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JUN - 6 2007

May 28, 2007

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-1541-P
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Musotto:

The following comments are offered in response to the proposed revisions to the home health OASIS document. The proposed revisions to the Home Health PPS published May 4, 2007 call for elimination of Significant Change in Condition (SCIC) payment adjustments. If this proposed elimination is adopted, completion of an "Other Follow – up" OASIS will not be necessary for payment purposes.

However, the Medicare Home Health Conditions of Participation contain language requiring that "Other Follow – up" OASIS be completed when there is a significant change in condition (484.55(d). As stated in the proposed rule, completion of these assessments identifying SCICs has been problematic, inconsistent, and burdensome for home health agencies. In addition, when a patient does experience a change in condition, the plan of care is updated at any time during the episode by contacting the physician and recording verbal/phone orders. This action by agency staff is not dependent upon completion of an OASIS.

Due to the increased burden and inconsistencies among agencies in completing the "Other Follow-up" OASIS, I would recommend the Conditions of Participation be revised to eliminate that requirement.

Sincerely,

Dinah Burton, RN, MSN

Dinah Burton, RN, MSN
Director Quality & Risk Management

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American Health Information
Management Association®

June 4, 2007

OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building, Room 10235
Washington, DC 20503

Dear Ms. Lovett:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') information collection requirements pertaining to the proposed revision of the OASIS, as described in the May 4, 2007 *Federal Register*.

AHIMA is a professional association representing more than 50,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnoses and procedure classification systems that serve to create the diagnoses related groups discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

AHIMA appreciates CMS' commitment to adherence to the ICD-9-CM coding rules and guidelines for completion of the diagnosis data elements in OASIS, including sequencing requirements, and the inclusion of instructions in OASIS to promote proper and consistent coding practices by home health agencies.

Our comments pertain to the proposed revisions for M0230/M0240/M0246:

1. Changes to the section are complex. Instructions must be very clear, with good examples listed, and of course the manual should be updated to offer many examples of correct coding.

1730 M Street, NW, Suite 502, Washington, IL 20036
*phone* (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

2. This is going to be confusing to professionals who are new to home health and have not worked in this area prior to the 2003 changes. They must understand reporting prior to the use of V codes on OASIS.
3. The instructions need to be clearer for column 4. Since it is only used if there is an etiology (column 3) and manifestation (column 4) then it would help if column 4 states: Complete **ONLY IF** the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situations. The ONLY code that is reported in Column 4 in the manifestation code. Would CMS want to collect information on all underlying diagnoses to V codes and not just limit it to those that are case mix diagnoses? This would provide detail for case mix considerations in the future.
4. We recommend the expansion of the MO240 data element to allow the reporting of at least 8 diagnoses to correspond to the secondary diagnosis fields on the UB claim form. It is not uncommon for home care patients to be treated for multiple chronic conditions. With the increase in the codes that impact case mix, it appears that multiple codes will determine payment. If the number of allowable codes is not expanded, the agency will be forced to sequence certain codes that maximize reimbursement which will skew the data and potentially impact integrity for policy decision-making. Collection of more complete clinical information would facilitate the evaluation of quality of care and future refinements to the home health prospective payment system. Without a full diagnostic picture, any system will produce inaccurate data that will then lead to flawed decisions.
5. In light of quality reporting, prospective payment system refinements, and other initiatives that demand increasingly greater detail about patients' clinical conditions, we urge the Department to consider accepting and processing **ALL** pertinent diagnoses. Without a complete clinical picture, the ability to accurately assess patient severity, evaluate outcomes, and make policy decisions is seriously jeopardized.

If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS
Melissa Musotto, CMS

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1541-P
CMS-1545-P-2 **Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008**

**Submitter :** **Date & Time:** **06/07/2007**

**Organization :**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Collection of Information**

Collection of Information

*We are attempting to use the TOY calculator to compare a few historic episodes. Our first road block is the availability of information in the CWF. The CWF (at least for us) shows the last two episodes. We need to see a history of episodes if we are to simulate retroactive responses for these historic episodes. Ongoing, we will need to be able to see up to four sequential episodes prior to our episode beginning.

*In order for us to better understand the impact of the proposed changes (and to our specific agency), it would be helpful if CMS would make available programming that would take our collective episodes in a specific time period (2006) and recalculate reimbursement using the proposed changes. If TOY is the answer to this, TOY needs programming changes since many of the TOY input fields result in inaccurate N/A response and then the totals do not add correctly and do not reconcile with the existing HHRG code. If there are errors with the existing HHRG calculation, how do we know the proposed new HHRG calcualtions are correct?

**GENERAL**

GENERAL

* In regard to the Early/Late designation of the episode, CMS should give the agencies the ability to look up four sequential episodes prior to the episode in question in order to complete the Oasis properly. CMS should automatically correct this answer (both favorably or unfavorably as it relates to reimbursement) as needed with updated information in the CMS system.

* Will the regulations be changed to only require Oasis be submitted for the calculation of the HHRG? For example, why would a follow up Oasis be required if the follow up Oasis is not factoring into the reimbursement (as it currently may be)?
*

**Impact Analysis**

Impact Analysis

* If 2003 Medicare claims are the latest Medicare claims available for use in this proposal, I think the informaiton is too old and should be updated. Surely CMS should have access to Medicare claims through 2006 or worse case 2005. I wouldn't think the 2003 information would give good comparisons to the financial impact the proposed changes would have on agencies today.