OASIS Alert

OASIS News: 2005 CODES: CAUTION REQUIRED

Now that the new 2005 ICD-9 diagnosis codes are in effect - and with no grace period to make the change - should you use the new codes on final claims after Oct. 1? Surprisingly, the answer could be 'no.'

Focus on the first date of service rather than on the claim date, experts say. If the 60-day episode began on or before Sept. 30, use the 2004 ICD-9 codes on the final claim, as well as on the request for anticipated payment (RAP), says consultant **Judy Adams** with Charlotte, NC-based **LarsonAllen Healthcare Group**. This is true even if you file both the RAP and the final claim after Oct. 1.

Tip: If the episode begins and ends before Oct. 1, use the old codes. If an episode spans Oct. 1, use the old codes. And if the initial visit for an episode occurs on or after Oct. 1, use the new codes, says a spokesperson for regional home health intermediary **Palmetto GBA**.

Don't change your normal billing procedure, Palmetto explains. Use a primary diagnosis code that reflects the primary reason for home health care. Match the primary diagnosis code on the FL 67 with the code reported on the RAP, the code in M0230 on the OASIS assessment and with item 11 on the 485 (Plan of Care), the RHHI instructs.

Beware of SCICs: If a claim reflects a significant change in condition, the ICD-9 code billed on the final claim must match the code on the OASIS "that produced the Health Insurance Prospective Payment System (HIPPS) code on the latest dated 0023 revenue code line," Palmetto advises. That is, the diagnosis codes on the final claim and the OASIS corresponding to the SCIC must match.

Snag: The HAVEN software is generating error messages when agencies enter 2005 ICD-9-CM codes for OASIS data, reports the **National Association for Home Care & Hospice**. Agencies should continue to use the 2005 codes when appropriate, because HAVEN will accept and lock the 2005 codes even though it does give you a warning, the **Centers for Medicare & Medicaid Services** told NAHC. CMS plans to fix the problem "in a future release," according to NAHC.

1. The end of the calendar year is almost upon us, and CMS has posted the 2005 OASIS Assessment Calendar tool on its Web site at www.cms.hhs.gov/oasis/hhnew.asp. The tool helps agencies correctly schedule OASIS recertification assessments in the last five days of the 120-day episode by listing recert windows for three subsequent recerts.

2. The HHS Office of Inspector General doesn't overlook home health agencies in its latest Red Book. The OIG recommends that CMS recoup overpayments due to agencies' mistakes answering M0175, the OASIS item on patients' prior hospital stays. CMS already is preventing such overpayments with edits, and will start making retroactive recoupments in January 2005.

3. You must learn to live without your paper remittance advices if you also receive RAs electronically.

   For years CMS has required fiscal intermediaries to cease sending paper RAs if providers switch to receiving electronic RAs, says a new Medlearn Matters article. But CMS recently learned FIs haven't followed that requirement.

   By Jan. 1, FIs must cease sending the paper notices a month after providers switch to the electronic RAs, CMS instructed in a recent memo. CMS aims to achieve a "totally paperless claims processing and payment system," it says. More information is at www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0447.pdf.

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