used for all patients at all points in care starting October 1. On the other hand the new version of OASIS **may not** be used prior to September 1—the older version must be used for all August assessments. During the month of September, **either** version of the data set may be used.

Overview

Assessment M0090 Date	Version of OASIS to be used
August 1-August 31	Old version (1098)
September 1-September 30	Either version
October 1 and after	New version (0800)

Regulatory Requirements: PPS Transition Timing

All patients who are admitted prior to the implementation of PPS and who will continue to be on service after the implementation date must have a Start of Care or follow up OASIS assessment completed in the new version sometime during the month of September. This is required to obtain the HHRGs and Case Weights necessary for determining the appropriate payment for services provided after October 1. All of the rules and scenarios listed below apply only to patients whose care will span this transition time.

For all patients admitted during the month of September, the easiest and most efficient way to meet this regulation is to do the patient’s Start of Care assessment in the new format. That way the requirement is met and no additional work is necessary. Likewise, the requirement is easily met for patients with a recertification assessment due during the month of September by simply completing that recertification in the new OASIS format.

For patients with a recertification due during the month of October, it is best to complete a recertification assessment in the new format during the month of September for meeting the PPS requirement.

When a patient has a start of care or recertification assessment completed in the old format during the month of September, a follow up must **also** be completed in the new format prior to October 1. It is easy to see the benefit to early training and implementation of the new data set. Using the new assessments starting very early in September means eliminating the need to “re-do” patient assessments and go through a great deal of extra work to get these patients “PPS certified.”

Overview

Recertification Timing	Version of OASIS to be used
Patient admitted during September	SOC assessment done in new version
Patient is due to be recertified during September	Recertification OASIS assessment done in new version
Patient is due to be recertified during October	Recertification assessment done in new version sometime in September in replacement of the October assessment
Old version OASIS SOC or recert completed in September	One time additional OASIS follow up in the new version sometime in September

Regulatory Requirements: Special Rules

There are a couple of other special rules to keep in mind for the patients whose care begins prior to October 1 and continues after.

The first is regarding the *next* recertification date—the one that will come around if the patients’ services continue through October and November. Despite the fact that the pre-PPS start of care or recertification assessment in the new format will be completed some time during the month of September, the new recertification window for **all** of these patients will be the 24th through the 29th of November. This is the same as the 60-day recertification window for an episode of care starting on October 1.

HCFA is calling this a one-time “grace period” when a patient’s certification period may last up to 90 days (this would apply for a patient admitted or recertified on September 1 and then not recertified again until November 29). It is interesting to note that this 5-day window also happens to be the Saturday through Wednesday after Thanksgiving. If you care for a large number of long-term patients you may want to start planning for a crunch time.

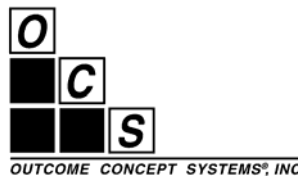
The second special rule is that the physician plan of care for the start of care or recertification assessment completed during the month of September must specify the difference between the services to be provided prior to October 1 and after October 1. This will be used in the separation of payments between pre-PPS reimbursement and PPS payment.

Recommendations

Due to the changes in the OASIS data set and the strict timelines HHAs are up against, it is essential to plan ahead for this difficult transition period. The agencies that make it through the transition time with the least amount of duplicated effort and the fewest mistakes will be off to a good start under PPS. Evaluate resources available to you, create a plan to work with those resources, make sure that all key players understand and are prepared to work with the plan, and then stick to it.

About Outcome Concept Systems

Outcome Concept Systems, Inc (OCS) is the pioneer in home care outcomes and benchmarking. OCS produces clinical documentation and software technologies to assess and quantify the effects--or outcomes--of home health services. OCS provides agencies with the tools they need to capture and graph outcome information, while allowing them to assess the costs associated with the outcomes achieved. OCS also owns the nation's largest and most comprehensive home health benchmark database, with more than 600 agencies actively submitting data. OCS' clients are given access to this database, in order to benchmark their agency's outcomes against system, state, regional and national norms. OCS' performance measurement systems have met all initial requirements for approval by the JCAHO.



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