

## OASIS Alert

### Survey & Certification: Study These OASIS Reports to Safeguard Survey Success

The new surveys have begun and your best defense may be a good offense.

The **Centers for Medicare & Medicaid Services** has ordered state survey agencies to implement a new home health protocol that requires surveyors to focus their investigation by using five OASIS-based reports. Surveyors must follow specific directions for each report that may produce patients for record review and/or home visits.

Most states planned to use the new procedure starting May 1, although some state survey agencies began earlier, noted CMS survey and certification staffer **Lynn Riley** in a presentation at the **National Association for Home Care & Hospice's** annual policy conference April 7.

Agencies can ward off bad survey results, prepare to defend themselves and prevent future problems by finding their own weaknesses using the new protocol before surveyors do. "Surveyors look at the same reports you look at," stressed CMS' **Heidi Gelzer** in the presentation.

And surveyors must follow the same instructions agencies can follow themselves, by looking at the pre-survey worksheet CMS has issued to its surveyors (available with detailed instructions at [www.cms.hhs.gov/medicaid/lcsp/sc0313.pdf](http://www.cms.hhs.gov/medicaid/lcsp/sc0313.pdf) on p. 13). Following the same path the surveyor will take allows you to figure out before the survey why your agency may deviate from the national reference and put a plan in place to correct the problem, advises **Bob Wardwell** of the **Visiting Nurses Associations of America**.

HHAs can anticipate where surveyors will strike by looking at these five reports:

**1. Outcome-based quality monitoring adverse event outcome reports** for the most recent quarter. If the adverse event report doesn't cover at least 60 patients, surveyors will look at the most recent six months, Gelzer noted.

HHAs can follow the surveyor's path by first looking at two "Tier 1" adverse event outcomes: emergent care for injury caused by fall or accident in the home and emergent care for wound infections, deteriorating wound status. If any patients at all show up under those events, they are automatically subjected to a record review and a home visit.

"Tier 2" adverse event outcomes are a bit less serious. Surveyors focus on patients with these six events only if the agency-specific incidence rate is at least twice the national reference rate in the report. Home visits are optional for patients with emergent care for improper medication administration, medication side effects or emergent care for hypo- or hyperglycemia. Only record review is indicated for patients with a substantial decline in three activities of daily living, discharged to the community needing wound care or medication assistance, discharged to the community needing toileting assistance or discharged to the community with behavioral problems.

Patients that experienced more than one adverse event are ideal targets for surveyor review, Gelzer pointed out.

**2. Outcome-based quality improvement outcome reports** for the most recent 12-month period. Surveyors will consider only outcomes that have sample sizes of at least 30 patients, Gelzer noted.

CMS lists 10 outcomes for surveyors to check, each with varying degrees by which the agency's number must differ from the national reference value to bring on extra scrutiny.

The outcome must both meet the threshold for difference and be statistically significant that means it shows up with at

least one asterisk on the OBQI report.

If none of the 10 outcomes on the worksheet meets those criteria, surveyors can look at other outcomes that are statistically significant and have a "large magnitude of difference" from the reference number. If none of the outcomes in the entire OBQI report meet that threshold, then surveyors won't focus on OBQI patient outcomes during a survey, Gelzer assured conference attendees.

**3. OBQI case mix report** for the most recent 12-month period. Look for acute conditions or diagnoses that are statistically significant and at least 15 percent higher than the reference rate in the report. Surveyors will select one to two records for record review, with or without home visits, from patients in any condition or diagnosis thus over-represented.

**4. OASIS submission statistics by agency reports** for the most recent six months. HHAs should check to see if they are submitting their data less often than monthly and/or having more than 20 percent of their records rejected. If so, surveyors will investigate a host of OASIS data submission-related issues, including if the OASIS submission vendor provides feedback reports to the agency and if the agency can provide final validation reports.

**5. OASIS error summary reports** for the most recent six months. Agencies will be in for scrutiny if Errors 102 (inconsistent lock data) or 262 (inconsistent M0090 data, RFA must be done on every 60-day cycle) show up for more than 20 percent of assessments, or if Errors 1003 (inconsistent effective date sequence) or 1002 (inconsistent record sequence) take place in more than 10 percent of assessments.

The new survey protocol won't change the overall number of patients reviewed, Riley emphasized. And looking at the five OASIS reports before coming on-site merely gives surveyors a place to start, not a license to automatically slap agencies with deficiencies, both CMS staffers stressed. The new protocol uses the reports to identify quality of care "indicators," not quality of care "determinations," Riley said.