Codify
BY AAPC

OASIS Alert

Assessment: Time Is Money - But Accuracy Determines if You Keep The Cash

Chart review for OASIS errors pays hundreds of dollars.

The two to three hours a clinician spends on the initial assessment can mean everything to your agency because it drives both reimbursement and outcomes. So make sure you're not throwing that time down the drain by selling your care short.

Based on its analysis of more than 2,000 start of care assessments, **Fazzi Associates** found that agencies still are underestimating patients' abilities, said **Rhonda Will** with the Northampton, MA-based consulting company. An accurate assessment is critical for reimbursement, but also for developing and supporting the plan of care. It ultimately helps the patient stay safely at home as long as possible, she added, speaking at the **National Association for Home Care & Hospice's** October annual meeting.

Fazzi Associates audited the 2,000 records against the correct answers based on the **Centers for Medicare & Medicaid Services'** instructions and found that 41 percent varied from the correct answers in the clinical domain, 33 percent in the functional domain and 22 percent in the service domain. This led to an average missed revenue of $513, Will said.

OASIS assessment problem areas haven't changed much in the last year, Will said. The following six areas continue to be trouble spots, as evidenced in the assessments they audited:

1. ADLs. Instead of reporting what activities of daily living the patient is able to do safely, clinicians often report what he actually is doing. This is especially true if the patient lives alone, Will reports.

Tip: Imagine the patient has a "ghost caregiver," Will suggests. Then ask yourself if the patient would be better off if the caregiver assisted, supervised or cued the patient. Does the patient need hands-on assistance?

Say you mark the patient as independent in an activity because no one is there to help, forcing him to perform the activity independently. You shouldn't mark the patient as independent in that ADL unless the patient performs the activity safely and correctly. If the patient really should be performing the activity with the assistance of a caregiver, then the patient isn't actually safely independent and you shouldn't classify him as such, she explained.

2. Wounds. Incomplete history of the wound and poor documentation can sabotage your reimbursement by not reflecting your efforts. Not understanding the way a wound looks during different stages of healing also creates problems for many agencies, Will noted.

Smart approach: Learn how to identify different types of wounds, Will recommended. Don't be afraid to go back to the doctor and ask what kind of wound the patient has. If you don't know what kind of wound you're caring for, you can't develop a good plan of care, she warned. And clinicians should have a copy of the Laguna Beach, CA-based **Wound, Ostomy and Continence Nurses Society's** OASIS Guidance Document for wound care - and use it, she said. This document both describes the healing at each stage for acute and chronic surgical wounds and defines the terms used.

3. Diagnosis. Some agencies still are not using V codes, Will reported. Other problems include inconsistency between the primary diagnosis and the plan of care, confusion about M0245 and lack of knowledge about case mix diagnoses.

Try this: "The primary diagnosis needs to reflect what drives the plan of care," Will emphasized.

4. Neuro/emotional/behavioral items. Even though these questions don't add many points to the clinical domain, they are very important in achieving outcomes and determining case mix weight, Will explained. Clinicians visiting a patient for the first time will have a hard time picking up enough clues to accurately assess this area. The interview technique may allow the patient to sound better than he is. The clinician may be inexperienced in assessing these areas or may not understand the implications of what she sees, Will said.

Best bet: See if the patient can follow through on commands or remember what you asked him to go get by the time he gets to the kitchen, for example, Will suggested. Consider the patient's situation and what she is facing before deciding she doesn't have problems with anxiety or depression.

5. M0175. This question looks for all inpatient facility discharges. Clinicians may not focus on this question because it doesn't seem to affect patient care, Will said. And finding an accurate answer can be very time-consuming. But agencies can't afford get this one wrong and throw away dollars, she told listeners. Your intermediary edits M0175 for when you owe them, it's up to you to find the cases where they owe you.

What to do: Look for the swing beds and the rehab beds in acute care hospitals. Gather as much information as possible from the referral source, and ensure that the clinician visiting the patient has this information.

6. M0825. The therapy threshold continues to create OASIS problems. To keep the patient safely at home, agencies need to focus on ADLs as well as on the wound, hip or diabetes, for example, Will said. Audited charts show "a lot of unmet therapy needs," she emphasized. And generic care plans make answering M0825 accurately very hard.

Trap: Inconsistent therapy use and inaccurate M0825 answers can come back to haunt agencies when the feds focus their attention on this question.

Bottom line: Education is not enough. Sharing responsibility between clinical staff and office staff is key to success. Considering that agencies Fazzi audited missed $513 per episode on average, a dedicated OASIS review person could pay for herself by catching the errors that are costing you money on a high percentage of your episodes, Will predicted.