Home Health ICD-9/ICD-10 Alert

Reader Questions: Try These Resources for Proper OASIS Coding Practices

Question: I have been in home health coding for many years and have just recently accepted employment with another home health agency. I am trying to find information on properly correcting OASIS errors on SOCs, and re-certs done by the

clinicians. I have read that only the clinician performing the OASIS assessment can make changes. Can you refer me to where I can find documentation stating that only the clinician should make changes and that if a form is used it must be

signed by the clinician?

Kentucky Subscriber

Answer: There are several resources that you may use, plus you can implement certain operational processes to decrease the number of corrections. The first line of defense, of course, is education of the assessing clinicians on OASIS data items. If the OASIS is completed correctly the first time, then there won't need to be corrections. The problem is that coding is technical, and most assessing clinicians neither have the time, the energy, nor the motivation to become expert coders.

Many agencies choose to have their assessors call in a report where the potential diagnoses are discussed with the coder. Once everyone agrees, then the assessor completes the coding M0 items. There are other processes that mean that the assessor actually chooses the diagnoses. Correction of OASIS data items is acceptable.

Resources to justify your position include OASIS Q&As from the Centers for Medicare & Medicaid Services Web site that state that the assessing clinician must determine the primary and secondary diagnoses and their severity. Another Q&A states that the coders cannot change the coding, even for technical errors, unless the clinician agrees.

Your next stop in resources is the Interpretive Guidelines at 42 CFR 484.48, which state that the agency may have a policy for OASIS correction. Any corrections made must have the clinician's agreement, but the guidelines also state that the policy should be flexible for supervisors to be able to make a change without the clinician's approval in case of staff turnover.

A recent email from CMS to the National Association for Home Care & Hospice stated that documentation of the agreement with the clinician (that documentation should include the time and date the discussion took place) is all that is required. However, a signature by the assessing clinician agreeing with the change is better. Another source is a CMS Survey and Certification letter.