Codify
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OASIS Alert

Documentation: Rethink Your Intake Process Before ICD-10 Presses the Issue

Start at the beginning to improve documentation.

Your intake department has an opportunity to gather valuable details about the patients your agency serves. From diagnosis coding to OASIS data, your job will be easier when intake staff know when to prone for additional information.

"Thorough documentation provided in advance not only prepares the field clinician for the first visit, but also helps the coder find the most specific code for each of the patient's diagnoses," says **Michelle Mantel, MSN, GNP-BC, RN, BCHH-C, COS-C, HCS-D**, quality assurance manager with **Gentiva Home Health** in West Palm Beach, Fla. Plus, when it comes to diagnosis coding, "the more information the better, especially with an eye toward more specific diagnosis codes in ICD-10."

When your intake department gathers the information you need up front, your agency benefits in a variety of ways, Mantel points out. It:

1. saves time for the coder who doesn't have to "track down the clinician or call a physician for clarification before coding the record and forwarding it for RAP release;
2. improves quality of care because "the field clinicians will have important data to provide the best care possible to the patient;" and
3. enhances compliance and reimbursement by promoting adherence to coding guidelines and maximizing PPS reimbursement through specific codes as opposed to NOS codes, which are rarely case-mix weighted.

When little to no clinical information is available at referral/intake, coders aren't the only ones who face a more difficult job, says **Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O**, AHIMA Approved ICD-10-CM Trainer/Ambassador of **Selman-Holman & Associates**, **LLC, CoDR□Coding Done Right** and **Code Pro University** in Denton, Texas. Lack of clinical information also makes it more difficult to:

Identify patient issues;
Develop a plan of care meaningful to the patient; and
Provide skilled care that will withstand the scrutiny of all the medical review home health agencies face.

'Evaluate and Treat' isn't Enough

Nurses who have been in intake for years, may have grown accustomed to taking a phone or fax referral that states "home health to evaluate and treat," says **Delaine Henry, COS-C, HCS-D**, with **Health Care Management and Billing Services** in Lafayette, La. As a result, "it's very difficult to get everyone to understand that we need more information, and it must be specific to each patient's current diagnoses, condition, and homebound status."

Provide Training

Your intake staff is responsible for training referral sources regarding the level of documentation your agency needs. But before they can educate others, the intake staff must receive education themselves, Henry says.

Mistake: "With a flurry of activity surrounding preparation for ICD-10, some agencies have left intake out of the equation when it comes to ICD-10 training," Henry says. For the greatest efficiency, intake staff "need to know more than just the fact that we need more documentation, they need to know at least the basics of diagnosis coding," she says.

It's not too late. Your intake department should have known the basics of ICD-9 coding, but many agencies are just now realizing the seriousness of issues with lacking referral documentation as they prepare for ICD-10, Henry says. "Not that everyone needs to be a certified coder, but everyone should attend basic training."

Ask the Right Questions

With good training, intake staff will become better able to determine when you need more information from a referral source. And they'll also know what questions to ask to clarify the diagnoses and patient issues.

For example: The intake department should know when to ask for more information about the patient, says **Judy Adams, RN, BSN, HCS-D, HCS-O**, with **Adams Home Care Consulting** in Asheville, N.C. "If the referral source is a hospital, ask for copies of the admission history and physical, the discharge summary would be fantastic, any operative reports or consulting specialists notes/reports, any culture reports or biopsy reports would also be helpful," she says.

Intake staff should be sure to get a copy of the face-to-face or a report of what arrangements are being made to obtain a face-to-face documentation, as well as a list of current medications, Adams says. And, "if the patient has been receiving therapy services, a copy of the therapist's assessments or status of the patient would also be helpful."