OASIS Alert

Reimbursement: SCICs DEMAND BOTH CLINICAL AND FINANCIAL ANALYSIS

What to do when patients have significant changes in condition continues to be a bane of many home health agencies' existence. And if you don't approach the situation from both a clinical and a financial perspective, you could lose big bucks.

HHAs must develop separate policies that address the clinical and financial sides of SCICs, urgesconsultant **PamWarmack**,presidentof **Clinical Connections** in Ruston, LA. Even though agencies must conduct an OASIS assessment when a patient has a SCIC, they don't necessarily have to bill for it, notes **Dave Macke**, director of reimbursement for **VonLehman & Co.** in Ft. Mitchell, KY.

The OASIS guidelines published in the Federal Register Jan. 25, 1999 instruct agencies to develop a policy that codifies their definition of a "significant" deterioration or improvement in a patient's condition. But the feds don't give any hard-and-fast guidelines to follow in making this policy agencies must decide for themselves, notes Warmack.

When developing these clinical guidelines, be as specific as possible, she instructs. Ideally, a new nurse should be able to look at your policy and know "without having to guess" when a patient "significantly" improves or deteriorates, Warmack tells **Eli**. For example, an agency might decide that a significant deterioration would require "a change in the patient's primary diagnosis, accompanied by a change in the physician's orders and a change in medication," she offers.

With these guidelines in place, clinicians will know when they need to go to a patient's home and collect a follow-up OASIS assessment due to a SCIC, Warmack says. "So the first thing you have to do is make those definitions in policy about when to do a follow-up," she instructs. "The other side of the issue comes with billing or reimbursement."

Agencies must base their decision on whether to bill for the SCIC on changes to the HIPPS code weight, according to the Home Health Agency Manual (see the flow chart on p. 57 for a graphic depiction of this decision process). If the change in condition doesn't translate into a change in the HIPPS code weight, you don't have to report a SCIC. For example, "sometimes a patient's condition changes, but it doesn't worsen or improve and the change doesn't affect the 23 items on OASIS" that determine payment, Warmack says.

If the SCIC does result in a change in HIPPS code weight, you must figure out whether the weight is increased or decreased. If it decreases (meaning the patient's condition has improved), you must report the SCIC only if you didn't plan for that decrease, the HIM 11 says.

Many agencies forget this point, Warmack warns. "If [an agency] admits a patient with daily wound care and my 485 says I envision that daily wound care will no longer be required after 30 days," then the agency wouldn't report a SCIC when that change comes to pass, she offers. On the other hand, if that wound completely heals in just two weeks, the agency would report a SCIC, because the clinician didn't foresee that change.

In some cases, a change in the HIPPS code weight corresponding to a higher payment category actually will cause the agency to lose money. That's because SCIC payment portions are calculated on visit dates, and a big gap could be left between the first portion's last visit and the second portion's first visit. In that case, the agency could lose more money for the time the patient was hospitalized, for example, than it would stand to gain from the increased case mix weight.

To keep from shooting themselves in the foot, agencies should take the time to carefully calculate whether to bill the SCIC. HHAs that routinely bill for SCICs probably are losing money they don't have to give up, warns Macke.

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