MDS Alert

MEDICAL NECESSITY: Breathe Easy When You Skill A Resident For Oxygen Therapy

O2 is no automatic shoe-in for a Part A stay.

Coding oxygen at P1ag will RUG a resident into clinically complex, which may sound like an open- and-shut case for skilling the person on that basis.

Not so fast: Determining whether the resident receiving oxygen truly needs daily skilled nursing services requires skillful decision-making and documentation to prevent payment losses.

Answer this key question: Can non-licensed personnel or the resident manage the oxygen -- or is the resident's respiratory status unstable enough that he requires daily skilled nursing assessment and observation? To answer that question, look to see if the resident has shortness of breath on exertion and requires changes in oxygen liter flow, suggests **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. "Does he have rales or rhonchi on a respiratory assessment?"

Know What to Document

Simply recording or monitoring the results of a pulse oximeter reading doesn't in and of itself support the need for daily skilled nursing care, say reimbursement experts. "If the resident is receiving skilled nursing care related to oxygen therapy, the documentation should reflect that," says Mines. For example, document a daily assessment of the resident's lung sounds and color in response to activity, etc., advises **Roberta Reed, RN, MSN,** director of clinical services for **Legacy Healthcare,** which has facilities in Ohio.

Also document the reason the resident is receiving the oxygen, says **Nemcy Cavite Duran, RN, BSN, CRNAC,** director of MDS for **William O. Benenson Rehabilitation Pavilion** in Flushing, NY. And make sure the nurses sign off on giving the oxygen on the treatment record, she adds.

Make your case: As part of documentation, you should include a note explaining why a resident is skilled -- or not, says **Diane Atchinson, RN, MSN,** president of **DPA Associates** in Kansas City, MO.

Code Sections I and J

If the doctor has diagnosed the resident with any respiratory illness, including COPD -- or an exacerbation of congestive heart failure -- code that in MDS Section I and on the UB-92, advises **Cindy Hart, LPN, CPC, MBA,** with **LW Consulting Inc.** in Jenkintown, PA.

Example: Say the team decides to do an OMRA for a resident who has finished all of his rehab therapy for an orthopedic problem and is now suffering from an exacerbation of his COPD, requiring oxygen and daily skilled nursing monitoring to adjust the oxygen therapy. "The COPD or other respiratory diagnosis should be on the UB-92 to support the need for skilled nursing care," says **Joan McCarthy, MJ, LNHA,** manager, healthcare, **RSM McGladrey Inc.** in Chicago.

Don't forget Section J: When a resident is receiving skilled nursing care for respiratory issues requiring oxygen, code his unstable status in Section J5, if applicable, suggests McCarthy. Also code symptoms in Section J1, such as shortness of breath and inability to lie flat due to shortness of breath, if the resident has them, she adds.