

OASIS Alert

Prospective Payment System: CMS OFFERS GUIDANCE ABOUT HOSPITAL STAYS

There has been much head-scratching about what a home health agency should do when a patient's hospital stay encroaches on her home health episode, but revisions to the Home Health Agency Manual have shed some light on the situation.

If a patient is in the hospital on the last day of one episode and the first day of the next (days 60 and 61), the agency must discharge her from home care for Medicare billing purposes, according to the **Centers for Medicare & Medicaid Services'** recent revisions. This gap in care means the agency can't bill the episodes as continuous, the manual instructs. When the patient returns to home care after her hospital stay, the agency should conduct an SOC OASIS assessment.

If the hospital discharges a patient on day 60 or 61 and the ROC assessment doesn't change the HIPPS code from a recert performed within the last five days, "home care would be considered continuous if [the agency] did not discharge the patient during the previous episode."

On the other hand, if the ROC assessment does change the HIPPS code, the agency must discharge the patient from home care, and Medicare won't consider the episode continuous, the manual explains. The same rules apply if a patient is admitted to the hospital on day 61 before she receives any home care.

Many HHAs have been confused about these situations for a long time, so it's good that CMS has offered this bit of clarification. Billers should consult these instructions when faced with these kinds of situations and review them against the specific case at hand, advises Chapel Hill, NC-based consultant **Judy Adams** with the **Larson Allen Health Group**.

Finally, the manual offers instructions on what to do in the rare case that an agency serves a maternity or pediatric patient under Medicare. "In these cases, an OASIS assessment must be performed on the patient exclusively in order to arrive at a HIPPS code to place on the RAP and the claim for the episode," the HIM 11 says.

That means the agency has to complete only the 23 OASIS items that determine payment, Krulish says. "You don't need to do the entire OASIS." Also, since agencies aren't allowed to transmit these assessments to the state, they should just keep them in the patient's record, Adams instructs.