OASIS Alert

Industry Notes

Missing OASIS Means Missing Out on Reimbursement

Missing OASIS assessments might be more common than you think and will torpedo your claims.

In edits of low case mix claims by HHH Medicare Administrative Contractor **NHIC**, one of the common reasons for denial was "Outcome and Assessment Information Set (OASIS) was not documented," NHIC says on its website. "The OASIS is required to be submitted to the state repository," NHIC explains.

This is an issue that Recovery Audit Contractors also are focusing on, reports **Judy Adams** with **Adams Home Care Consulting** in Ashville, N.C. RAC interest in this area is "relatively new," Adams notes.

Region C RAC **Connolly Inc.** listed "OASIS not completed timely" as an approved issue on its website last November. This issue seems bizarre, experts agree. Adams hasn't come across this problem much. Perhaps "the HHAs are just not transmitting the OASIS timely and the claim is being submitted before the OASIS is in the system," Adams guesses.

But maybe the problem is just that reviewers aren't matching up the correct claims and OASIS, NHIC implies. "When submitting records for Medical Review, consider including the OASIS transmission record or tracking sheet," the MAC tells providers. "This assists the reviewer in accessing the OASIS record for the appropriate claim."

Don't Jump to Conclusions with ICD-10 Typo

Relax: You may have read in a newly revised MLN Matters article that ICD-10 is taking effect this Oct. 1, but that's not the case.

Wrong info: "You must include International Classification of Diseases, 10th Edition (**ICD-10**) codes on 33x Type of Bills (TOB) that you submit with Dates of Service/Discharge on or after October 1, 2013," CMS says in MM7704.

Right info: "The ICD-10 implementation date within the MM7704 article was not updated and appears incorrectly as October 1, 2013," explains HHH MAC **CGS** on its website. Watch for a corrected version of the article to appear soon. Meanwhile, the incorrect version is at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7704.pdf.

Get the Latest from CMS on 'Improvement Standard' and Coverage

Medicare contractors who have used the so called "improvement standard" to deny home health and other post-acute claims are on notice to stop, thanks to a new fact sheet issued by the **Centers for Medicare & Medicaid Services**.

"The Medicare statute and regulations have never supported the imposition of an 'Improvement Standard' rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition," CMS says in the sheet. "A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage."

Bottom line: "Coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves," CMS says.

CMS has issued the fact sheet after settling a lawsuit over the issue, Jimmo v. Sebelius. The sheet doesn't expand

coverage, but merely clarifies existing coverage policies, the agency maintains.

Spreading the word: CMS plans to issue updated program manual language, new transmittals and MLN Matters articles, and other materials, it says. CMS will complete the manual revisions and educational campaign by next January. CMS also will review a random sample of HHA, skilled nursing facility, and outpatient therapy coverage decisions "to determine overall trends and identify any problems," it says. It also will review "individual claims determinations that may not have been made in accordance with the principles set forth in the settlement agreement."

The fact sheet is at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf.

Get Your Claim Dates Straight for ICD-10

Not sure how to handle diagnosis codes on claims that span the Oct. 1, 2014 implementation date? The **Centers for Medicare & Medicaid Services** has spelled it out for you in a newly revised MLN Matters article.

Claims with both ICD-9 and ICD-10 claims submitted for dates of service on after Oct. 1, 2014, will be returned as unprocessable and you'll receive no reimbursement for them. Therefore, report only the ICD-10 code(s) after Oct. 1, 2014, says MLN Matters article MM7492.

MACs will use the "through" date on final home health claims to determine whether an ICD-9 or ICD-10 code is required, CMS says. But agencies may find coding instructions rather confusing for claims that straddle Oct. 1. For home health final claims, "allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes," CMS tells the MACs.

Requests for anticipated payment (RAPs) "can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported," the article says.

"Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013."

Home health outpatient claims for Part B services like therapy will split claims based on date of service, with ICD-9 codes on claims with dates of service through Sept. 30 and ICD-10 codes for claims Oct. 1 and later.

Also: Be ready to make the transition swiftly when it's time to switch to ICD-10. CMS will not allow a grace period after Oct. 1.

The article is online at
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7492.pdf.

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