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OASIS Alert

Compliance: Prior Stay Inaccuracies Are Coming Back To Cost Agencies

HHAs struggle to find answers.

More money soon will be flowing out of agencies' pockets and back to the government.

The **HHS Office of Inspector General** hasn't yet concluded its series of reports on M0175 inaccuracies, resulting from a nationwide audit on the issue. But CMS decreed Oct. 24 that HHAs will have to pay back money they received for patient episodes in which a hospital stay wasn't marked when it should have been.

OIG reports on the issue indicate "the Medicare program is vulnerable to make excess payments on HH PPS claims when certain OASIS assessment information is reported in error," the **Centers for Medicare & Medicaid Services** says in the transmittal.

M0175 asks if a patient has been discharged from a hospital, rehab facility, skilled nursing facility or other nursing home within 14 days of the start or resumption of care. The patient earns zero points if she had a hospital stay, one point if she did NOT have a hospital stay, and two points if she had a rehab or SNF stay.

By 14 days, the feds mean the 14 days immediately preceding the date of the assessment for start of care, resumption of care or first day of a new certification period, CMS instructs in Chapter 8 of the OASIS Implementation Manual. Count the day of the home health assessment as zero, the previous day as one and so on, instructs fiscal intermediary **Cahaba GBA** in its Web questions and answers.

The only reimbursement impact comes if the patient had no hospital stay and also had a rehab or SNF stay, explains consultant **Laura Gramenelles** with Hamden, CT-based **Simione Consultants**. You can add the no-hospital-stay point to the two points for a SNF or rehab stay and have three points in the service category of the home health resource group (see OASIS Alert, Vol. 4, No. 3, p. 28).

When agencies fail to report a hospital stay while at the same time reporting a skilled nursing facility or rehabilitation facility stay in M0175, it can bump the episode's health insurance prospective payment system (HIPPS) code up to a higher-paying "K" or "M" in the fourth position - a difference of about $200 and $600 per episode, respectively. If agencies record the SNF or rehab stay AND the hospital stay, they don't see the increase.

The OIG believes HHAs inappropriately have collected more than $25 million by omitting a hospital stay when claiming a rehab or SNF stay for a patient, the **National Association for Home Care & Hospice** reports.

Edits Will Catch Most Errors

Meanwhile, CMS has instructed intermediaries to put in place new pre- and post-payment edits that will check whether home health agencies correctly identify an inpatient hospital stay in the 14 days, according to an Oct. 24 instruction from the agency (Transmittal No. 13).

Three new edits will take effect April 1:

1. **Pre-payment RAPs.** When requests for anticipated payment come in with a "K" or "M" in the HIPPS code, the claims payment system automatically will check the patient's claims history for an inpatient hospital stay within 14 days of admission to home care. If it finds one, the system will return the RAP to the provider, so the agency can correct and resubmit it.

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2. **Pre-payment final claims.** When a final claim comes in with a "K" or "M" in the HIPPS code, the system again will check it against the patient's claims history for an inpatient stay. If one has shown up since the RAP check, the system automatically will adjust the claim to the lower-paying HIPPS code using an "L" or "J," respectively.

3. **Post-payment claims.** Because hospitals have up to 27 months to submit and be paid for their claims, CMS annually will analyze its National Claims History file to ferret out claims that were paid at the higher, no-hospital stay rate, but whose patients eventually did end up with a hospital stay recorded during the 14-day time period. The intermediaries then will recoup the money for those claims retroactively.

CMS May Help Agencies Find Errors in Their Favor

Since the crucial information is already available to the government, "an analysis should be carried out on the impact of incorrect responses to M0175 that resulted in lower payment to home health agencies, as well as those resulting in higher payment," NAHC insists. CMS is considering upcoding a claim if the agency's mistake is in the government's favor, CMS Administrator **Tom Scully** remarked in the Nov.5 Open Door Forum for home care providers, in response to repeated requests by **Bob Wardwell** with the **Visiting Nurse Associations of America**.

Even though the feds have more information than you do, they expect you to uncover the hidden institutional stays to answer M0175. "Clinicians should make every reasonable attempt to obtain and report accurate data on the type of facilities and the dates of beneficiary discharge within the 14 days preceding the [home health agency] episode," the OIG says in its report on M0175.

Although CMS expects M0175 recoupments to be only about one-tenth the size of the partial episode payment (PEP) funds also being recouped now, the takebacks are likely to rankle HHAs more than PEPs, Wardwell suspects. In most cases, agencies have put forth "honest efforts" to collect accurate hospital stay information to the best of their abilities.

Many agencies don't take into account that some hospitals have beds designated for different purposes - acute stay, SNF and rehab among them, notes consultant **Rose Kimball** with **Med-Care Administrative Services** in Dallas. And they often are operating under the misapprehension that they are supposed to check only one answer under M0175, instead of all that apply.

HHA staff often mark only the most recently concluded stay, instead of the hospital stay and a following stay in a SNF or rehab facility, Kimball adds. That's where overpayments often occur.

Editor's Note: The transmittal is at www.cms.gov/manuals/pm_trans/R13CP.pdf.

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