OASIS Alert

Reader Question: Learn What To Do When Payers Split An Episode

Good clinician notes can save the day.

Question: When a patient switches from traditional Medicare to an HMO in the middle of a home health episode, what do we do? We have been told at multiple levels of Medicare and by different HMOs that:

1. The payer source that begins the episode is responsible for the entire episode, even if the payer changes midway. (This has not worked so far, but maybe we need to use a different code?) OR

2. We must discharge the patient with an OASIS. Then we should readmit the patient with a new SOC OASIS and a new SOC date and plan of care. Problems we see with this are the need to create documents some time after the visits and the risks of partial episode payments or low utilization payments because of splitting the episode between two payer sources.

Answer: Many home health agencies have this question, now that more Medicare patients are under managed care, says billing expert **Aaron Little** with **BKD** in Springfield, MO. Little outlines three potential approaches, depending on which type of payer the patient starts and ends the episode with:

1. If a patient changes from any pay source to traditional Medicare, you must complete a new start of care OASIS and should also complete a new plan of care. For billing purposes, bill a RAP and final claim for the traditional Medicare episode just like any other routine Medicare episode without any special coding requirements.

2. If a patient changes from traditional Medicare to an HMO that pays based on the Medicare episode payments, you must complete a new start of care OASIS even if you find out after the fact that the change occurred. In these situations the HHA has to go back to the first qualifying visit date after the HMO coverage began and prepare a late OASIS using the clinician's notes from that day. It is not absolutely necessary to complete a new plan of care in this situation. For billing purposes, you should bill a final claim for the traditional Medicare episode with a discharge status code of 01 and bill a new RAP and final claim to the HMO as though it were a routine Medicare episode without any special coding requirements.

3. If a patient changes from traditional Medicare to any payer that doesn't pay based on the Medicare episode payments, the only requirement is to change the pay source indicated on M0150. No new plan of care is required. For billing purposes, bill a final claim for the traditional Medicare episode with an 01 discharge status code without any special coding requirements.