APPENDIX B – OASIS DATA ACCURACY

1. DATA ACCURACY

Medicare Home Health Care Conditions of Participation §484.20(b) Standard: Accuracy of Encoded OASIS Data stipulates that the encoded OASIS data must accurately reflect the patient's status at the time the information is collected. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to the State. Once the qualified skilled professional completes the assessment, the HHA should develop means to ensure that the OASIS data input into the computer and transmitted to the State agency (or CMS contractor) exactly reflect the data collected by the skilled professional. Chapter 12 of the original *OASIS Implementation Manual* contains recommendations for conducting data quality audits on a routine basis. This information is summarized below. In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the State.

2. DATA QUALITY AUDITS

Data-driven systems, such as OASIS data collection and outcome measurement, depend on the accuracy of source data describing patient health status. It follows that minimizing data errors that could affect accuracy of clinical data or outcome analyses is a necessary condition. This function is the responsibility of the agency since, ultimately, agency-level outcome reports reflect the data agencies input into the system. Internal staff development and training must focus on data accuracy not only at the start-up of OASIS data collection, but on a continuing basis. We recommend that data quality audits be conducted in agencies on a routine basis. Some data audit activities should be conducted monthly, while others can be conducted at less frequent intervals, such as quarterly.

The following guidelines provide a method for monitoring the quality of data in an agency. Types of audits, their recommended frequency, and categories of staff members (to conduct data audit activities and summarize findings) are suggested. If problems are identified, it is also recommended that the agency develop and implement a plan to correct data quality problems. Table B.1 displays the data quality audit approaches discussed and summarizes the purpose, frequency, and procedures for each. .

Table B.1: Data Quality Audits.

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Clinical Record Audit	To verify accuracy of OASIS patient status items compared to other related patient documentation	Monthly	Review at least five SOC records and five discharge records. Compare OASIS items to other documentation from the SOC or discharge visits and from other visits surrounding SOC or discharge.	QI coordinator or clerical staff

Table B.1: Data Quality Audits. (cont'd)

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Data Entry Audit	To verify accuracy of OASIS data entry and the data in the clinical record (or using double data entry)	Monthly	Either: (1) Obtain a hardcopy of OASIS data that were entered for five patients. Compare to OASIS items in clinical record; or (2) Data enter OASIS information for five patients twice. Compare data entered the first time to data entered the second time for each patient.	QI coordinator, IS/IT coordinator, or data entry staff
Clinical Audit Visits	To verify accuracy of OASIS assessment data, i.e., evaluate assessment methodology and assessment skills of clinical staff	Quarterly	For at least three or four patients, a supervisor or peer auditor attends the SOC visit. The auditor completes OASIS items while the care provider conducts the assessment and completes SOC paperwork. OASIS items are compared for consistency between auditor and care provider.	QI coordinator, clinical supervisor, or clinical staff

a. Monthly Audit Activities

Clinical Record Audits: Clinical record audits allow an agency to monitor the validity of OASIS data. The quality check assesses the congruence of OASIS data with other patient status information found in the clinical record. This audit allows an agency to check for systematic bias in describing patient status. Most often, this will take the form of exaggerating illness or disability at start of care to enhance the justification for providing services and, under prospective payment, to maximize payment. There may also be a concomitant bias in the opposite direction for a discharge assessment, driven by a desire to make patient outcomes appear in a more favorable light or simply as a justification for discharge (e.g., the goal of reaching a certain level of functioning has been met).

To conduct a clinical record audit, an abbreviated record review can be conducted for at least five new admissions and five patients discharged from the agency (but not due to an inpatient facility admission). Records should be randomly selected, in order to evaluate data quality for a cross-section of patients and care providers. The selection process might be as follows:

- Choose a standing date for record selection (for example, the first Tuesday of every month). On that day each month, alphabetically compile a list of all skilled care patients admitted to the agency for the previous month. For example, if the record selection date for February falls on February 3rd, compile a list of all patients admitted to the agency from January 3rd to February 2nd.

- Count the number of patients on the list. Divide that number by five, rounding down to the nearest whole number. For example, if there are 42 patients on the list, 42 ÷ 5 = 8.4, which would be rounded to 8. This number, n, will be used to select records. Divide this number by 2 to obtain the starting point, m, for selecting records.

