OASIS Alert

Prospective Payment System: HMO SWITCH MEANS MORE PAPERWORK

Home health agencies no longer must feel like they're wandering about in a darkened netherworld when faced with strange billing situations the **Centers for Medicare & Medicaid Services** has offered a guiding light.

In recent revisions to the Home Health Agency Manual, CMS adds section 475.5, "Special Billing Situations Involving OASIS Assessments." "Maintaining the link between payment episode periods and OASIS assessment periods is central to the [home health prospective payment system]. However, in some circumstances these periods may be difficult to synchronize," the manual admits.

Agencies sometimes encounter a patient whose payment source switches from a Medicare HMO to Medicare fee-for-service, leaving many HHAs puzzling over how to handle the situation. Whilethissituationdoesn'tariseterriblyfrequently, it still happens, and it's important for agencies to know how to deal with it, urges consultant **Linda Krulish**, president of **Home Therapy Services** in Redmond, WA.

As soon as the patient switches over to Medicare FFS, the agency should complete a new start of care OASIS, the HIM 11 instructs. "With that assessment, a [request for anticipated payment] may be sent to Medicare to open an HH PPS episode." HHAs should verify the payor source for Medicare HMO patients on a weekly basis, CMS counsels.

If an agency doesn't learn about a patient's switch in payor source in a timely manner, and didn't collect a new SOC OASIS at the time of the switch, "a correction to an existing OASIS assessment may be necessary to change the reported payor and to complete the therapy item," the manual says. An agency should correct the OASIS collected most recently after the FFS start date, CMS instructs.

If an agency did not collect OASIS data for a patient under HMO coverage and it has discharged the patient, "the HHA may use [its] medical records to reconstruct the OASIS items needed to determine a HIPPS code applicable to the period of Medicare fee-for-service eligibility and coverage," the HIM 11 notes.

If a patient switches from Medicare FFS to HMO coverage during a PPS episode, that episode ends on the date of the patient's switch, and the agency will receive a partial episode payment (PEP) adjustment for the patient.

Editor's Note: March 29 Transmittals 300 (the HHA manual) and 1853 (the Intermediary manual) are at www.hcfa.gov/pubforms/transmit/transmittals/comm_date_dsc.htm.