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OASIS Alert

Industry Notes: PANEL WEIGHS IN ON OUTCOMES SELECTION

A panel of experts, including industry representatives, recently met to make its recommendations for the home health outcomes Medicare will release to the public for comparison next year.

Each member voted for their top 12 measures by secret ballot, explains **Bob Wardwell** with the **Visiting Nurse Associations of America**. The **Centers for Medicare & Medicaid Services** most likely will have to choose its final outcome measures soon to get the pilot project for five or six states in place by April as planned, expects Wardwell, a former CMS official.

The project will publicly compare home health agency outcomes in high-profile outlets such as newspaper advertisements.

CMS currently is conducting such a project with nursing homes.

Meeting participants seem to have preferred measures on the outcome-based quality improvement report that are risk-adjusted, that focus on improvement rather than stabilization, and that "agencies have demonstrated they can influence through OBQI activity," Wardwell reports. Adverse events, new outcomes and non-risk-adjusted outcomes are out, he predicts.

In choosing the states for the pilot project, CMS will consider size, urban/rural ratios, racial diversity and participation in the OBQI pilot project with quality improvement organizations, among other things, Wardwell says.

The Joint Commission on Accreditation of Healthcare Organizations will allow accredited home care organizations to "defer" the reporting of ORYX data until core measures are agreed upon, JCAHO says in a release.

"However, these organizations will continue to be expected to meet standards-based requirements for performance measurement, and to present relevant performance data and actions taken in response to these data during the Joint Commissions on-site surveys," JCAHO warns.

Prepare for your admission visits to get even longer and more trying for patients under new instructions from CMS. But on the bright side, unpleasant tangles with Part B providers over services and items subject to home health consolidated billing should ease by next spring.

The home health conditions of participation require HHAs to "inform beneficiaries of the disciplines that will be furnishing their care." That notification includes explaining that the primary HHA must provide therapy and medical supplies, CMS stresses in Oct. 25 program memorandum A-02-104.

Therapists and suppliers have encountered payment problems because their claims are being denied for patients under an open home health plan of care, CMS says.

HHAs explanation of bundling to patients should alleviate "the problems currently being encountered by some independent providers as a result of the enforcement of home health consolidated billing," according to the memo.

Automatic denials of claims due solely to a diagnosis of a progressively debilitating disease are taboo for Medicare contractors, an update to the Medicare Program Integrity Manual makes clear.

"Contractors may not install edits that result in the automatic denial of services based solely on the diagnosis of progressively debilitating disease where treatment in the early stages may be reasonable and necessary," CMS says in

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Oct. 25 Transmittal No. 31, an update to the PI Manual Chapter 3, Section 5.1.1 on prepayment edits.

That means denials for therapy for conditions such as Alzheimers and Parkinsons disease are strictly off limits unless substantiated by other factors, observers note.

Correction: There was a misprint on Vol. 3, No. 10, p. 103. The chart notes that agencies should begin using ICD-10 on Oct. 1, 2002. That should have read "ICD-2003."

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