- Count from the first patient alphabetically, select the mth patient, and select every nth patient after that. Using the above example, you would select the 4th person and then every 8th person on the list for record review.

The same procedure should be used to select records for discharged patients. Compile a list of patients discharged from the agency within the previous month. Divide the number of patients by five, and use that number (n) to select patients for record review.

In the event that you have fewer than five patients admitted to or discharged from your agency, review all records. It should be noted that many agencies choose to audit a larger sample and some audit 100% of records.

Procedure for Clinical Record Audits: For new admissions, review the start of care (SOC) OASIS items and compare to other admission documentation and two or three subsequent visit notes, if they occur within the first week after SOC. In addition, if care providers from two disciplines perform assessments on the patient within one week of SOC (e.g., registered nurse conducts comprehensive assessment visit and completes OASIS items; the physical therapist visits two days later and evaluates the patient), the documentation should be compared. Reviewers should evaluate whether any discrepancies between the SOC OASIS assessment and the other documentation are sufficiently significant to indicate a data quality problem. For example, if the SOC OASIS items indicate that the patient is fully independent in ambulation, but other documentation indicates that the patient needs assistance when walking, a data quality problem may exist. Assess for any discrepancies between sociodemographic items (e.g., patient ID number or age) in addition to discrepancies in clinical assessments (ICD codes, all clinical assessment OASIS items).

The records for discharged patients should be reviewed in the same manner. All discharge OASIS patient status items should be compared to other discharge information as well as to the previous two or three visit notes (if those visits occur within the same week of discharge). If there are large differences in descriptions of the patient, a potential data quality problem exists.

If differences are found that cannot be explained by other documentation in the clinical record, the care provider who completed the OASIS should be contacted to determine if the discrepancies were real (e.g., the patient did change significantly between the SOC visit and a visit the next day) or if an error was made when recording OASIS data. If data quality problems exist, the problems can be corrected. If clinical documentation must be amended, this should be done according to agency policy. Any corrections to OASIS data in the clinical record must also be reflected in the OASIS database maintained by the agency, and if data submission has already occurred, a correction must be submitted to the State.

Data Entry Audits: Data entry audits allow agencies to monitor the accuracy of data entry. Data entry errors in fields such as birth date or health insurance number are often detected through other agency procedures (e.g., billing -- if the data entry software communicates with other agency systems), while patient status data are not typically subjected to such verification. Such errors, however, can affect outcome analyses and should be

monitored. This type of audit may not be relevant for agencies using electronic health records, as data entry occurs concurrently with the clinical assessment.

To conduct a data entry audit, a small sample of Medicare and/or Medicaid (skilled care) patient records should be checked at monthly intervals. In this evaluation, the clinical documentation is compared to the OASIS data that was entered to assess for data entry errors. This can be done by visual inspection or by double data entry, where the same record is data entered twice.

Procedure for Data Entry Audits: From the monthly list of Medicare and Medicaid patients admitted to the agency, select at least five records. The sample records need not be randomly selected, but if more than one person is responsible for data entry, some records entered by each staff member should be assessed. These may be the same records you use for the clinical audit. Obtain a printout of the information that was data entered or view the data online (the procedure for doing this will vary, depending upon the software you choose). Compare the response to each OASIS item in the clinical documentation with the computer printout or screen display of entered data. An alternative method is to have two staff conduct data entry of the same records independently and to compare the data records item by item.[1]

If discrepancies exist between the data that were entered and the OASIS items in the clinical record or between the OASIS items that were data entered twice, it is important to follow up with appropriate personnel. The agency database should be corrected and if necessary a correction should be submitted to the State. If data entry errors appear to be pervasive, a plan of action to remedy the problems should be developed and implemented.

