OASIS December Newsletter

Home Health Updates and Reminders!

PDGM and iQIES: Are You Ready?

Are you in compliance with two critical updates? Don't take a chance on not getting paid!

Obtain your patients MBI number now!

Starting January 1, 2020, you **must** use the Medicare Beneficiary Identifier (MBI). Your claims will be rejected if you submit with the Health Insurance Claim Number (HICN), and reject all eligibility transactions.

Many providers are using the MBI for Medicare transactions now, but CMS cautions agencies to double check and make sure you have every patient's MBI number prior to January 1, 2020.

Don't have an MBI? Complete the following to obtain the MBI number:

- Ask your patients for their card
- Use your Medicare Administrative Contractor's look up tool. https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/Novitasphere
- Check the remittance advice. The MBI is listed on the remittance advice for every claim with a valid and active HICN.

Time is running out! Register now for iQIES

Failure to obtain access to iQIES prior to December 23, 2019 will impact your ability to submit assessment data needed for payment purposes, as the system will have a scheduled downtime so that the data migration can occur in preparation for the

January 1, 2020 release. Claims that cannot be matched to assessments will be returned to the HHA, preventing Medicare payment.

Completing onboarding by December 23, 2019 will allow you time to avoid some common onboarding delays, such as system downtime in preparation for the January 1 release, and possibly the need to utilize the manual proofing process when registering with HARP. In addition, CMS anticipates a surge in iQIES access requests as January 1st approaches, increasing the chances of delays in help desk response times.

If your organization has not yet requested access to iQIES, we recommend that you request access as soon as possible. For instructions on obtaining access, descriptions of roles available to your organization and other important iQIES information, please refer to the onboarding guide
link: https://qtso.cms.gov/system/files/qtso/iQIESOnboardingGuide-WebVersion_0.pdf.

*Only certain roles have access to the user tool in iQIES. Please read the role descriptions carefully before choosing your role.

Please note that at this time, only certified Home Health Agencies will be onboarded to iQIES. For technical assistance, please contact: help@qtso.com or by phone: 800-339-9313.

PDGM Transition Tips

As you know, PDGM is fast approaching and home health agencies need to be aware of a few transition tips related to the OASIS assessments.

Instructions for RFA 4 Recertification Assessments

To allow for the 5-day recertification window for episodes of continuous care that begin 1/1/2020 through 1/5/2020, there may be cases where the RFA 4 - Recertification assessment is completed in the last five days of 2019. In these cases, CMS is **temporarily waiving the requirement that HHAs enter the actual OASIS completion date in M0090, and instead enter the M0090 date of 1/1/2020**. HHAs should be aware that in the event they attempt to submit the RFA 4 - Recertification assessment with an artificial M0090 date of 1/1/2020 prior to 1/1/2020, they will receive a fatal error preventing the transmission of the assessment. Therefore, **HHAs should not transmit these assessments until 1/1/2020.**

This waiver will not be applicable to any other assessment performed either before or after this brief period, when all existing OASIS instructions regarding item M0090 apply. CMS is issuing this waiver, which is essentially a one-time exception, to facilitate the transition to the Patient-Driven Groupings Model (PDGM). CMS will alert State surveyors of this one-time exception.

For additional information please click the following link to access the CMS OASIS-D1 Memorandum: OASIS Educational Resources Locate the link to the memorandum under our "What's New" section.

QUESTION 1: OASIS-D1, PDGM and iQIES all start on January 1, 2020. Please confirm if all RFA 4 Recertification assessments that fall between December 27, 2019 and January 1, 2020 should use OASIS-D1 and use the iQIES system to submit?

ANSWER 1: All RFA 4 Recertification assessments with a M0090 Date Assessment Completed on or after December 27, 2019 for a payment period that begins January 1, 2020 or later should use OASIS-D1.

QUESTION 2: Since PDGM uses 30-day periods of care rather than 60-day episodes of care as the unit of payment, do the 30-day PDGM payment periods affect when OASIS needs to be collected?

ANSWER 2: While the PDGM case-mix adjustment is applied to each 30-day period of care, other home health requirements will continue on a 60-day basis. Specifically, certifications and recertifications continue on a 60-day basis and the comprehensive assessment will still be completed within 5 days after the start of care date and completed no less frequently than during the last 5 days of every 60 days beginning with the start of care date, as currently required by § 484.55, Condition of Participation: Comprehensive assessment of patients.

Question 3: Some OASIS items are allowed to be considered optional and the clinician may enter an equal (=) sign in the item which indicates the agency is treating the item as optional. Are vendors permitted to "hard code", auto-populate a response of "(=)" for allowed OASIS items? If so, could the system allow users to still change the response from (=) to one of the previously allowed values?

