OASIS Alert

Compliance: 10 Tips To Avoid Downcoding

Documentation should be your best friend.

Medical review costs an agency time and money -- prevention is the best strategy.

Providers are hearing from both regional home health intermediaries and program safeguard contractors as pre-payment and post-payment medical reviews increase, says **Mary St. Pierre** with the **National Association for Home Care & Hospice**.

The more you understand the issues medical reviewers are targeting, the more you can do to head off these disruptions, she told listeners at the recent NAHC National Policy Conference in Washington.

Warning: The number one reason for claim denials following additional development requests is failure to submit the required documentation on time. So focus on developing a system for identifying, responding to and tracking ADRs, St. Pierre says.

While providers always will be subject to some additional development requests, a history of accurate claims will minimize the consequences when errors do arise, she adds.

Other strategies St. Pierre suggests for avoiding downcoding include:

1. Creating a system for identifying prior stays. Fiscal intermediaries are focusing on identifying M0175 errors in which the agency records a rehab or skilled nursing facility stay but fails to record a hospital discharge within 14 days of home care admission. This error results in an overpayment of $200 to $600 (see Eli's OASIS Alert, Vol. 5, No. 3).

2. Avoiding contradictory documentation. Compare what visit staff are saying in the medical record. If you see a contradiction between clinicians, be sure they explain the reason in the record, she advises.

3. Focusing on patient status at the time of the visit. Don't concentrate on making the visits agree. It's not a problem if on assessment the nurse says the patient can't walk across the room and that afternoon the therapist says the patient was able to walk down the stairs -- as long as you explain the difference. For example, the patient may have taken pain medication before the therapist's visit, St. Pierre suggests.

4. Understanding V codes. Use V codes for aftercare during healing and recovery, not for when the treatment is for a current disease or injury, she reminds HHAs. And if you're providing multiple services for a disease or injury, code that, rather than using a V code for one of the services.

5. Putting all diagnosis codes on the plan of care. It doesn't matter where you put it, but M0245 must also be on the POC, St. Pierre explains.

6. Retaining required paperwork. If a home care patient goes to adult day care, be sure you keep a copy of the day care facility's license information. You must have this to still consider the patient homebound, she says.

7. Documenting intermittent nursing. If skilled nursing is the qualifying service and you are providing it for more than 21 days, you must establish with the doctor a finite and predictable endpoint -- which must be realistic and attainable. Clearly identify this on the POC, St. Pierre warns.

8. Watching the dates. You must send (fax, mail or hand deliver) the POC to the physician before you submit the

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request for anticipated payment. And the physician must sign and date the POC and any interim orders, and return them to you, before you submit the final claim, she notes.

Tip: If the physician didn't date these, you should use a date stamp on the front of the form when you receive it.

9. Keeping documentation legible. If the FI can't read the record, it won't help. Documen-tation also should be complete, concise, consistent, accurate, specific, objective, timely and professional, St. Pierre advises.

10. Determining care individually. Your plan must be based on the unique needs of each patient. Don't assign a prescribed number of nursing or therapy visits to a specific condition or disease, she cautions.

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