b. Quarterly Audit Activities

Clinical Audit Visits: Clinical audit visits provide an opportunity to verify the quality of patient status data collected by clinicians. It is recommended that each quarter agencies conduct supervisory (or peer) audit visits to at least three to four patients. These audit visits should occur at the admission comprehensive assessment visit. Within a one-year period, each clinical staff member of an average-sized agency thus can receive an audit visit. The supervisor or peer auditor should complete the SOC OASIS items while observing the care provider conducting the SOC visit. The care provider and auditor should not discuss OASIS items between themselves during the visit. The QI coordinator (or designated person) then compares each item on the SOC OASIS items completed by the care provider to the OASIS items completed by the auditor. Discrepancies should be noted. Any differences between OASIS items should be discussed jointly by the care provider and auditor to determine the reasons for the differences and to ensure that care providers fully understand the OASIS items. It is not necessary to select a random sample of patients for the audit visits, but the QI coordinator or QI team should ensure that a variety of patients and care providers are represented.

[1]The exact mechanism for accomplishing double data entry will depend on the data entry software your agency uses, and may require some database programming at the agency or by your vendor. HAVEN, for example, does not directly support double data entry, although it can be accommodated by a HAVEN user with some expertise in database management.

3. SUMMARIZING AUDIT ACTIVITIES

a. Documentation

Agencies should summarize findings from all audit activities as they are completed. Because these audit activities will be an ongoing quality monitoring activity, it may be helpful to include summaries of findings in quarterly QI reports. If data quality problems are identified from the audit activities, investigations should be conducted into the cause(s) of the problems, and action plans developed and implemented to resolve the problems. Approaches to assure that accurate patient-level data are utilized to describe patient status and to compute outcome measures increase the likelihood that agency-level outcome reports accurately describe the effectiveness of patient care.

b. Chapter 12 Worksheets

Chapter 12 of the OASIS Implementation Manual contains worksheets that may be helpful to you in summarizing your findings, but there are no requirements for their use. Agencies may develop their own summary forms or modify current monitoring forms to include the data quality audit results. These are available at the following link (download Part I Chapters): http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage .

c. Making Corrections To Oasis Data

The following information is posted on the www.qtso.com website for making corrections to OASIS data. For more item-specific questions, refer to CMS posted Q & As on the CMS website (see link in Chapter 5 Resources)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: S&C-01-12

DATE: **April 20, 2001**

FROM: Director
Survey and Certification Group

SUBJECT: New Outcome and Assessment Information Set (OASIS) Correction Policy for Home Health Agencies (HHAs)—ACTION and INFORMATION

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

With the scheduled spring 2001 update of the OASIS state-based systems, HHAs will have the ability to electronically correct nearly all errors found in their production OASIS submissions. Currently, the OASIS state-based systems allow HHAs to electronically correct non-key fields in assessments that contain errors. Correcting key field errors and removing assessments that are submitted in error are subject to a process that, until the state system update is in place, can only be corrected by asking state staff to manually make the appropriate corrections or deletions in the state's database. Making such manual deletions has been time consuming and prone to error and many correction and deletion requests have not been fulfilled.

State System and Software Update

We expect the OASIS state-based systems to be updated the week of April 30 - May 4. By May 7, HHAs will be able to correct nearly all erroneous assessments themselves. In order to transition to the automated correction process, state agencies should no longer accept requests for key field changes. Instead, HHAs should be instructed to use the new inactivation procedures that will be available to them beginning May 7 to correct assessments containing key field errors. State agencies should clear up any backlog of requests for key field changes by April 29. The state system update will not change the current process for making non-key field changes.

Concurrent with the update to the OASIS state-based systems, a new version of the Home Assessment Validation Entry (HAVEN) software, HAVEN 5.0, will be distributed to HAVEN users free of charge and will also be available for download from the OASIS website at www.hcfa.gov/medicaid/oasis/havensof.htm. HAVEN 5.0 will give HHAs the ability to electronically correct nearly any kind of assessment errors.

Key Fields and Non-Key Fields

A description of key fields is below. Non-key fields are all other fields making up the OASIS data set that are not key fields.