ANSWER 3: The vendor may prefill the response with an equal sign "=" and may allow the provider to change the response if the agency chooses not to treat the item as optional.

QUESTION 4: Per the 2019 Home Health Final Rule and the proposed rule for 2020, it appears that CMS expects HHAs to discharge a patient if the patient requires post-acute care from a SNF, IRF, LTCH or care in an inpatient psychiatric facility (IPF). The HHA could then readmit the patient, if necessary, after discharge from such setting. This goes against the common current practice of completing a transfer and then ROC for patients transferred to any inpatient setting, unless they are not expected to need further home care.

Should we still complete M0100 RFA 6 Transferred to an inpatient facility – patient not discharged from agency when a patient is transferred into any inpatient setting and we expect to receive this patient back after their inpatient stay and RFA 7 Transferred to an inpatient facility- patient discharged from agency when we do not expect to receive the patient back after the inpatient stay? Should we still complete a M0100 RFA 3 (ROC) when a patient is

discharged from any inpatient facility while still under the services of the agency?

ANSWER 4: There is no change in the OASIS guidance in how agencies may use M0100 RFA 6 and 7 when a home health patient is admitted for an inpatient hospital stay. In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 – Transferred to an inpatient facility – not discharged from agency. If the patient was not expected to return to your agency after this inpatient facility stay, you would compete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

However, if the patient required post-acute care in a SNF, IRF, LTCH or IPF prior to returning for home health services, CMS expects the home health agency to discharge the patient by completing the *internal agency discharge paperwork* (the OASIS Discharge assessment is not required following the Transfer OASIS when the patient does not return to the agency after Transfer) and then to readmit the patient with a new Start of Care. This will allow appropriate admission status assignment for PDGM. There is no need to update or change the transfer OASIS to reflect this discharge.

If a home health patient is admitted directly to a SNF, IRF, LTCH or IPF for a qualifying stay (stays as an inpatient for 24 hours or longer for reasons other than diagnostic testing), you would complete RFA 7 – Transfer to an inpatient facility – patient discharged from agency, then readmit the patient with a new Start of Care if they were referred for further home health services.

QUESTION 5: Is the RFA 5 - Other follow-up being used for payment again under PDGM?

ANSWER 5: The Other Follow-up assessment may be used by agencies when a patient experiences a significant change in condition that was not anticipated in the patient's plan of care and would warrant an update to the plan of care. Under PDGM, if the M0090 Date Assessment Completed for the RFA 5 is before the start of a subsequent, contiguous 30-day period and results in a change in the functional impairment level, the second 30-day claim would be grouped into its appropriate case-mix group. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group.

QUESTION 6: Under PDGM, if a patient experiences a significant change and we complete an RFA 5 - Other Follow-Up assessment that changes the functional grouping for the initial 30-day period thus resulting in a different case mix grouping, can we resubmit the original claim?

ANSWER 6: No, similar to PPS, the case mix group cannot be adjusted within each 30-day period, but completion of an RFA 5 - Other Follow-up may impact payment for a subsequent 30-day payment period. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group to ensure the claim can be matched to the Follow-up assessment. HHAs can submit a claims adjustment if the assessment is received after the claim has been submitted and if the assessment items would change the payment grouping.

Questions related to claims processing may be directed to the HHA's Medicare Administrative Contractor.

QUESTION 7: Beginning with episodes with a M0090 date of January 1, 2020 or later, for M2200, do we count the number of therapy visits anticipated for the 30-day payment period or for the 60-day certification period?

ANSWER 7: As M2200 - Therapy Need will continue to be collected for risk adjustment, and to support other payers who may be using PPS-like payment models, M2200 will continue to report the number of therapy visits that are planned for the 60-day certification period, unless otherwise directed by the individual payer.

These and other Q&As may be found on our website at: OASIS Educational Resources under the "What's New" section.

RESOURCES:

HHA Center Webpage which has an interactive grouper tool for HHAs to use to see how their case-mix weights would be established with their patient populations. The HHA Center webpage also has the PDGM case mix weights, LUPA thresholds, and agency-level impacts available for download at https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html

MLN Article MM11081: Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11081.pdf

MLN Article MM11527: Home Health (HH) Patient-Driven Groupings Model (PDGM) –

Revised and Additional Manual Instructions at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11527.pdf

PDGM webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

Your Oklahoma QIES Help Desk team wishes you all a very safe and happy holiday season! We are thankful for each one of you and the work you do to improve the lives of our elders. We wish you a very

prosperous New Year and look forward to working with you in the coming year!

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