OASIS Alert

Industry Notes: Update Your OASIS-C Guidance Manual

Errata sheet adds clarification on wounds, incontinence.

Don't let OASIS-C changes sneak in under your radar.

The **Centers for Medicare & Medicaid Services** has issued an "errata" sheet and an updated OASIS-C Guidance Manual.

The errata sheet, issued in December 2012, contains changes to several OASIS-C items, including new details about how to respond to M1710 □ When Confused.

Select response "0 □ Never" if the patient had no confusion in the last 14 days, CMS advised.

If your patient has experienced confusion, choose from responses 1 to 4, with each higher-numbered response representing "a worsening of confusion frequency," CMS said. Select "1 □ In new or complex situations only" when "the patient's confusion is isolated to a new or a complex situation" such as "when a new caregiver was introduced or when a procedure was performed the first time."

Look to responses 2, 3, and 4 "when confusion occurs without the stimulus of a new or complex situation, or when confusion which initially presented with a new or complex situation persists days after the new or complex situation became more routine," CMS said.

"Responses 2, 3 and 4 differ from each other based on the time when the confusion occurred," CMS said. Select response "2 □ On awakening or at night only" if the confusion only happened when your patient awoke from sleep or during the night. Select response "3 □ During the day and evening, but not constantly" if the confusion "occurs during the day and evening, but is not constant."

And if your patient's confusion wasn't constant, "but occurred more often than just upon awakening or at night," select response "3 □ During the day and evening, but not constantly," CMS said.

Other updates include:

M1012 □ Inpatient Procedure: "It is no longer necessary to enter Inpatient Procedures as M1012 is not used for quality or payment functions," CMS said in the errata sheet. However, you can't leave this item blank. Instead, CMS will accept answers such as "NA" or "UK."

M1308 □ Current Number of Unhealed Pressure Ulcers: CMS has clarified this often confusing item by revising the second bullet under the Response-Specific Instructions to read: "For Column 2, report the number of Stage II or higher pressure ulcers that were identified in Column 1 and were present on the most recent SOC/ROC, even if it was at a different stage."

M1610 □ Urinary Incontinence or Urinary Catheter Presence: CMS added the instruction that you should not report a catheter solely utilized for irrigation of the bladder or installation with an antibiotic in this item.

You can find the updated OASIS-C Guidance Manual and the errata sheet at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.

New BPIP Boosts Self-Management

If you're struggling to improve your patient's self-management, you'll be happy to hear that the HHQI National Campaign has released a Best Practice Intervention Package (BPIP) focused on this topic. The BPIP includes information, tools, and resources to help your staff with self-management support including individual motivation, patient activation, and action planning.

Resource: To download this or other BPIPs on topics such as reducing acute care hospitalizations and improving management of oral medication, visit www.homehealthquality.org/Education/BPIPS.aspx.

Guard Against Email HIPAA Violations

Don't be confused by whether changes to the HIPAA privacy rule bar sending unencrypted emails, because you still can in some cases. The HIPAA rule published on Jan. 25 will extend the HIPAA regulations to business associates (including any contractors your practice uses), and they must be in compliance by Sept. 23. However, the encryption standards have not changed, said

If you're communicating with the patient in this manner, "you do need to take appropriate security precautions," Rodriguez says. While there are basic guidelines in the regulation as to what those precautions are, there's more than one way to do it. "However, an unencrypted email would ordinarily be at a level of risk of inappropriate disclosure that would be inconsistent with the HIPAA security requirement, and therefore it would be ill-advised."

Look for NCDs to Include ICD-10 Codes

The **Centers for Medicare & Medicaid Services** is urging contractors to add ICD-10 codes to National Coverage Determinations. Ever since rumblings of ICD-10 first began, providers have wondered when NCDs would replace applicable ICD-9 codes with the corresponding ICD-10 codes and it appears that time has come.

On Jan. 18, CMS instructed contractors to start the process of creating and updating NCDs that contain ICD-9 codes. CMS said that carriers should assign comparable ICD-10 codes to them by the ICD-10 implementation date of Oct. 1, 2014. The directive was part of MLN Matters article MM8109.

This should help providers immeasurably, since inclusion of applicable ICD-10 codes on NCDs could at least offer a window into how Medicare payers will view each new diagnosis code and which codes it deems payable for particular services.

To read the complete MLN Matters article, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8109.pdf

Review these Cancer Claims

Get ready for Palmetto GBA to review your home health claims, specifically claims with dates of service from Oct. 1, 2011 through Dec. 31, 2012. Palmetto will look into V3210 and V3312 of the Home Health Prospective Payment System Grouper, which did not award points for basal and squamous cell carcinoma for home health services.

Palmetto is focusing on these claims because CMS added basal, squamous and unspecified malignant cancers in V3413, retroactive to Oct. 1, 2011. Now CMS wants to award points for the entire 173 code category back to this date.

Action point: You may want to review any claims with dates of service submitted from Oct. 1, 2011 through Dec. 31, 2012 "to make a business decision as to whether or not to adjust the claim based upon a different Health Insurance Prospective Payment System (HIPPS) score determination made by V3413 of the HH PPS Grouper," Palmetto advises.

Leon Rodriguez of **HHS's Office of Civil Rights** during a Jan. 29 **Centers for Medicare & Medicaid Services** Open Door Forum.