OASIS Alert

Industry Notes: CMS CLARIFIES ITS VIEW OF PATIENT IMPROVEMENT

The **Centers for Medicare & Medicaid Services** doesnt distinguish between patients who improve slightly under a home health agencys care and those who improve by leaps and bounds when it comes to outcome-based quality improvement.

Thats the word from a recent question-and-answer set CMS posted to its OASIS Web site. "A patient improves when the scale value for the particular health attribute being measured indicates less impairment at discharge than at start (or resumption) of care," the Q&A says.

This definition applies to all kinds of conditions, CMS notes, and "whether a patient improves one level on the scale, two levels, or more does not matter all these situations would be measured as improvement."

The Q&A also clarifies that CMS looks at and computes improvement and stabilization measures separately, the OBQI process will not replace the current quality and utilization review requirement under the Medicare conditions of participation, and surveyors do not have the authority to ding agencies for choosing target outcomes they wouldnt have chosen.

Also, CMS warns agencies to use aggregate data only when engaging in marketing efforts based on OBQI data. Using patient identifiable information equals a major breach of privacy.

The Q&A is at www.hcfa.gov/medicaid/oasis/hhqcat15.htm.

As long as your diagnosis codes dont affect reimbursement, CMS takes a pretty relaxed approach to them, according to the revised Home Health Agency Manual. HHAs must be careful to match the primary diagnosis code on the plan of care, OASIS and reimbursement claim exactly, CMS says. If agencies use a manifestation code in accordance with ICD-9 coding guidelines, then they must be careful to match the primary and secondary codes, since they both could set the payment levels.

"Beyond these guidelines, Medicare does not require that the sequence of the codes on the three forms must be identical," CMS notes. This move might be part of CMS effort to appear more provider-friendly, observers speculate.

The revised manual is at www.hcfa.gov/pubforms/transmit/transmittals/comm_date_ dsc.htm. For more information, see Elis HCW, Vol. XI, No. 13, p. 104.

HHAs now have another resource at their fingertips to help them stay on top of the ever-changing world of Medicare rules and regs. Following through on promises made last year, CMS has unveiled on its Web page the first issue of the Quarterly Provider Update.

The issuance lists regulations CMS issued during the previous three months, as well as rules the agency has under development.

The Update is posted on CMS Web site, at www.cms.hhs.gov.providerupdate/.

Most HHAs are raking in $750 per episode under the prospective payment system, according to recent calculations from the **General Accounting Office**. But the methodology and data the GAO used to reach this dollar figure are flawed, industry representatives tell **Eli**.

Regardless, the GAOs upcoming report likely will put a damper on the industrys efforts to squash the 15 percent cut to reimbursement set for this October.

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The health care industry will see $100 million in savings over the next 10 years, thanks to proposed changes to the Health Insurance Portability and Accountability Act, the **Department of Health and Human Services** estimates.

A whopping $103 million in savings will come from eliminating the consent requirement, which required covered entities to obtain written consent from patients to use or disclose protected health information for treatment, payment or health care operations.

The consent requirement, however, will be replaced with a requirement compelling covered providers "to make a good faith effort" to obtain written acknowledgment from patients indicating they have received notice of their providers privacy practices. The acknowledgment requirement will add $184 million to the HIPAA cost tally, and threatens to pose a significant administrative burden.

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