

In order to facilitate the implementation of OASIS changes needed for the proposed changes to the home health prospective payment system (PPS) that are expected to be implemented on January 1, 2007, the Centers for Medicare and Medicaid Services (CMS) hosted a teleconference Open Door Forum for home health software vendors. The call, held on July 25, 2007, focused on details and timing of changes to the OASIS data set and corresponding software changes.

A CMS contractor spokesperson initiated the Open Door by announcing that the final rule for PPS reform will be issued in the near future. For vendors that plan to model their software programs after HAVEN, the current HAVEN will be replaced with version 1.06 and made available once completed on the CMS and QTSO web sites along with version 2.01 of the grouper software, codes, and test files. CMS will also provide pseudocodes for those vendors that plan to develop their own software. The grouper logic will be used for both episode and non-routine supply payment rate calculations.

## Billing Codes

The PPS contractor representative also announced that CMS plans to introduce a 5 character HIPPS coding system for home health claims, along with an 18 character matching key. The new HIPPS code will not include a data validity flag as found in the current code. The algorithm will convert numbers to letters and dates to Julian dates. HIPPS code positions will be as follows:

- 1=grouping step
- 2=clinical domain
- 3=functional domain
- 4=service domain
- 5=non-routine supply group

The 18 character matching key will also be changed. The new matching key will provide information about the OASIS that served as the basis for the HIPPS code, including the start of care date, assessment date, assessment type, and the clinical, functional, and service utilization scores. Matching key information will be used by CMS to auto-adjust payment rates when early/late episode and/or number of therapy visits differ on the final claim than was projected. The match key logic is:

- 1-4 =start of care dates
- 5-8 =date assessment completed
- 9 =reason for assessment
- 10 =episode timing (early/late)
- 11 through 18=clinical and functional severity levels points under each of the four equations.

If claims are not submitted in the correct format, they will be returned to the provider (RTP). Final pseudocodes will appear on the CMS web site for downloading with the final rule.

## HAVEN

The HAVEN contractor discussed the new data specifications for HAVEN version 1.6. Once HAVEN changes are finalized, records submitted with the old version of data specifications will be rejected. **The new specs for HAVEN will be available mid-December (approximately 12/17/2007). These new specs will be Section 508 compliant, i.e. include Microsoft Speak for use in a "visually impaired" mode.**

## Agency Compliance and Resources

A representative from the CMS Office of Survey and Certification addressed the responsibilities of home health agencies related to these changes. Home health agencies will be required to make changes to their forms and work with their vendors to incorporate the OASIS data set and software changes in order to be in compliance with the condition (484.20-Reporting OASIS data and 484.55-Incorporation of OASIS items). **Agencies whose software vendors are unable to meet CMS' deadline for compliance with the changes should use HAVEN in the interim.** State automation and education coordinators will be available to provide assistance to home health agencies.

**CMS hopes to publish revisions to the OASIS User Manual to reflect the changes to the OASIS data set needed for PPS reform within the next two months, assuming there are no major changes to the proposals to PPS in the final rule.** The new OASIS data set will be released after the final rule is published in the *Federal Register* and the form is approved by the Office of Management and Budget (OMB).

**CMS also plans to migrate, in a state-by-state phased-in fashion, from dial-up transmission of OASIS data to internet transmission.** Notification of home health agencies when it is their turn to migrate to internet transmission will be posted on their State welcome page. **It will be advantageous for agencies to have broadband access for this conversion.**

The formal presentation was followed by questions from the Open Door participants. Significant questions and responses are summarized below.

**1. Will diagnoses be weighted?**

**A. Primary diagnoses will be considered separately from all other diagnoses. Separate points will not be allocated for multiple diagnoses from the same grouping.**

**2. How many diagnoses will be counted since M0246 is limited to six v code replacements?**

**A. A case mix will get points for only one diagnosis on each line. The diagnosis that is assigned the highest number of points will be selected.**

**3. How should M0246 be used?**

**A. M0246 is an optional field that is to be used only if coding rules require that a v code replace a payment diagnosis.**

**4. Will Medicare Advantage plans comply with OASIS and PPS reform?**

**A. Each Medicare Advantage plan that pays on an episode basis will make its own decision as to whether to change its case-mix and payment methodology to reflect fee-for-service PPS reform.**

**5. Will home health agencies be required to submit a specific amount of OASIS data in order to avoid the 2% reduction mandated by pay for reporting?**

**A. This information will be made available in the final rule.**

**6. How will the Common Working File (CWF) be used for determining whether an episode is early or late?**

**A. Since CWF is able to see two episodes back-to-back CMS will be able to use it to determine whether an episode is early or late, and make any necessary payment corrections automatically.**