Codify
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# OASIS Alert

## Reimbursement: CREATE A TEAM APPROACH TO PROSPER UNDER PPS

**5 tips to improve collaboration.**

You could have the most accurate coder on Earth, but if the clinician's documentation doesn't support the answers to M0230, M0240 and M0245, the episode will be downcoded on medical review.

Diagnosis coding plays an important role in determining the home health episode case mix, and case mix drives reimbursement. Despite this fact, many agencies have difficulty fostering good communication between the financial and clinical staff.

Nurses tune out when you talk about reimbursement, reports Grand Rapids, MI-based consultant **Arlene Maxim** with **Healthcare Management Consultants**. They don't make the connection between reimbursement and getting their paycheck, and want to focus on providing care, not choosing codes, she says.

Coders, on the other hand, may focus on the details and miss the big picture, Maxim continues. She cites an example where the coder began worrying about how to code the percutaneous endoscopic gastrostomy while missing the fact that the diabetes actually was primary.

Successful agencies under the prospective payment system create a team approach for the entire episode, says consultant **Karen Vance** with **BKD** in Springfield, MO. Some ways to encourage team members to draw on each person's strengths include:

**1. Have the clinician determine the direction.** Ask clinicians to think about what their focus of care will be for the next 60 days, Maxim suggests. What will take up most of their time? If the clinician expects therapy to be involved in the patient's care, ask her what she expects therapy to do. Once the clinician analyzes the focus, the coder can find the right codes, she counsels.

**2. Provide a system for collaborating on coding choices.** Don't expect clinicians to also be coding experts. You can't just put a coding book in a clinician's hands and say, "Have at it," says long-time coder **Ida Blevins** with **St**. **John's Hospital Home Health Services** in Springfield, IL. At the minimum, have a coding go-to person who reviews coding choices and keeps up with coding requirements, experts recommend.

**Example:** Most agencies have a quality review person check the OASIS assessment to be sure all the questions are answered, Maxim says. This person confers over the phone with the clinician to finalize the coding choices, and then the nurse signs off on any changes.

Many agencies provide a tentative code for the clinician before the assessment visit, based on the referral. But you need to be sure someone reviews this code after the assessment is completed, because the preliminary code often needs to be changed.

**3. Remove the coding choice from the rest of the OASIS assessment**. Some agencies place a removable note over the coding question. This ensures the answer is tentative until the codes are checked with the agency's coder or supervisor and then confirmed with the clinician.

Maxim recommends using a separate form. Using a separate sheet helps free people to answer the coding question at the end of the assessment, rather than in the order it appears in the OASIS (M0210), she finds.

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Using a separate sheet also helps clinicians and coders communicate about choices and sequence of codes, before deciding on the final choice. Instead of feeling like they are tampering with the OASIS assessment, they can collaborate as they should and then make the form part of the OASIS,  says Maxim.

**4. Avoid contradictory documentation.** Codes and medical records must agree, experts warn. Target visits based on the assessment and diagnoses. Be sure everyone agrees on the plan of care, Vance emphasizes. This is especially important if more than one discipline is involved. Medical reviewers often use nursing visit notes to disqualify therapy visits, reports **Rose Kimball** with Dallas-based **MedCare Administrative Services.**

**5. Enhance communication.** Set a goal for clinicians to use in measuring documentation, Maxim recommends. For example, if you suggest to clinicians that 70 to 80 percent of their documentation within the episode needs to reflect the primary and secondary diagnoses, then the clinician knows that seven or eight out of 10 visits should support those diagnoses, she says. Even if that number is high, focusing on a goal will remind the clinician the team agreed on the importance of those diagnoses.

**Tip:** Once you have made the coding choices, be sure all staff know what they are, Kimball says. Otherwise, clinicians will continue to focus on what they think is most important and your documentation will fall short, she adds.

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