Key Fields	
Patient Identifiers:	
M0040_PAT_LNAME	Patient last name
M0040_PAT_FNAME	Patient first name
M0064_SSN	Patient social security number
M0066_PAT_BIRTH_DT	Patient date of birth
M0069_PAT_GENDER	Patient gender
HHA Identifiers:	
HHA_AGENCY_ID	Unique Agency ID code
Assessment Event Identifiers:	
M0100_ASSMT_REASON	Reason for completing assessment
M0090_INFO_COMPLETED_DT	Date assessment information completed (This is a key field only on recertification or follow-up assessments where RFA=04 or 05)
M0030_START_CARE_DT	SOC date (This is a key field only on SOC assessments where RFA = 01 or 02)
M0032_ROC_DT	ROC date (This is a key field only on ROC assessments where RFA = 03)
M0906_DC_TRAN_DTH_DT	Discharge, transfer, death date (This is a key field only on transfer to inpatient facility assessments where RFA = 06 or 07, death at home assessments where RFA = 08 and discharge assessments where RFA = 09 or 10)

With the implementation of Version 1.20 of the OASIS data specifications in May, HHAs will be able to electronically correct key field errors in production records in addition to non-key field errors and also remove erroneous records using an automated methodology called inactivation. With the ability to inactivate erroneous OASIS assessments, as described below, HHAs will be able to remove assessments from the state system's active database that have been submitted in error. These records are not actually deleted, but are moved from the active database to a history database that contains records that have been modified or inactivated. This approach keeps an audit trail of modified and inactivated records, but "hides" them from the normal state system reporting procedures.

Determining When to Inactivate an Assessment

If an error has been made in one or more **key fields,** or if an assessment was submitted in error, the HHA will no longer need to notify the state OASIS automation coordinator. The erroneous assessment can and should be inactivated by the HHA. **The inactivation procedure should be used if it is necessary to correct an assessment with errors in key fields. Use of the inactivation procedure is not applicable to correcting assessments with only non-key field errors.** In other words, if an assessment contains errors in only non-key fields, then correction type 3 listed below should be used.

In order to determine whether to submit an inactivation request, the user should apply the following rules:

A. If an assessment was submitted in error (i.e., it should never have been submitted), it must be inactivated. For example, if a discharge assessment was submitted by the therapist; however, the patient is still being visited by the nurse, an inactivation request must be submitted for the erroneous discharge record. Another reason to inactivate an assessment would be if the submitted assessment contained the wrong patient name.

B. If an assessment was submitted which contained an error in any of the key fields listed above, then an inactivation request must be submitted. Normally, the HHA will also submit a new, corrected assessment in this situation. For example, if the HHA discovers that the patient's last name on the start of care (SOC) assessment is spelled "Smyth," while on the follow-up (FU) assessment it is spelled "Smith," it needs to make the appropriate correction. When the HHA determines the discrepancy, the incorrect record must be inactivated and a new corrected record must be submitted.

C. If an assessment was erroneously submitted in a masked format, that is, it was later discovered that the patient was a Medicare or Medicaid patient but was not originally indicated as such at M0150, then an inactivation must be submitted. Normally, the HHA will also submit a new, corrected assessment in this situation. For example, if the value at M0150 for a submitted and accepted assessment is not equal to 1, 2, 3, or 4, *and it should have been*, then an inactivation request should be submitted

Note: There is no automatic mechanism to reactivate a record that has been inactivated. Consider the case where a discharge assessment is submitted to the state system for a patient, but is inadvertently inactivated. There is no means to "undo" the inactivation and thereby "reactivate" this discharge. Instead the HHA must submit the discharge record again. An inactivated record can only be "undone" by the re-submission of the record.

Deleting Assessments

In certain infrequent situations, inactivation is not sufficient to correct assessment errors since inactivation alone does not remove the assessment record from the OASIS state system. Two situations require deletion of an erroneous assessment, rather than inactivation. States will continue to need to submit deletion requests on behalf of HHAs, upon request, to the Iowa Foundation for Medical Care as per current policy outlined in our November 2, 1999 technical memorandum (State Technical Support Office (STSO) Memorandum 1999-075). Described in that memorandum are the following situations requiring deletion.

A. If an assessment exists on the state's database that should never have been stored there, according to current policy it must be deleted. For example, if an assessment was erroneously submitted in an un-masked format (i.e., it was marked at M0150 as 1, 2, 3 or 4) and later it was discovered that the patient was <u>not</u> a Medicare or Medicaid patient because one of these pay sources was incorrectly selected on M0150 (i.e., it should not have marked 1, 2, 3, or 4), the assessment must be deleted from the OASIS state system.

