Codify by AAPC

OASIS Alert

Documentation: Don't Throw Away Hard Earned Cash

Now that home health agencies bill by the episode rather than by the visit, one instance of careless documentation can cost you thousands of dollars.

An agency's goal should be appropriate reimbursement for each episode, emphasizes consultant **Linda Stock Rutman** with the **LarsonAllen Health Care Group**, which means accurate documentation is as important as the actual care provided.

The clinical record must support your answers to the OASIS questions that affect the episode payment level, warns **Pat Sevast** with **American Express Tax and Business Services** in Timonium, MD. Otherwise, during medical review the intermediary can substitute its own OASIS answers and downcode the HIPPS code, resulting in decreased reimbursement, she says.

To ensure you don't cheat yourself out of the reimbursement you deserve, experts recommend taking the following actions:

1. **Document the beneficiary's eligibility.** The regional home health intermediary can deny an entire episode if you fail to adequately document a qualifying factor, such as homebound status, Rutman notes. Don't just record the reasons you consider the patient homebound during the initial assessment. Periodically reinforce the documentation, "including on-going evidence [of homebound status], especially if the patient is progressing toward her goals," she warns.

2. **Insist on complete and timely record-keeping.** Providing incomplete documentation is like throwing away money you've already earned. Inaccurately documented therapy visits will not count toward the 10-visit therapy threshold that adds about $2,000 to an episode payment, experts caution.

   And if you poorly document skilled nursing visits, you allow the intermediary to declare visits not medically necessary, perhaps cutting payments by invoking a low utilization payment adjustment.

3. **Focus on the accuracy of the OASIS assessment.** An accurate assessment at start of care will lead to accurate reimbursement, advises **Pat Laff** of **Laff Associates** in Hilton Head, SC. Then in your follow-up visits, document the issues raised in the initial assessment.

   Warning: Pay special attention to ADLs. Deficits in activities of daily living often are under-documented, Laff says, "leaving the [reimbursement] scores lower than they should be." Unlike therapists, nurses frequently neglect to ask patients to perform a return demonstration of a task, he reports.

   Documentation must support the services you provide and should show a patient's needs, Rutman says. Including specific observations in the record can deflect any future suggestion that your assessment was arbitrary.

   Critical areas to document include reasons for the primary diagnosis, co-morbidities, evidence of functional limitations, pain interfering with daily activities, shortness of breath and incontinence, Sevast notes.

   If the clinical record often doesn't support the OASIS assessment, the intermediary may suspect fraud and abuse, warns

CPT® 2023 American Medical Association. All rights reserved.

North Andover, MA-based consultant **Maureen Yadgood**. And all documentation is part of the clinical record in liability cases, she reminds providers.

CPT® 2023 American Medical Association. All rights reserved.