OASIS Alert

Reimbursement: Documentation Downcodes Delete Dollars

Follow these 5 steps to undo the damage.

No matter how good your patient care or how impressive your outcomes, without accurate documentation your agency could go under.

Downcoding for documentation that contradicts the OASIS assessment is the most common denial reason for home health agencies, experts agree. And **Palmetto GBA's** latest denial reason stats back up that assertion, with 5DOWN in the top spot.

"The OASIS must support itself, and the rest of the documentation in the record must support the OASIS," stresses consultant **Lynda Dilts-Benson** with **Reingruber & Co.** in St. Petersburg, FL. "Otherwise, you will be downcoded."

Fatal flaw: HHAs' documentation can fail to support any of the 23 M0 items that set payment for the patient, but here are the problems experts see the most:

1. **M0490 (Dyspnea), 6 points.** The assessing clinician will mark box 2, 3 or 4 on the assessment, but notes will fail to documentany shortness of breath when ambulating or performing other activities, Dilts-Benson relates.

2. **M0420 (Pain), 5 points.** The clinician will mark that the patient has pain daily or all the time, but the visit notes will record that the patient has no pain, notes billing consultant **Rose Kimball** with **Med-Care Administrative Services** in Dallas.

3. **M0390 (Vision), 6 points.** The OASIS says the patient is partially or severely impaired, but the documentation doesn't reflect it, Dilts-Benson says.

4. **M0230 (Diagnosis), 11 to 20 points.** "In the denials we have seen, many times the exact reason for the downcode has been because the documentation didn't support the diagnosis codes billed," reports reimbursement consultant **M. Aaron Little** with **BKD** in Springfield, MO.

   When HHAs have case-mix diagnoses such as arthritis or diabetes as primary in M0230 and non-paying diagnoses such as congestive heart failure, hypertension or COPD as secondary (M0240), Palmetto often will bump the paying diagnosis down to the secondary spot and strip the HIPPS code of the related points, Kimball relates.

Nasty result: Denials hurt agencies' bottom lines because either HHAs have to take the time, effort and expense of appealing the denial, or they never appeal and lose out on the money altogether. With the rural add-on expiring April 1, rural agencies will find they have less margin for billing errors than ever before, Little predicts.

5 Steps To Decrease Downcodes

Score with these tips from the experts:

1. Share OASIS. Staff will have a hard time ensuring their documentation supports the assessment if they don't know what's on it. Often, HHAs have OASIS specialists fill out the assessments, and rank-and-file nurses, therapists and aides make routine visits, notes Dilts-Benson.

In these cases, every visiting staff member should have a copy of the OASIS so they can document accordingly.

Furnishing staff members with an OASIS copy "will give them a basis from which to make their own continuing assessments on how the patient is responding to the POC," she explains.

2. Document the 23 M0 payment items. Teach your staff to use their documentation to support those 23 OASIS payment items that are specific to each case. "If you don't educate your employees on the front end, you'll pay on the back end," Dilts-Benson cautions. "And it's really hard to get off focused medical review."

3. Rethink pain assessment. If the OASIS describes a patient as having intractable pain but the visit notes say the patient is having no pain, it raises big red flags in addition to denials. Have staff ask "When is the last time you had pain?" Kimball suggests. Then the patient is likely to answer in a way that gives a more comprehensive picture of their pain.

4. Get the downcode 411. HHAs often lose money on OASIS-based downcodes because they don't even realize what they were downcoded for, Little says. Find out the exact reason for the denial, Little urges. If you don't know from the denial code, call and speak to someone in the medical review department if necessary, he advises.

5. Exercise your appeal rights. Once you've figured out why the claim is denied or downcoded, review the documentation to determine whether you think the denial was warranted, Little says. If not, request a reconsideration of the claim at the intermediary level. HHAs are often successful at this first level of appeals, he adds.

If your intermediary upholds its denial, you can continue through the appeals process, notes consultant **Pam Warmack** with **Clinic Connections** in Ruston, LA.