B. If test files and/or batches have been submitted as production files and/or batches in error, they must be deleted.

Types of Corrections an HHA Can Make in HAVEN 5.0

The new version of our data entry software, HAVEN 5.0, will offer the following menu of corrections an HHA can make.

1. Assessment was Submitted to the State and was Rejected. The HHA can unlock the assessment (the lock date changes to reflect the date the correction was made), make the necessary changes, re-lock the assessment, and re-submit it. Because of the built-in edit checks, HHAs using the HAVEN software should not expect records to be rejected by the state system for this reason. Note that the following examples are provided for illustration purposes to troubleshoot HAVEN-like software, but cannot occur in HAVEN.

   EXAMPLE 1: The HHA Agency ID field in one or more assessment records does not match the HHA Agency ID in the header record of the submission file. The entire submission file is rejected and no data is loaded into the state database.

   EXAMPLE 2: The patient=s last name was missing from the assessment file (data record). The HHA may have inadvertently left this field blank. The OASIS state system must have the patient=s last name. The data record in this example would be rejected and no data from this record would be loaded into the state database.

   In these examples, the HHA would make the necessary corrections and re-submit the record. Since the OASIS state system never accepted the original assessment, the correction number field IS NOT incremented in this situation. HHAs may still receive a warning if submission/timing guidelines have been exceeded.

2. Assessment was Submitted to the State and was Accepted. Correction to Key Fields is Necessary. With the implementation of the OASIS state system update, this option will display but will no longer be available and is disabled in the new HAVEN 5.0 software. To correct an assessment with key field errors, first inactivate the assessment, then create a new assessment for re-submission, as applicable. See option 4.

3. Assessment was Submitted to the State and was Accepted. Correction to Non-Key Fields is Necessary. If an HHA determines that a correction(s) must be made to **non-key fields only** (i.e., any fields in the OASIS data set not contained in the key fields listed above), the HHA should re-open the assessment, revise the targeted non-key fields, and re-lock and re-submit the corrected record. The lock date changes to reflect the date the correction was made.

   Note: 'CORRECTION_NUM' is a counter field contained in the programming of the HAVEN software used to track corrections made to an assessment record. The counter field is set to 00 when an assessment record is initially locked. The counter field is incremented in this case. Both the original assessment and the corrected assessment will

be stored in the state database. When this type of correction occurs, the rule requiring the lock date to be within 7 days of the assessment's completion date (M0900) is waived for the corrected record.

4. Assessment was Submitted to the State and was Accepted. Inactivation of the assessment is necessary. This is a new option in HAVEN 5.0 that allows HHAs to correct key field errors by inactivating the assessment(s) containing key field errors and re-submitting a new, corrected assessment. Unlike making non-key field changes, as described in correction type 3 above, the HHA does not simply unlock the assessment record, make the necessary key field changes, re-lock the record, and re-submit it. Instead, the HHA is taken directly to the assessment in question where it can be viewed in a read-only format. While in read-only mode, when the HHA confirms that the assessment should be inactivated, HAVEN will ask the HHA to commit to this selection. The correction number field on the HAVEN Management screen displays an 'X' and the assessment status is set to "Locked (Export Ready)." The 'X' indicates that this assessment has been prepared for inactivation.

   When the HHA selects this correction type, a copy of the original assessment record is created. To re-submit the assessment with the necessary corrections, the HHA first exports the assessment that is being inactivated. From the HAVEN Management screen, the HHA then selects the inactivated record in question and clicks on the 'Correct Assessment' button. A popup box will appear asking if the HHA wants to make any corrections to this assessment. When the HHA clicks on the 'OK' button, a copy of the original assessment appears. The HHA makes the necessary changes and re-submits the assessment. The correction number for this assessment is reset to 00. The lock date changes to reflect the date the correction was made.

The attached flow chart depicts the most common situations necessitating correction.

