OASIS Alert

Reimbursement: OASIS Accuracy Can Make Or Break Your Agency In 2008

Start adapting to the new reimbursement system now with these 3 tips.

You can't avoid the 2008 payment cuts, but you can minimize them using one basic tool -- your OASIS assessment.

The 2008 prospective payment system revamps the mathematical calculation that determines the home health resource group (HHRG) and the episode payment. "This [new PPS payment plan] is a complicated beast," said **Jeff Lewis**, CEO of Baton Rouge, LA-based **Lewis Inc.**

And, yes, somebody has to know how to calculate these payments, but it's not your clinicians, Lewis told listeners in an educational session at the **National Association for Home Care & Hospices'** October annual conference in Den-ver. Clinicians just need to know how to provide the correct answer for each OASIS question -- the answer that fits the patient, he said.

Studies show that too many OASIS assessments still are inaccurate or incomplete, Lewis said. "Agencies will be grossly underpaid in the 2008 payment plan if their assessments are incomplete," he warned. Look to your own agency's data to discover strategies to stay profitable under the payment cuts coming your way, he suggested.

Understand Where The Cuts Are

Reimbursement under both the current and the new systems depends on the diagnosis codes and the OASIS questions that make up the clinical, financial and service components of the home health resource group. But the **Centers for Medicare & Medicaid Services** has changed each of these components in the new system.

Knowing what changes will affect your agency the most lets you focus on adapting to those changes first, Lewis said. Here are just a few of the tips he shared:

1. Code all the diagnoses the patient has. Diagnosis coding skill will matter more than ever in 2008, but so will thoroughness. Agencies that meticulously code all the diagnoses can expect to receive diagnosis-based reimbursement in 20 percent more episodes than in 2007, Lewis' research found.

Good news: Most providers will get at least some improvement in diagnosis-based episode reimbursement next year, says Lewis. This is because more diagnoses receive case mix points in 2008 (see related story, p. 104). The better job you do using diagnosis codes to describe your patients, the more likely you are to receive the reimbursement you deserve.

Bad news: Agencies that got the most diagnosis-based payment in 2007 will be the biggest losers in 2008. Focusing only on coding the case mix orthopedic, neurological, diabetic and trauma diagnosis codes paid well in the past, but the payment is spread out over many more diagnoses next year, Lewis explained. And even last year's top diagnoses pay less in 2008. Diagnoses that added the most reimbursement in 2007 added $950. The highest diagnosis-based added reimbursement in 2008 will be $550, he said.

Don't overlook: Only codes in the first six diagnosis code positions in M0230 and M0240 "speak to CMS," Lewis said. CMS looks to these first six codes when considering reimbursement and risk adjustment, so put codes that count in these spaces.

Watch for: Agencies are likely to see the unexpected benefit of improvement in hospitalization rates, Lewis predicted. This will result from better risk adjustment once agencies see the financial benefit of reporting all the patients' diagnoses.

2. Learn about combination coding and OASIS payments. The new PPS rule often requires the combination of a specific code and the right answer to a certain M0 question before extra payment kicks in (see Eli's OASIS Alert, Vol. 8, No. 10, p. 93 for a detailed explanation of this new approach).

Bottom line: There is no substitute for OASIS accuracy.

Catch-22: You'll see your results as hard won improved accuracy, but CMS will see it as case mix creep in the years to come, Lewis expects. But if you don't improve, you won't survive as an agency to be around to complain.

3. Provide ongoing training on the clinical dimension M0 items. Agencies will qualify for non-diagnosis clinical M0 items much less often in 2008, Lewis said. These items are M0250, therapies; M0390, vision; M0420, pain; M0450/460, pressure ulcers; M0476, stasis ulcers; M0488, surgical wounds; M0490, dyspnea; M0530, urinary incontinence; M0540, bowel incontinence; M0550, bowel ostomy; and M0800, injectable drugs.

CMS has changed both the points resulting from different OASIS answers and the number of points required to qualify for additional clinical reimbursement. The new system will likely pay extra for clinical points from these M0 items in 25 percent of episodes, compared with 90 percent of episodes in 2007, Lewis said.

This clinical component will result in payment cuts to all agencies when compared to 2007, Lewis said, but the most accurate agencies will lose less. Only by improving your accuracy and completeness on these questions can you minimize your losses from the clinical M0 questions in 2008.

Tip: Start planning improved and ongoing OASIS training for your clinicians (see related story, p. 102). The better the picture you can paint for CMS about your patients, the more likely it is that the payment will be closer to your costs.

Note: More information on adjusting to the new PPS is in the CD or MP3 download of Lewis' presentation: "Outcomes Centered Management: Tuning Up For The Long Haul," available through http://www.nahc.org.