OASIS Alert

Reimbursement: CMS RULE-BENDING COULD BREAK AGENCIES

When providers miss deadlines, the **Centers for Medicare & Medicaid Services** makes sure they pay the price, but when CMS misses deadlines providers still have to pay the price.

Case in point: CMS's failure to meet a deadline is causing increased confusion among home health agencies over already-complicated diagnosis coding rules. Medicare rules require the patient's diagnosis codes to match on the OASIS assessment, the reimbursement claim and the plan of care. But because CMS couldn't get its act together in time for free OASIS transmitting software HAVEN to accept new diagnosis codes that went into effect Oct. 1, CMS now is bending those rules.

"This is a typical example of the lack of consideration to home care providers in dealing with reimbursement documentation requirements," fumes consultant **Pam Warmack** with **Clinic Connections** in Ruston, LA. "We're not even caught by surprise anymore we expect the government to screw up." This particular screw-up involves new diagnosis codes that replaced 357.8 (other inflammatory and toxic neuropathy).

According to ICD-9-CM coding guidelines, as of Oct. 1 that code no longer exists, since it was replaced by three more specific codes 357.81 (chronic inflammatory demyelinating polyneuritis), 357.82 (critical illness polyneuropathy, acute motor neuropathy) and 357.89 (other inflammatory and toxic neuropathy).

CMS is updating the case-mix grouper software and HAVEN software to accept the new codes but it won't get around to releasing the updated HAVEN software until December. That means HHAs must use the new five-digit codes on their claims and POCs, but use the old four-digit code on OASIS "to obtain the correct HHRG/ HIPPS code for payment," CMS instructs in an Oct. 10 message to providers.

Providers should enter 357.8 on OASIS "to obtain the correct HHRG/HIPPS code for payment," but should enter either 357.81, 357.82 or 357.89 on the claim, explains consultant **Prinny Rose Abraham** with **HIQM Consulting** in Minneapolis.

If HHAs accidentally use the new code in HAVEN, they will get a warning message but still will be able to submit the code. "But the HIPPS code will not be calculated correctly," CMS warns.

This special exception will give agencies headaches and could delay or reduce their reimbursement, worries Warmack. "Most HHAs prepare diligently for changes," and it's frustrating when CMS doesn't follow suit, she says. "Change is costly, and the federal government doesn't seem to care."

The change is also time-consuming for agencies, notes consultant **Pat Sevast** with **American Express Tax & Business Services** in Timonium, MD. "It will take a lot of time flagging certain bills and OASIS documents to check," she says.

CMS tries to downplay the situation by insisting "357.8 is rarely applicable." Only one in 14,000 in "a large sample of recent start-of-care OASIS assessments" used the code as a primary diagnosis, the agency claims.

CMS has issued specific instructions about this code, likely because it will affect reimbursement, Warmack suggests. It is also the only diagnosis coding change that involved programming changes, notes Abraham.

Medical review personnel should "relax the requirement for agreement between primary diagnosis on the claim and OASIS in this special case," CMS reassures agencies.