Documentation of Corrected Assessments

When a comprehensive assessment is corrected, the HHA must maintain the original assessment record as well as all subsequent corrected assessments in the patient's clinical record for five years, or longer, in accordance with the clinical record requirements at 42 CFR 484.48. If maintained electronically, the HHA must be capable of retrieving and reproducing a hard copy of these assessments upon request. It is acceptable to have multiple corrected assessments for an OASIS assessment, as long as the OASIS and the clinical record are documented in accordance with the requirements at 42 CFR 484.48, Clinical records.

Timeliness of Corrections

Currently there are no requirements regarding the timeliness of correcting and inactivating assessment records, either in terms of when they must be completed (locked) or submitted. However, we urge HHAs to make corrections and/or submit inactivations as quickly as possible after errors are identified so the state system will be as current and accurate as possible. This affects the data used to calculate the HHA's Outcome-Based Quality Monitoring reports.

Clinical Implications of Corrected Assessment Records

When corrections are made to an assessment already submitted to the state system, the HHA must determine if there is an impact on the patient's current care plan. If there is an impact, in addition to the correction made to the assessment, the HHA must make corresponding changes to the current care plan. If there are any other records where the correction has an impact, for example, the Home Health Resource Group, the Plan of Treatment (HCFA Form-485), or the Request for Anticipated Payment, the agency should make corresponding changes to that record, as applicable. The agency should establish a procedure to review the impact of any corrections made to assessment records and make corresponding changes to other records that are affected.

Regarding Corrections in Lieu of Required Assessments

Collection and submission of information on SOC (Reason for Assessment (RFA) 1, 2), Resumption of Care (ROC) (RFA 3), FU (RFA 4), Other FU (RFA 5), Transfer (RFA 6, 7) and Discharge (RFA 8, 9, 10) assessments are required by the comprehensive assessment requirements at 42 CFR 484.55. The correction process described here does not preclude the need for accurate patient assessment at the required time points.

The inactivation of an assessment and subsequent correction and re-submission of a new assessment, or a correction to a non-key field cannot be used in lieu of the appropriate OASIS assessment for documenting an unanticipated change in patient condition that was not envisioned in the original plan of care. If there is an unexpected change in the patient's clinical condition due to a major decline or improvement in health status that warrants a change in plan of treatment, the appropriate OASIS assessment is expected to document the change, i.e., the ROC or Other FU assessment, as appropriate. This is in keeping with the regulation at 42 CFR 484.20 (b), accuracy of encoded OASIS data that states, "The encoded OASIS data must accurately reflect the patient's status at the time of assessment." It is necessary to have one document for the patient's assessment, care planning, and payment purposes.

Multiple Corrections in a Record

Correcting assessments with key field errors can only be done by inactivating the incorrect assessments and replacing them with the corrected assessments, as previously described in correction type above. Correcting assessments with non-key field errors can only be done by re-opening the assessment, revising the targeted non-key fields, re-locking and re-submitting the assessment, as previously described in correction type 3 above. 'CORRECTION_NUM' (the counter field) is implemented in non-key field changes. For more specific information concerning the process of correction and inactivation, please refer to the Version 1.20 OASIS data specification notes on the OASIS web page at http://www.hcfa.gov/medicaid/oasis/datasubm.htm.

Questions and Answers Regarding the Automated Correction Policy

Q1. Will HHAs be allowed to change the Reason For Assessment in HAVEN at OASIS data item M0100 if they have submitted the wrong type of assessment?

A1. No. HAVEN will require that the HHA inactivate the erroneous assessment and re-submit a corrected assessment.

Q2. An OASIS transfer assessment (RFA 6) was collected, encoded, and submitted to the state. The resumption of care assessment (RFA 3) was also collected, encoded and submitted. Subsequently it was determined that the assessments were submitted for the wrong patient. Will the submission of an inactivation request for the transfer assessment (RFA 6) also serve to inactivate the incorrect resumption of care assessment (RFA 3), or is it necessary to submit a separate inactivation record for both incorrect assessments?

A2. The submission of an inactivation record for the OASIS transfer assessment (RFA 6) will not inactivate the ROC assessment (RFA 3). It is necessary to submit an inactivation record for both erroneously submitted assessments. It is important to note that an inactivation inactivates only a single record.

