OASIS Alert

Documentation: 5 Elements Interact to Keep Your Claims Secure

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An accurate OASIS assessment is important, but it's just one of five elements you need to stay on top of in order to secure payment. Make sure your documentation is in sync across these areas, or risk denials.

Secure these Risk Areas

The **HHS Office of Inspector General** has identified five risk areas for home health agencies. All five of these areas have also been indicated as major reasons for denial by the four Home Health and Hospice Medicare Administrative Contractors (MACs), said **Ann Rambusch, MSN, RN, HCS-D, HCS-O, COS-C,** with **Rambusch3 Consulting** in Georgetown, Texas.

The five risk areas that could derail your claims include:

1. Homebound status.
2. Qualifying (skilled) services.
3. Medical necessity for skilled services.
4. Physician certification and Face-to-Face encounters.
5. The plan of care.

All five of these areas are related to documentation in the medical record, Rambusch points out.

Keep Claims Clear with Five Elements

Your documentation is the greatest defense against the risk areas the OIG has established. When you submit a claim to Medicare, there are five elements critical to the claim, Rambusch said during the recent Eli-sponsored audioconference Coding and Documentation Vital to Your Home Health Claims. Making certain these elements are in place will help secure payment and uphold a claim if it ever goes to review, she said.

1. **The comprehensive assessment.** This is the biggest thing to make sure you get right, Rambusch said.
2. **The documentation.** Good documentation considers not just the comprehensive assessment as a whole, but each of the specific elements within, Rambusch said. "Documentation is like money ⬜ you can't have too much of it."
3. **The diagnosis codes assigned.**
4. **The physician orders.** These must be written and signed correctly and include frequency and duration, Rambusch said.
5. **The plan of care.** The POC must be specific to each unique, individual patient, Rambusch said.

These five items are inter-related and co-dependent, Rambusch explained. You can't separate one from the others ⬜ all five must support the claims you submit to Medicare.

Don't Put All Your Eggs in One Basket

Just because you're thorough in one area of the medical record doesn't mean you're in the clear. For example, the codes you list or the OASIS responses you select don't automatically support the medical need for skilled services. Just because you check something off or add a code doesn't mean you're supporting medical necessity, Rambusch said.

Instead, the entire medical record throughout the home health episode should demonstrate and support medical

necessity. You can't rely on just the OASIS or the comprehensive assessments.

For example: Simply listing 781.2 (Abnormality of gait) in M1022 and on the OASIS assessment doesn't necessarily support need for physical therapy, Rambusch said. The diagnosis must be supported throughout the medical record and throughout the episode of care.

When you take the time to make certain that all five elements are complete and accurate, you help support:

- · Compliance with rules and regulations.
- · Patient outcomes (risk adjustment).
- · Severity of illness/Intensity of skilled services the patient requires.
- · Measure of resources consumed including use of supplies, and time and attention in terms of number of visits.
- · Accurate HHRG assignment.
- · Accurate claim submission.
- · Appropriate reimbursement.

Keep Your OASIS Accurate

A properly completed OASIS assessment is one essential component of these five elements. Make certain you're complying with the **Centers for Medicare & Medicaid Services'** expectations when completing the OASIS, Rambusch said.

CMS requires that one clinician is responsible for accurately completing a comprehensive assessment. This is easy enough when you're able to complete the OASIS in one visit, but becomes more difficult when it takes repeat visits. For example, if a dressing covers your patient's wound on the initial visit, the same nurse must return within five days of the start of care to assess the wound, Rambusch said. She can then change or indicate the status of the wound at that time.

CMS also requires:

- · Accurate completion of the OASIS and the comprehensive assessment. CMS expects accuracy because there's money involved in the claim, Rambusch said.
- · Corrections to OASIS are transparent and follow CMS correction policy. To comply with this requirement, you must establish that a correction was made, how it was made, and that the assessing clinician (the only person who can approve changes) agrees with the correction, Rambusch said.
- · Completion of OASIS items following CMS' Item Specific Guidance in the OASIS-C Manual.
- · Staying current with evolving CMS OASIS guidance updates.

Follow Correct Coding Practices

Accurately reporting the diagnoses that impact the plan of care is another essential component of denial-proof claims.

CMS expects home health agencies to follow appropriate coding practices. This will ensure the integrity of the home health diagnoses assigned to the OASIS. "CMS means business here," Rambusch said. "You must follow coding guidelines. We can't make up something special for home health that isn't done by the rest of the [health care] industry."

CMS also expects home health agencies to:

- · Avoid the practice of allowing the case mix status of a diagnosis to influence the diagnosis selection process.
- · Report any indication of fraudulent coding directly to the administrator of the HHA.
- · Comprehensively assess each patient's overall medical condition and care needs before selecting and assigning the OASIS diagnoses or responses to OASIS questions.