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OASIS Alert

OASIS News: Wage And Hour Issues May Accompany OASIS Changes

On-call pay could put you at risk of FLSA fines and penalties.

Are you paying staff to attend an OASIS training session without realizing the wage and hour law implications? Don't wait until an employee sues you to find out.

"Violations of the wage and hour provisions of the Fair Labor Standards Act (FLSA) and analogous state statutes are the single largest liability exposure for employers," warn attorneys **Joseph Sokolowski** and **Lindsay Zamzow** of **Fredrikson & Byron** in Minneapolis. "Since 1997, wage and hour litigation has tripled while most other employment litigation has stabilized or declined," the labor law attorneys note in an article on their Web site.

Protect yourself: Remember to pay non-exempt employees for orientation and inservice training, urged attorney **John Gilli-land II** in a recent **Eli**-sponsored audioconference series, 40 Wage-and-Hour Mistakes Healthcare Providers Make -- And How to Avoid Them. And those hours count toward overtime, if applicable, advised Gilliland, with **Gilliland & Markette** in Indianapolis.

If you've changed your on-call policies to prevent re-hospitalizations or if clinicians are working longer hours to keep up with OASIS and prospective payment system changes, consider the impact on your FLSA compliance before you get hit with fines and penalties.

Smart: On-call violations are so common that "if you're paying nonexempt employees to serve in on-call status, have your pay arrangements for them and your recordkeeping reviewed to be sure you're doing it properly," Gilliland recommends.

Note: For a healthcare focused discussion of pay issues and how to avoid them, order a CD or transcript of Gilliland's conference by calling 1-800-508-2582. To get 15 percent off the cost of your conference, use the reader code 15%OFF AUDIOHH.

• **Say goodbye to last year's Home Health Quality Improvement Campaign**, the **Centers for Medicare & Medicaid Services** tells providers. This means all continuing education programs that were part of the campaign ended Feb. 28, CMS says.

Home health agencies will not be a required part of the Quality Improvement Or-ganizations' next contract round, according to CMS. But agencies will still have access to the best practice tools and online education material available at http://www.homehealthquality.org and http://www.medqic.org, CMS says.

• **Regional Home Health Intermedi-ary Cahaba GBA will be scrutinizing claims** for hypertensive patients with long stays, and so should you. In a widespread probe review on the topic, Cahaba medical reviewers denied 86 percent of claims reviewed. "The most problematic issue ... was that the documentation for the skilled nurse visits did not support medical necessity," Cahaba says.

Be cautious in using observation and assessment visits that are not in response to a change in the patient's condition and do not result in a modification in the plan of care, Cahaba instructs. And include especially clear documentation for these visits to decrease denials.

• **CMS may shut down its pilot project** on disease management. The agency launched the Medicare Health Support

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program in 2005 to help coordinate care for patients with chronic conditions such as diabetes and heart failure. "Phase I of the program is not meeting the statutory requirements of improved clinical quality outcomes, improved beneficiary satisfaction, and the achievement of financial savings targets," CMS says in a statement on its MHS Web site.

• **In its March 1 report to Congress, MedPAC** recommended an HHA rate freeze in 2009. MedPAC justifies the freeze by pointing to agencies' continued double-digit Medicare profit margin. MedPAC expects HHAs to have an average 16.8 percent margin in 2007, despite a rate freeze in 2006.

The move would cut HHA spending by $250 million to $750 million in 2009 and up to $5 billion over five years, MedPAC says.

• **The HHS Office of Inspector Gen-eral continues to spotlight** relatively few problems with home health agencies compared to other providers, according to the recently released Health Care Fraud and Abuse Control Program report for 2006. The report touted the program's $2.2 million in judgments and settlements in fiscal year 2006. "The HCFAC account has returned over $10.4 billion to the Medicare Trust Fund since the inception of the program in 1997," the OIG notes.

• **The new prospective payment system grouper doesn't recognize** a manifestation code, unless it's directly following an appropriate and complete etiology code, **Abt Associates** confirms. Under the old PPS this didn't matter.

To determine which etiology/ manifestation code combinations receive case mix points under the new PPS, look to the pseudocode.

Example: The manifestation code 336.2 (Subacute combined degeneration of spinal cord in disease classified elsewhere) will count toward case mix and payment only if it is preceded by 266.2 (B-complex deficiency NEC), 281.0 (Pernicious anemia) or 281.1 (B-12 deficiency anemia NEC) on the same line in M0230/M0240/M0246. (Note: This example is corrected from the original article in Eli's OASIS Alert, Vol. 8, No. 12, p. 114).

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