Q3. If an HHA makes a correction to a key field after having previously submitted 3 non-key field corrections on the same assessment, will the corrected assessment reflect that the HHA has made 4 changes or 1 change?

A3. If the HHA inactivates the last assessment that had a correction number of 03, then it has inactivated that record (i.e., the original and all 3 correction assessments). Normally, the HHA will also submit a new, corrected assessment to replace the inactivated assessment. When this occurs, the correction number of the new corrected record is 00. Any subsequent corrections to non-key fields using correction type 3 would be reflected in the correction number field as 01 and would increase incrementally from there, as applicable. Note that key field corrections take precedence over non-key fields. Correction to both types of errors in a single assessment cannot be done without the inactivation process. An assessment with only key field errors must be inactivated, corrected, and re-submitted. An assessment with both key field and non-key field errors must first be inactivated, then replaced with the corrected record. An assessment with only non-key field errors does not require inactivation. The HHA can simply re-open the assessment, make the applicable non-key field changes, re-lock the assessment and re-submit it.

Q4. If the HHA identifies that an error was made in a patient's Social Security number after having submitted several assessments on that patient containing the error, will the inactivation process retroactively correct all erroneous submissions?

A4. No. Each assessment submitted to the state system containing the error must be individually inactivated and a corrected assessment submitted in its place. If an HHA inactivates one assessment record, it has inactivated one record. It is important to note that an inactivation request inactivates only a single record.

Q5. An HHA has an assessment with a key field error and will submit a request for inactivation. The HHA will need to submit a new corrected assessment to replace the erroneous record. Can it submit both records in the same submission batch?

A5. Both the inactivation request and the replacement record may be included in the same submission batch.

Q6. Can an HHA submit non-key field corrections, inactivation requests, and new assessments in the same batch?

A6. Yes. An HHA can submit all of these record types in a single batch, if it chooses. The state system follows a sorting algorithm that processes all of the inactivations first, then processes all other records (both originals and corrections) by effective date.

Q7. Will the state system accept assessments created using HAVEN 4.0 once it has been updated?

A7. Yes, but note that HHAs will not be able to inactivate erroneous assessment records with this version of HAVEN.

Q8. Will HAVEN 5.0 allow correction of assessments that were created using HAVEN 4.0?

A8. Yes, HAVEN 5.0 allows correction of assessments created in prior versions of HAVEN. Highlight any assessment that has Locked (Exported) status, then click the Correct Assessment button. The HHA has 3 possible options: correct an assessment that was rejected, create a non-key field correction assessment, or create an inactivation record. Note that in HAVEN 5.0, the key field correction option is disabled. In order to perform a key field correction, it is necessary to inactivate the assessment(s) for the patient and then create replacement assessment(s) with the corrected key field information. It is important to make the key field changes in the Maintain Patient Database screen and update the replacement assessment accordingly before locking and exporting the assessment!

Q9. The HHA inadvertently submitted a bunch of nonsense information that should have been submitted as test data, but was submitted as production (live) data. What should the HHA do?

A9. Inactivation will not solve this problem. The HHA should contact the state's OASIS automation coordinator and request that the erroneous data be deleted from the state system. The coordinator should follow the deletion procedures outlined in STSO memorandum 1999-075.

Q10. Where can I find STSO memorandum 1999-075 concerning deletion requests?

A10. State agency personnel can retrieve this memorandum and all other STSO (now called QIES Technical Support Office (QTSO)) memoranda on the state-specific area of the QTSO website at www.ifmcis.org/stso.

Effective Date

The automated correction policy is effective May 7, 2001. Effective March 30, 2001, state agencies are no longer accepting requests from HHAs for key field corrections. Between now and April 29, 2001, state agencies should complete any key field corrections requested by HHAs prior to March 30.

Training

This policy should be shared with all OASIS Education and Automation coordinators, home health agency surveyors, their managers and the state/regional office training coordinator and

home health providers.

