OASIS Alert

OASIS News: EXPECT MORE TIME FOR OASIS VISITS

Seek clinicians' buy-in on this mandatory form.

As if the OASIS discharge assessment wasn't enough for clinicians and patients, the **Centers for Medicare & Medicaid Services** has added an expedited review notice.

Although the new notice - which took effect July 1 - isn't actually part of the OASIS assessment, agencies are required to deliver and explain it to the patient. Admission and discharge assessment visits are one likely place to insert this new task, experts suggest.

The new form is designed to give beneficiaries the chance to appeal the termination of their Medicare services. Even if very few patients choose to do so, agencies must notify all patients.

Tip: Agencies may deliver the generic notice any time up to two days before their services will end, CMS says. But there are some exceptions to the rule requiring expedited review notices, including when the beneficiary goes into the hospital; when the beneficiary dies; when services end for reasons other than coverage ending - such as staffing or safety concerns; when the patient is discharged because she is in the hospital on the 60th day of the episode but she will be starting another episode when she returns home; and when the agency can't locate the patient. You should document these special circumstances, experts advise.

CMS may offer further exceptions in upcoming Q&As, officials said. Providers can expect additional Q&As, official stated in a June 20 special Open Door Forum. More information is at www.cms.hhs.gov/medicare/bni.

1. **Expect more questions from physicians overseeing** your home health agency's care plans. Two Texas physicians received $15,897 in wrongful reimbursement for 236 care plan oversight (CPO) services on nine claims, the **HHS Office of Inspector General** said in a new audit report (A-06-04-00083).

   Physicians can bill for CPO only once per patient per month, the OIG notes. And physicians must spend at least 30 minutes on CPO to bill for the service.

2. **Congress is going to hear all about** whether your minutes of care furnished and your reported costs match your payments under the prospective payment system. The **Medicare Payment Advisory Commission** plans to research those topics as part of its study of home health PPS, according to its June report to Congress.

   The influential advisory body also plans to look at post-hospital versus non-post-hospital patients and patients' characteristics such as marked frailty, type of caregivers and cognitive problems.