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OASIS Alert

Industry Notes: RHHIs TIGHTEN THERAPISTS' WOUND CARE CRITERIA

You can kiss your therapists' wound care visits good-bye when adding up your 10-visit threshold, if a restrictive local medical review policy becomes final.

Regional home health intermediaries will deny physical therapists' wound care visits if their state practice acts don't specifically spell out what types of wound care the therapists may provide, according to LMRPs recently proposed by RHHIs **Cahaba GBA** and **Palmetto GBA**.

And the other two RHHIs, **United Government Services** and **Associated Hospital Services of Maine**, soon will propose similar policies, according to a Cahaba official.

Therapists "may provide the specific type of wound care services defined in the State practice act," says Palmetto's policy, proposed Feb. 5. The comment period on Cahaba's policy, which contained a similar statement, closed Feb. 4.

But critics charge that very few therapy state practice acts specify wound care duties in the detail required for billing under the draft medical review policy. The Cahaba source admits the RHHI "is not aware of any state acts that specify wound care."

To see the LMRP, go to www. pgba.com, click on 'Providers,' 'RHHI' 'Medical Policies,' and 'Draft.' Palmetto will accept comments on the policy through March 22.

1. **If your agency is having trouble accessing** your new outcome-based quality improvement reports, the problem might be your Web browser.

   If you're using a Netscape Web browser, you need a software plug-in to view your reports, said **Mary Cox** of the **Iowa Foundation for Medical Care** in the **Centers for Medicare & Medicaid Services'** Feb. 22 Webcast introducing the new OBQI reports.

   That plug-in is available on the OBQI and OBQM reports page that you access off the normal OASIS submissions page, Cox directed.

   If a couple of tries with the plug-in don't do the trick, home health agencies can contact the IFMC, which is the national OASIS contractor, at 1-877-201-4721 or e-mail them at haven_help@ ifmc.org, says **Mary St. Pierre** with the **National Association for Home Care**.

   A document instructing HHAs in how to access their OBQI and OBQM reports is available at www.hcfa.gov/medicaid/oasis/222hhagd.pdf.

2. **If a home health agency misses the five-day assessment and reassessment window** for completing OASIS, CMS can sanction it for failure to meet the Medicare conditions of participation, says a recent Q&A document posted on CMS' Web site. However, in an "isolated instance in which an HHA is unable to complete the OASIS within five days of a start of an episode," that agency should fill out the OASIS immediately and still can use it to establish a home health resource group for the payment for the entire episode. The same holds true for a subsequent 60-day episode.

   Also, if an agency learns at the end of an episode that a patient is Medicare-eligible and consequently hasn't completed

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any OASIS assessments for the patient, the agency may use its medical records to "reconstruct the 23 OASIS items needed to determine an HHRG applicable to the period of Medicare eligibility and coverage," CMS says.

The Q&A is at www.hcfa.gov/medicare/hhoasis/htm.

3. **HHAs can use their OBQI reports as marketing tools,** according to presenters at CMS' Feb. 22 OBQI Webcast.

   Each new OBQI report will carry the warning that "this report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes." Keeping patient-identifiable information confidential is a condition-level requirement, a CMS official said in the Feb. 22 OBQI broadcast

   In one of the question-and-answer sessions, the CMS official stressed that patients' data are confidential and the reports aren't approved for public use. However, agencies are welcome to use the data for marketing if they refrain from using any individually identifiable, patient-specific information and instead use aggregate data, it seems.

4. **Your diagnosis coding of patients with multiple sclerosis, Alzheimer's, Parkinson's and CVA** could land you in hot water. For Foley catheter patients, a primary diagnosis of a neurological disease such as these will raise red flags at regional home health intermediaries.

   To determine the primary diagnosis for patients with these conditions, you must figure out if your agency is treating "multiple aspects of care versus a single aspect of care," RHHI Cahaba GBA says in its last installment of "Coding Clues" for HHAs, in its January Medicare A Newsline.

   Using the general neuro diagnosis is fine for patients who require care for "multiple problems related to the chronic condition," Cahaba explains. But using the general neuro diagnosis is a big no-no for patients requiring services "for only one aspect of their chronic condition," Cahaba instructs.

   Cahaba's article is at www.iamedicare.com/provider/NEWSLINE/2002/010102.pdf/.

5. **If your therapists don't watch what they say**, they could sink your agency's speech therapy claims. That's according to yet another LMRP proposed by **Palmetto GBA** that will make reaching the 10-visit therapy threshold harder than ever.

   The draft policy lays out four deadly terms that therapists should avoid in documentation if agencies hope to have therapy visits stand up to medical review: "doing well," "improving," "less pain" and "tolerated treatment well."

   Further, the policy notes that reviewers will consider speech therapy visits medically necessary only if the patient's condition is expected to improve. Palmetto will take comments on the policy through March 22.

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