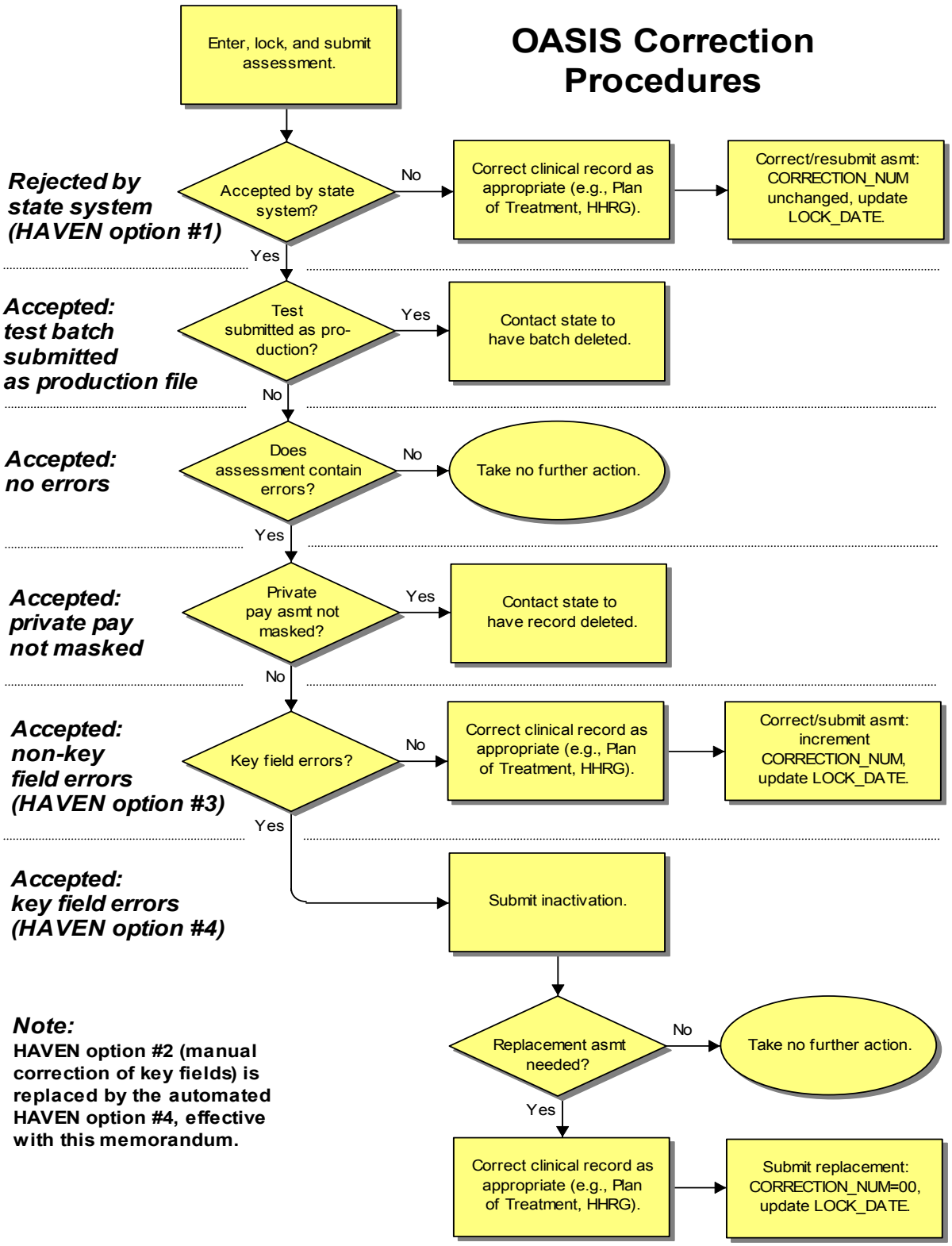
If you have any questions about these instructions, please contact Tracey Mummert at (410) 786-3398 or Mary Weakland at (410) 786-6835.

/s/
Steven A. Pelovitz

Attachment

cc: Regional Office OASIS Coordinators
State Agency OASIS Educational Coordinators
State Agency OASIS Automation Coordinators

Attachment



Note:
HAVEN option #2 (manual correction of key fields) is replaced by the automated HAVEN option #4, effective with this memorandum.

Prepared by:TMUMMERT/CMSO/SCG/CCPB/3-27-01/correct.doc/final 4-5-01//janiel/cmso/scg/released 4-9-01 for review