OASIS Alert

Assessment: What To Watch For With Two-For-One Assessments

Don't get caught in the therapy trap.

You always knew it was silly -- now the **Centers for Medicare & Medicaid Services** agrees.

CMS says it will eliminate the follow-up OASIS assessment (RFA 4) when a resumption of care assessment (RFA 3) has to be filled out at the same time. This action follows a recommendation nearly a year ago by the HHS Advisory Commit-tee on Regulatory Reform

Starting Oct. 1, agencies can just fill out the RFA 3 and use it to generate the case-mix category for the next episode as well, explained CMS' **Carol Blackford** during the agency's April 23 satellite and Internet training session on wound care.

Currently, when a patient has a hospital stay and returns home in the last five days of the prospective payment system episode, the home health agency must at the same time fill out the RFA 3 OASIS to finish out the episode and the RFA 4 OASIS to begin the subsequent episode.

CMS has said since the end of 2001 that it's OK to drop the RFA 4 when the patient returns from the hospital in the last five days of the episode, notes Chapel Hill, NC-based consultant **Judy Adams** with the **LarsonAllen Health Care Group**. But in the past you could use the shortcut only if you weren't also claiming a significant change in condition after resumption of care. Now you can use the two-for-one assessment as well as a SCIC.

And many agencies couldn't take advantage of the exception, because their HAVEN or other OASIS software systems wouldn't accept it, Adams tells **Eli**.

"Maybe this time, this process will work," Adams hopes. CMS will release a new HAVEN version Oct. 1 when the change takes effect, the agency promises.

Hidden trap: There is one hitch with dropping the RFA 4 assessment. The RFA 3 OASIS item on therapy, M0825, will apply to both the current episode and the subsequent episode.

If the answer for M0825 is the same for both episodes, it's no problem. But if the answer is "yes" for the current episode and "no" for the subsequent episode, agencies will have to fix the billing situation by hand, CMS warned.

What to do: If you fill out M0825 as "yes" on the RFA 3 but the patient's following episode won't meet the 10-visit therapy threshold, the PPS grouper will generate the wrong HIPPS code for that episode, CMS' **Wil Gehne** explained to broadcast listeners. That means you'll have to substitute the non-therapy HIPPS code for the following episode's RAP and final claim, Gehne instructed.

CMS even furnished a handy "translation" chart giving agencies a listing of home health resource groups and HIPPS codes with and without therapy.

Caution: "This is an important change," Blackford said. Agencies must never mark N/A for M0825 on the RFA 3 when there is a subsequent episode, she stressed. v

Editor's Note: The chart and information on viewing the session are at www.cms.hhs.gov/oasis/hhtrain.asp.

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