OASIS MATTERS
March 2018

News From The Texas OASIS Help Desk

Table of Contents

The New 2018 Home Health Medicare Conditions of Participation Are Here!

As you probably are aware, the new Home Health Conditions of Participation (CoPs) for Medicare Certified agencies became effective January 13, 2018. Besides reorganization and renumbering for many of the regulations, some new ones were added and some old ones were greatly expanded on.

For OASIS, Medicare certified home health agencies still have to collect and transmit OASIS data on all Medicare/Medicaid patients receiving skilled services just as before; including patients with HMO/Star and Advantage plans. This did not change.

Here are a few CoPs related to OASIS that had notable changes effective January 13, 2018:

- § 484.40 CoP: Release of patient identifiable OASIS information was renumbered.
- § 484.45 CoP: Reporting OASIS information was updated to reflect current language stating that submission is to the CMS system and that transmission must occur within 30 days of the assessment completion date (M0090).
- § 484.50 CoP: Patient Rights continue the requirement of an OASIS privacy notice for all patients for whom OASIS is collected.
- § 484.55 CoP: Comprehensive assessment of patients was reorganized and allowance for a physician ordered resumption of care date was added.

- §484.65(b) CoP: Quality Assessment and Performance Improvement (QAPI**)** includes the new standard "program data" information on the fact that "the program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program."

To review all of the new Medicare regulations, the following link has been provided: Federal Register New Conditions of Participation 2018

New For C-2 Effective 1/1/2018!
Expansion of the 1 Clinician Convention!

Effective January 1, 2018, with the release of the updated OASIS-C2 Guidance Manual, expansion of the 1 clinician convention (rule) occurred. Which means collaboration that had been previously allowed only on certain OASIS Items, is now allowed on all. The assessing clinician will be allowed to elicit feedback from other agency staff, in order to complete any or all OASIS items integrated within the Comprehensive Assessment. However, the Comprehensive Assessment will continue to be the responsibility of only one (1) clinician.

The collaborating healthcare providers should have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.). In these collaborative efforts, all staffs are expected to function within the scope of their practice and state licensure.

Agencies may have the comprehensive assessment completed by 1 clinician, **but** if collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts**;** including how assessment information from multiple clinicians will be documented within the clinical record ensuring compliance with applicable requirements, and accepted standards of practice.

The CMS Question and Answer (Q&A) related to this new OASIS convention along with more information on all the OASIS Conventions listed in Chapter 1 of the OASIS-C2 Guidance Manual can be found by searching CMS.gov or at the following link: 1 Clinician convention/OASIS Guidance Manuals

Got Claims Bouncing Back like Ping-Pong Balls?

Understanding Returned Claims

First off…OASIS Education Coordinators (OECs) **do not** do billing or claims, so we are not able to help if you call about a claim denial; **and** you will be referred to Palmetto GBA for assistance.

BUT since we seem to receive & refer a lot of claim denial calls, we have decided to provide the following information obtained from the Palmetto GBA website to assist you.

Has your home health agency (HHA) been swept up in claims being returned to provider (RTP) due to no OASIS found? Can't figure out why your claim bounced? The key to this unfortunate situation is understanding and prevention.

Enforcement Leads to Better Compliance

Linking a HHAs Medicare payment to submission of an OASIS assessment is one way CMS is enforcing agency compliance with OASIS data collection and OASIS reporting requirements mandated by the Medicare CoPs. **The OASIS CoP requirements are not new**; only the method of enforcing HHA compliance is. Palmetto is using a new computer "linking" program.

Final Claim with a Matching OASIS Assessment ⟶ Claim Processes for Payment

As of April 1, 2017, Medicare began automatically denying final (end of episode) claims if no corresponding OASIS assessment was found. Not just any assessment, the assessment that drove the payment for the end of episode that was billed. For claims submitted after October 6, 2017, claims started being returned to the provider (RTP), and the provider is expected to make any necessary corrections to submitted OASIS assessments then handle resubmission of the claims as instructed. So why can't they match the OASIS? How does this work?

OASIS Items are used to match the Assessment to the Claim

M0010: Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN)

M0063: Patient's Medicare Number

M0090: Assessment Completion Date

M0100: Reason for Assessment equal to: 01 (SOC-Start of Care), 03 (ROC-Resumption of Care), or 04 (Recert)

M0010 and M0063 on the OASIS assessment must match what was submitted on the claim. **M0090 and M0100 are actually embedded in the OASIS claims matching key (treatment authorization code) per the grouper software.**

Final Claim with No Matching OASIS Assessment ⟶ What is the receipt date of the claim? More than 40 days from the M0090 date?

