OASIS Alert

OASIS News: No Quick Fix For OASIS Questions

OASIS has its problems, and resolving them isn't on the same fast track as changes to Home Health Compare.

The **Centers for Medicare & Medicaid Services** has decided to make changes this fall in the quality outcome measures included in home health agencies' publicly reported results, without waiting to revise the underlying tool, a CMS official said in the Feb. 17 Home Health Open Door Forum.

CMS is taking input on the OASIS instrument from a number of sources, including a risk adjustment study, the OASIS Technical Expert Panel (TEP) and the **National Quality Forum.** Programming a new OASIS instrument, finalizing it and implementing the changes will take two or three more years, the staffer explained.

Good news: After its revision this fall, Home Health Compare will retain its footnote indicating that certain New York HHAs serve a chronic long-term population, the CMS official said. "Because these patients are different from traditional home care patients, the quality measures reported for these agencies are not directly comparable to other agencies and may not reflect the actual quality of care and services," a link with the footnote explains. Efforts to identify chronic care populations in other states are underway, the agency says.

1. **CMS is soliciting comments** on OASIS data use and reporting as part of routine Paperwork Reduction Act requirements, according to the Jan. 25 Federal Register. Interested parties have 60 days to comment on aspects including the accuracy of the estimated burden. More information is at www.access.gpo.gov/su_docs/fedreg/a050125c.html.

2. **CMS hopes to issue sometime this year** the final rule requiring hospitals to report statistics on their home care referral to organizations with which they have financial relationships, the agency said at the Feb. 17 Home Health Open Door Forum. The requirement was included in the Balanced Budget Act of 1997 and CMS proposed a rule on it in April 2002.

   Meanwhile, the **HHS Office of Inspector General** is reinforcing BBA patient choice requirements in its newly finalized supplemental compliance guidance for hospitals, published in the Jan. 31 Federal Register. The OIG's compliance guidance tells hospitals that, as part of the discharge planning process, they must provide the patient with a list of Medicare certified HHAs serving the patient's geographic area and identify any HHAs with which they have a financial interest.

3. **The number of claims denied** due to incorrect patient name or Health Insurance Claim number has tripled since Medicare changed its policy to require an exact match for beneficiary first initial, last name and HIC number, CMS warns. CMS issued a special Medlearn Matters article to help providers avoid these problems, at www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0516.pdf.