Home Health Coding and OASIS Expert

OASIS Submission: Does Your OASIS Submission Meet the Mark?

Prepare for another OASIS impact on your Reimbursement.

Your focus on choosing the most accurate OASIS responses could be too narrow if you're not also making certain the assessments are getting through the submission process. Keep an eye on the July 2015 deadline for hitting a new OASIS submission benchmark or you could risk a 2 percent cut in payments.

Reminder: For the first time, the **Centers for Medicare & Medicaid Services** will require a "minimum submission threshold" for OASIS, the agency finalized in the rule published in the Nov. 6 Federal Register. Starting July 1, home health agencies will have to hit a minimum OASIS submission threshold of 70 percent under Medicare's newly finalized "pay-for-reporting performance system model," the **Centers for Medicare & Medicaid Services** says in the 2015 home health prospective payment system final rule. That means HHAs must successfully submit an OASIS record for 70 percent of those episodes qualifying as a "quality episode of care," according to the rule.

"Only those OASIS assessments that contribute, or could contribute, to creating a quality episode of care are included in the computation" for the benchmark, CMS said in the proposed rule.

The consequence: HHAs that do not meet the QAO metric benchmark will face a 2 percent reduction in PPS reimbursement rates, CMS says.

CMS did not bend to commenter pressure to push the start date off a year or more. "We believe that use of the 70 percent standard is one that is attainable by any HHA, whether it is a large corporate entity or very small family run business," CMS says in the final rule. "HHAs have been statutorily required to report OASIS for a number of years and therefore should have many years of experience with the collection of OASIS data and transmission of this data to CMS. Given the length of time that HHAs have been mandated to report OASIS data, we believe that HHAs will adapt quickly to the implementation of the 'pay-for-reporting' performance requirement."

However: CMS does relent on requiring agencies to meet an 80 percent benchmark in 2016 and 90 percent benchmark in 2017. "After carefully considering the comments submitted, we have reconsidered our proposal for implementation of a 'pay-for-performance' performance requirement over a 3 year period," CMS says in the rule. "The 'pay-for-reporting' performance requirement is a new reporting requirement that can have a significant financial impact any HHA that is not able to meet the requirements."

Regardless, CMS has settled on July 2015 and believes that's plenty of time for compliance since the requirement to transmit OASIS has been in place for some fifteen years, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of Selman-Holman & Associates and **CoDR Coding Done Right** in Denton, Texas.

Reminder: The state-based OASIS submission system is scheduled to shut down permanently at 6p.m. on Dec. 26, 2014. Beginning at 12a.m. midnight on Jan. 1, 2015, HHAs must begin to submit their OASIS assessments via the national ASAP system. With the implementation of the ASAP system, HHAs will no longer submit OASIS assessment data to CMS via their state databases.

Plan ahead for the dead time between 6 p.m. on Dec. 26 and Jan. 1. OASIS is required to be transmitted within 30 days of M0090 Date assessment completed. For example, if 30 days falls on Dec. 28, the agency will need to plan on readying the assessment for transmission and strive to transmit on or prior to Dec, 26 to be compliant, Selman-Holman says.

How Can You Prepare?

"Data regarding current compliance are readily accessible to agencies in their OASIS Error Reports available through

CASPER (Certification And Survey Provider Enhanced Reports)," says **Beth Johnson, MBA, BSN, RN, CRRN, HCS-D, HCS-O**, President of Johnson, Richards & Associates in Brighton, Mich. "Agencies should assign responsibility for scheduled accessing and distribution of these reports, as well as OBQI, OBQM, and PBQI reports, in order to accurately track and respond to opportunities for improvement."

Don't miss: CMS also recently proposed changes to the Conditions of Participation for the first time in 25 years, Johnson notes. Included in the proposed changes is a requirement that agencies develop, implement, and maintain an agency-wide, data-driven quality assessment and performance improvement (QAPI) program, she points out.

"The logical first step to compliance is the ability to access data already tabulated for you in order to understand how your agency is performing at baseline," says Johnson. Begin by taking a look at the CASPER User's Guide found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/downloads/HHQICASPER.pdf.

Submission May Not Be Good Enough

The **National Association for Home Care & Hospice** urges CMS to "clarify whether the standard requires both submission and acceptance and whether OASIS acceptance must be within the performance period," it says in its comment letter on the proposed rule. "CMS consistently uses the term 'submission', when in fact; we suspect CMS intends that the OASIS must be accepted into the state database during the performance period to count toward the submission threshold."

NAHC also recommends that CMS "clarify that a patient who has only recertification assessments recorded during a performance period will not be included in the quality assessment rate calculation," it says. "This will accommodate long term patients where a SOC/ROC assessment would have been conducted prior to the performance period."

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