OASIS Alert

Survey & Certification: Know When New ABN Rules Interact With OASIS

Single skilled nursing visits may be more than a financial drain.

If you haven't digested the new information about advance beneficiary notices, you are running out of time.

Two situations in which clinicians may find that OASIS and ABNs interact are (1) when making single skilled nursing visits and (2) when a significant change in condition leads to a reduction in care.

Single Visits May Take Even Longer Now

The cost of a single skilled nursing visit made without the expectation of more visits, or in which the patient is not admitted to home care, often becomes part of your agency's overhead expenses.

Reality: Many agencies provide a single skilled nursing visit despite the fact that in most situations Medicare doesn't pay for it. For example, if the nurse visits to do the OASIS assessment and doesn't admit the patient to home care because he isn't homebound, the visit isn't paid.

Beware Fraud and Abuse Risk

Even a visit where the patient qualifies for the home care benefit in other ways is not paid if the only care ordered is a single SN visit. The SN visits must be intermittent to qualify the patient for the benefit, the **Centers for Medicare & Medicaid Services** reminds agencies (for more on intermittent SN, see OASIS Alert, Vol. 6, No. 8).

Some agencies have a policy of charging the patient for single SN visits that don't qualify for Medicare payment, experts say. This could be because they're concerned about the kickback implications of providing a free service, says attorney **Robert Markette, Jr.** with Indianapolis-based Gilliland Markette & Milligan. Or because if they charge Medicaid for single SN visits, they must charge everyone, experts suggest.

New wrinkle: But if you are initiating non-covered services and plan to charge the patient for it, you must issue an ABN prior to the visit, says consultant **Judy Adams** with Charlotte, NC-based LarsonAllen Health Care Group. Failure to do so puts you in violation of the home health conditions of participation, experts agree.

CMS has finally revised the home health ABN and agencies must use the new notice after May 31. The instructions for the new notice "significantly broaden" the circumstance in which you will need to provide patients with an ABN, a CMS official said at the Feb. 28 home health Open Door Forum.

Watch for: One situation clinicians may encounter is with a patient who does qualify for Medicare coverage, but who also wants services that aren't medically necessary based on the OASIS assessment. Here the agency must provide an ABN if part of the services will be non-covered.

Caution: Despite the ABN hassle, agencies may find it worth billing patients for single visits, Markette says. An agency providing visits for free is inviting fraud and abuse scrutiny, especially if these free visits benefit one or several good referral sources, he advises. It could look to the **HHS Office of Inspector General** as if one of the reasons for the free visits was to encourage referrals--constituting a kickback, he notes.

Mandatory SCICs Also Take ABN Hit

There aren't many situations in which you must bill for a significant change in condition, experts say. But you must file a

SCIC whenever an unanticipated improvement in the patient's condition decreases the HIPPS code (resulting in a lower episode payment), CMS instructs (see OASIS Alert, Vol. 6, No. 8). If this improvement results in a decrease in services, you must provide an ABN.

Note: To receive a copy of the new ABN forms and instructions, send an email to Eli's OASIS Alert editor **Marian Cannell** at marianc@eliresearch.com with "ABN Instructions" in the subject line.