No Matching OASIS Assessment and greater than 40 days since M0090 ⟶ Claim Returned to Provider (RTP)

Palmetto GBA provides home health agencies with a job aid entitled *"Understanding Claim Denials with Reason Code 37253"*. This job aid provides detail information on how OASIS items are used to match a claim to a corresponding OASIS assessment, appeal information, and handle claims returned to provider (RTP). This job aid can be accessed on the following link: Understanding Claim Denials with Reason Code 37253.

Remember: You must contact Palmetto GBA for all billing/claims questions.

So How Do I Make Sure My Assessments Are Correct?

We can't repeat this too many times: **The only way** to ensure that an OASIS transmission has been absolutely and successfully transmitted to the CMS National Assessment Submission and Processing (ASAP) System, and is correct with no error or warning codes…is to review your Final Validation Reports (FVRs) each and every time you submit OASIS.

FVRs **must** be reviewed for rejections, errors, and warnings.

FVRs are found in CASPER Reporting. From the Welcome to the CMS QIES Systems for Providers welcome page, select the CASPER Reporting link to log into the CASPER Reporting application to retrieve FVRs. The CASPER log in box will appear (Use the same user ID/password that you used to access the OASIS Submission System and upload your assessments).
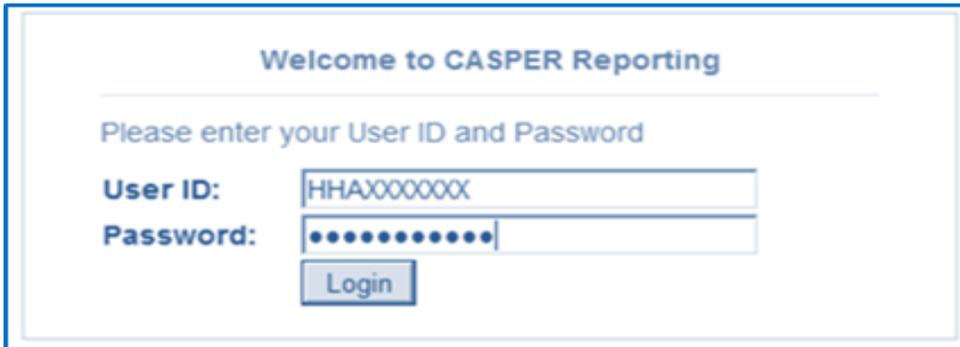
CASPER Reporting log in box

System Generated and On-Demand Final Validation Reports

System Generated in the agency's Validation Report (VR) Folder

When your OASIS submission is successful a system-generated OASIS Agency FVR is returned in the agency's shared validation report (VR) folder.

The naming structure of the folder is as follows: [State Code] HHA [Facility ID] VR: Example: TX HHA XXXXX12 VR. System-generated OASIS Agency FVRs are available for 60 days in your agency's shared VR folder, after which time they are purged.
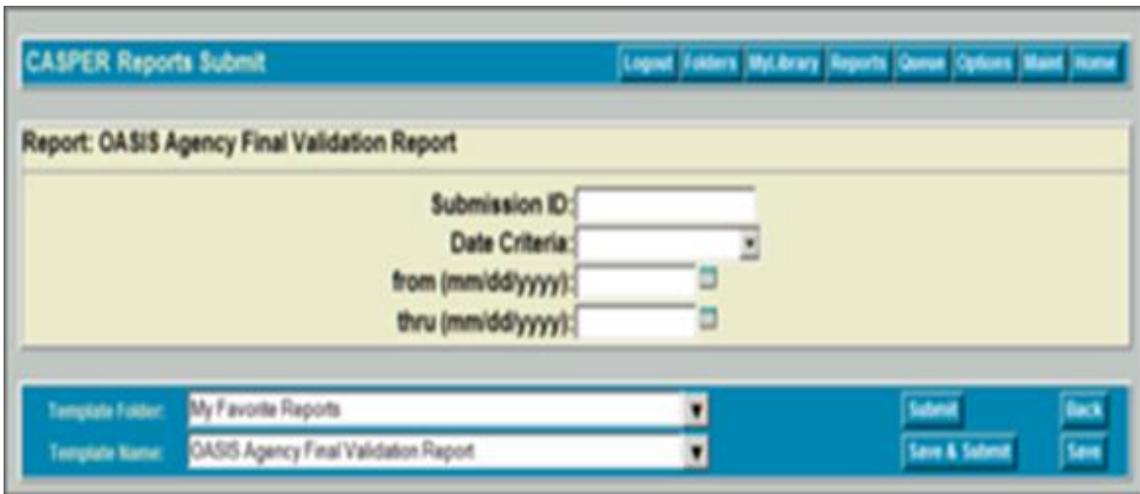

Example of agency agency's shared VR folder

On-Demand Final Validation Reports

On Demand FVRs can be used to obtain Validation Reports by Submission date or time period, and also by Submission Batch ID. Users can also rebuild FVRs for OASIS-C submitted prior to 01/01/2015.

