OASIS Alert

Edits: Safeguard Observation and Assessment Claims with Strong Documentation

No OASIS means no payment in this edit.

Your low case mix claims are under fire in **NHIC's** recent round of edits. And your documentation is the key to securing reimbursement.

In the last half of 2012, NHIC issued ADRs for nearly 5,000 claims under three edits: 5AC01 – billing of the home health resources groups (HHRGs) 3AFK*; 5AC02 – billing the HHRG 1AFK*; and 5AC03 – billing 5 to 7 visits for full episode payment.

Those HIPPS codes selected for review related to an HHRG of C1F1S1, "which is the lowest possible score for a PPS episode," points out **Judy Adams** with **Adams Home Care Consulting** in Asheville, N.C. When patients' case mix scores are that low, "it raises questions about the medical necessity of home health services," Adams tells **Eli**.

Background: The data you capture in the OASIS assessment combined with the patient's planned therapy use during the episode determine the Home Health Resource Group (HHRG) score used to calculate Medicare reimbursement.

Other MACs have been targeting these low case mix claims as well, Adams adds.

"Right now, this is what they're going after," agrees consultant **Betty Gordon** with **Simione Consultants** in Westborough, Mass.

Home health agencies didn't submit timely documentation for 9 percent of the claims, the HHH Medicare Administrative Contractor says in an article recently posted to its website. Of the claims NHIC reviewed, medical reviewers denied 52 percent.

The top reasons were:

- 55H3A – skilled observation was not reasonable and necessary (56 percent)
- 55HTB – no physician certification (15 percent)
- 55H2B – homebound (14 percent)
- 55HTG – physician orders not signed timely (5 percent)
- 55H2C – OASIS not documented (less than 5 percent)
- 55H4D – therapy services didn't require a therapist (less than 5 percent).

Know Your Observation Coverage Basics

HHAs claiming observation and assessment had better have great documentation to back it up. "Nursing services for observation are covered when the patient's condition is changeable," NHIC explains. "Once the patient's condition stabilizes, the nursing services are no longer medically necessary."

To show medical necessity for O&A, agencies typically need "documentation of changes in diagnosis, exacerbations, medication or treatment changes that continue to put the beneficiary at risk for further plan of care changes," HHH MAC **CGS** said in an article on the topic it issued last year. "Nursing may continue observation and assessment when there have been continued changes and risks for further need to change the plan of care."

Important: Look to this statement from the Medicare Benefit Policy Manual to help understand O&A coverage, CGS suggested: O&A "of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized."

More Than Patient Condition Change Required To Qualify

The patient's condition isn't the only factor, however. Treatment changes also must be present to justify the skilled service need. CGS points to this section of the Manual: "Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition which itself does not require skilled services and there is no attempt to change the treatment to resolve them."

Skilled observation & assessment is frequently misunderstood or abused by many, claims consultant **Lynda Laff** with **Laff Associates** in Hilton Head Island, S.C. "There are still people who think a patient continues to qualify for skilled services because they 'might have a problem' in the next few weeks," Laff says. "If that were the case, anyone would qualify!"

To qualify for Medicare coverage, "there has to be documented evidence of a change in the patient's condition and/or new or changed medications,"

Laff explains. And that means a significant med change "not Tylenol for heaven's sake" requiring teaching and monitoring.

Remember: That coverage doesn't last forever. When the patient "did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode," the Manual says.

Not Documented, Not Done: Even when patients qualify for skilled observation and assessment, clinicians often are failing to document that sufficiently in the record, experts point out. "The documentation generally does not support an initial change or evidence of a need for changes in the plan of care during the episode," Adams highlights.

Don't Forget the OASIS

Agencies with claims caught in edit 55H2C OASIS not documented also lost out on reimbursement.

Remember, you must submit the OASIS to the state repository. And when "submitting records for Medical Review, consider including the OASIS transmission record or tracking sheet," NHIC suggests. "This assists the reviewer in accessing the OASIS record for the appropriate claim."

Note: NHIC's article is online at www.medicarenhic.com/providers/articles/HHPrepayResults022013.pdf.

For more industry news, see Eli's Home Care Week. Information on subscribing is online at www.aapc.com/codes/coding-newsletters/my-homecare-week-alert.