OASIS Alert

Medical Review: Prevent Denials with OASIS Keys

Proving medical necessity gets trickier in second and later episodes.

One way to protect yourself against the most common home health agency denials is to ferret out your at-risk patients and proactively beef up their documentation before their claims come under scrutiny.

Denials for homebound status and medical necessity top HHH Medicare Administrative Contractor **Palmetto GBA**'s HHA denial list for the most recent quarter. You can find patients who may have problems in this area by using your OASIS assessment, advises consultant **Lynda Laff** with **Laff Associates** in Hilton Head Island, S.C.

Do this: "Look at OASIS functional scores to determine whether F scores are 2 or above," Laff instructs. "If not, the patient may not be homebound. Any patient scoring as independent or requiring only minimal assistance (use of a device) to ambulate could be considered not homebound and [the Centers for Medicare & Medicaid Services] would determine that the services could be provided in the MD office or outpatient setting."

If reviewers rule your patient not homebound, all the greatest medical necessity documentation in the world won't matter. "Not homebound trumps skilled need for services," Laff points out. In other words, once a patient is determined not homebound, the whole claim is denied.

When you are satisfied that the patient's homebound status is well supported, you can move on to medical necessity issues identified with the OASIS diagnosis items (M1020/M1022/M1024).

"Review the OASIS diagnoses and determine whether the appropriate codes were assigned to reflect the primary reason for home care," Laff recommends. "Then cross-reference visit notes to identify that clinicians have thoroughly documented that the patient received skilled services."

Medical necessity can get trickier when the patient is in second and later episodes. In those cases, "check the primary diagnosis to determine the validity of the need for ongoing care," Laff advises.

For example: Say a patient's first episode has congestive heart failure as the primary diagnosis with hypertension secondary, but the recertification indicates the primary diagnosis is HTN with no documented change in the patient's blood pressure. That will be a big red flag to medical reviewers, Laff warns.

"In my experience with auditing, I frequently see rotating diagnoses with no evidence of a change in the patient's condition to support the need for identifying that diagnosis as primary and that the patient required recertification," Laff tells **Eli**.