Admission Policies under the new OASIS-C

The Need for a Competent and Capable Contingency Plan for Each Patient is Critical under OASIS-C

The new OASIS-C is a reflection of new data about why patients deteriorate and are hospitalized. Wounds, falls, and depression are new areas of concern as reflected by the re-tooling of the OASIS assessment. Your admission policies have a significant effect on how many visits you will make and achieving discharge in a timely manner.

When you admit an patient that requires many visits, you should be able to depend on a competent caregiver to facilitate the home health careplan. Implementing a policy that requires a competent and available emergency contact will help you to reduce the number of visits, achieve timely discharges, and produce solid clinical and functional outcomes.

The Rationale

The average reimbursement per episode will continue to decrease. For example, the national average utilization for patients needing intensive wound care is 12 to 19 SN visits over 6 to 8 weeks. The days of making BID or even daily visits are long gone, except in rare cases where the Agency can expect an outlier payment. Given the average national utilization, your Regional Intermediary (RI) will expect you to maximize the patient's resources and include family and other supportive assistance in teaching and discharge planning. If you submit a Final Claim with visits that are significantly under or over the average utilization, your RI will start auditing your clinical documentation.

Recommendations

In order to admit a patient for physician-ordered home health services, you should have a policy stating that the patient must have a competent, appropriate, and available contingency plan. Although CMS does not have a specific standard or CoP requiring an emergency contact, most state laws governing HHA licensure have this requirement.

What You Should Do

1. Follow your state licensure requirements and only accept patients who have a competent and available emergency contact.
2. Require the emergency contact to be present for skilled visits.
3. Teach the emergency contact skilled procedures.
4. Provide written teaching guidelines for skilled procedures.
5. Have the patient and emergency contact complete a log that shows when they performed skilled procedures in-between home visits