OASIS Alert

Coding: USE ACCURACY TO SHOW YOUR OASIS EXPERTISE

Focus on correct coding will result in maximum payoff.

Agencies are so focused on the OASIS C process measures and communication requirements that accurate diagnosis coding can easily get lost in the shuffle.

Before OASIS C, it was somewhat easier to see how the diagnosis codes you chose would impact your agency's reimbursement. Now, coding by itself doesn't often make the difference in dollars, says **Jan McLain** with **Adventist Health System Home Care** in Port Charlotte, Fla.Instead, code selection and correct OASIS scoring -- both supported by clinical documentation -- combine to present a solid picture of the care you provide.

Interaction: "What I see most often is that the OASIS scoring makes the difference in dollars " and it's the OASIS scoring and the clinical documentation that help me know the codes listed by the clinician are not the most specific or appropriate," McLain says. Rather than battle for payment after the fact, ensure accuracy and appropriate reimbursement while decreasing additional documentation requests (ADRs) with this help:

Check Codes Against Record, Care Plan

As an experienced coder, you should make sure that your agency is in compliance with all of the coding regulations and that each episode is fully coded up front to best describe the patient's actual health status, says **Judy Adams,** president and CEO of **Adams Home Care Consulting** in Chapel Hill, N.C.

You should strive to capture all of the payment your agency is entitled to receive and ensure that the coding matches the OASIS, plan of care, and bill.

Don't miss: But you'll need to do more than coding. You should check and validate the OASIS responses against the clinical record and plan of care to be sure everything is consistent and justified, Adams says. This additional review ensures the accuracy of the OASIS information which is used to determine outcomes.

Taking a more thorough approach that combines looking at the codes and OASIS scores along with the medical record will pay off. For instance, you'll prevent:

 ADRs,

 Added costs from canceling requests for anticipated payment (RAPs), and

 Rebilling episodes.

Being Thorough Pays Off

As an experienced coder, you should search the entire medical record for information to support your diagnosis codes. Look for additional diagnoses that can impact the patient's care, and other issues that can be brought to the clinician's attention, Adams points out.

All of home health care requires team work and that certainly includes development of the HHRG associated with each assessment, Adams says. In addition to extra reimbursement and more accurate outcomes, making a thorough review of the OASIS and the medical record will ensure that the claim is compliant with all regulatory and reimbursement requirements which can decrease risk of loss during medical review.

The questions raised by comparing diagnosis coding to the OASIS and the clinical documentation ensure accurate and frequently increased reimbursement, McLain says. Plus this information creates a basis for accurate assessment of health care trends, outcomes, and, in the future, pay for performance.

Don't Ignore ROC Coding

Many agencies spend extra time coding the start of care (SOC) and the recertification because of the impact on payment, but then only place one or two codes on the resumption of care (ROC), points out **Lisa Selman-Holman,** consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas.

However, the coding on the ROC is important for accurate risk adjustment. The ROC is a beginning point to an outcome episode just like with the SOC, so accurate coding is essential, Selman-Holman says.

Bottom line: With OASIS C, the common sense and integration of all the information provided is what ensures accurate payment, McLain says.