The On Demand FVR is found in the "Reports" tab in the upper right corner of your screen. You would then select "HHA Provider" in the Report Categories in the left box and scroll through the pages until you find the "OASIS Agency Final Validation Report". A selection is made for a time period or Submission ID, and the submit button is clicked. The report is returned in the agency "In Box" which is located in the Folders tab.

On Demand OASIS Agency Final Validation Report screen

For more detailed information on all CASPER reports utilize the CASPER Reporting User's Guide for HHA Providers that can be found on the "Welcome to the CMS QIES Systems for Providers" welcome page and on the qtso.com website under OASIS/User guides and training.

But it's Just a Warning…

Don't By-Pass the Warnings!

M0063 is used to match the OASIS assessment to the claim.

Warning message -915 will appear on the FVR if the patient's Medicare beneficiary number (M0063) transmitted on the OASIS does not match the number stored in the QIES ASAP system. This warning from QIES ASAP system does not indicate if M0063 is right or wrong, only that it is different from what was previously stored on the QIES ASAP system. ***Action to Take:*** Verify the M0063 transmitted on the OASIS is correct. If not, submit a corrected OASIS assessment to address the error before submitting the final claim.

M0010 is used to match the OASIS assessment to the claim.

Warning message -3170 will appear on the FVR if the CMS Certification Number (CCN) in M0010 of the record differs from the CCN that is currently in the QIES ASAP system for the home health agency. How does this occur? Here's an example: The CCN was entered incorrectly in the agency's software used to create the submission file.

Action to Take: Verify the CCN in the encoding software is correct. Submit a corrected OASIS assessment to address this warning before submitting a final claim.

Remember, all rejections and warnings need to be reviewed and corrected as applicable. Not just the warnings impacting billing. The submitted OASIS assessments must always be accurate. This is a CMS mandated requirement.

Errors Happen! CMS OASIS Correction Policy

HHAs are required to collect and transmit OASIS data in accordance with CoPs §484.20, Reporting OASIS Information and §484.55 Comprehensive Assessment of Patients.

HHAs can electronically correct key field errors and non-key field errors on assessments found in their accepted OASIS assessment records. Besides describing the different types of corrections an agency can make, the CMS OASIS Correction Policy covers these additional topics:

- Documentation of Corrected Assessments
- Clinical Implications of Corrected Assessments
- Regarding Corrections in Lieu of Required assessments and
- Timeliness of Corrections

The CMS OASIS Correction Policy can be found in Survey and Certification Letter: 15-18 Survey and Certification Letter: 15-18.

In Other News!

OASIS-D

Get ready for the next BIG change in our forever changing OASIS land. CMS has indicated the OASIS-D data set will be effective 1/1/19.   For more information go to this link and open the CMS-10545 zip file: CMS-10545.html

QTSO link update

There is a new link to the QTSO website. If you have the QTSO website in your favorites or bookmarks, please update to the new https://qtso.cms.gov address. Be sure to clear the cache in your browser so the old address won't be a problem.

If you have any questions concerning this information, please contact the QTSO Help Desk at help@qtso.com or 1 (888) 477-7876.

Technically Speaking

Information and Tips from the OASIS Help Desk

Standard Data Format and OASIS~

In keeping with Regulation: 42 CFR 484.45(d), HHAs must encode and transmit OASIS data using software that conforms to CMS standard electronic layout, edit specifications, data dictionary and that includes the required OASIS data set.

One way to do this is to purchase software from a software vendor. If a HHA uses purchased software, it must conform to all CMS standardized electronic record formats; edit specifications, and data dictionaries. The software must also include the required data sets, and of course agencies will need to contact their computer support personal and software vendors providing the OASIS data encoding software if the agency has difficulty using, or verifying the purchased software conforms to CMS requirements.

Help! I can't afford to purchase software just to encode and transmit OASIS!

jHAVEN is the answer!

jHAVEN (java-based Home Assessment Validation Entry) is a **FREE** CMS software option available to HHAs. Agencies can choose to use the free jHAVEN software for data entry, editing, and validation of OASIS data in order to transmit OASIS to the QIES ASAP System. **Should we say again that it is free**?

jHAVEN Downloads, Installation and User Guides can be found using the following link: QIES Technical Support Office - jHAVEN Download

Wondering if you're using the correct data version?

Data specifications are available at the following link: OASIS –Data-Specifications

OASIS Data sets are available at this link: OASIS-Data-Sets

Helpful Resources and Links

(CTRL + Click to access the link)

OASIS Resource Page: OASIS Resource page

Contact Information

OASIS Helpdesk 512-438-4122
OASIS Helpdesk Email: oasis.help@dads.state.tx.us