OASIS Alert

Reimbursement: IMPROVE PROFITABILITY: TEACH CLINICIAN/CODER COOPERATION

Receive your rightful reimbursement with a case management approach to diagnosis coding.

Even if you have the most accurate coder in the world, if the clinician's answers and medical record documentation don't support the choices in M1020 (Primary diagnosis), M1022 (Other diagnoses), and M1024 (Payment diagnoses), the intermediary will downcode the episode on medical review.

More home health agencies than ever use designated coders to answer the OASIS diagnosis coding items, experts report. But unless your coders and clinicians learn to work together, dollars will disappear in the knowledge gap between these two important people.

Follow Five Steps To Assigning Accurate Diagnoses

Clinicians performing an OASIS assessment tend to concentrate on the immediate tasks they must complete at start of care, reports home health coder and nurse **Jan McLain** with **Adventist Health System Home Care** in Port Charlotte, Fla. Also, clinicians often don't see the big picture in diagnosis sequencing, she says.

To assign and sequence the appropriate diagnosis for each patient, McLain follows these five steps and records the information on a congruency form:

1. Look at what the admitting clinician says is the focus of care and review the diagnosis codes and sequence that the admitting clinician selected.

2. Read the plan of care, review the orders, check the frequency of visits, look for any new or changed medications, etc.

3. Search through any referral or hospital information to which you can gain access.

4. Do a congruency review to compare the OASIS with the plan of care.

5. Follow up with the clinician to address any discrepancies or questions.

Review Available Documentation To Get Complete Picture

Looking closely at the medical record can raise questions about coding choices, McLain finds. And getting the answers may change your case mix points.

Follow this case study to see how whycoder-clinician communication is crucial. McLain received a plan of care for a new patient with a new Foley catheter, and a new stage 1 pressure ulcer on the coccyx.

OASIS Documentation: The nurse had entered the following information on the OASIS assessment:

• Attention to Foley;

• Attention to non-surgical wound;

• Pressure ulcer;

• Urinary incontinence;

• Skilled Nursing orders 2w1, 1w1, 1m2;

• Inpatient diagnosis: syncope attack; and

• Medical diagnosis within past 14 days:cerebrovascular accident (CVA) with weakness.

Functional scoring on the OASIS said this patient could get to the bathroom independently with or without a device, although the patient was sponge bathing at the bedside. And for the OASISambulation item the response was a 3 -- "Able to walk only with the supervision or assistance of another person at all times."

Hospital documentation: McLain saw that this patient was fairly independent prior to fainting at church and was then diagnosed at the hospital with a cerebrovascular accident (CVA) with dominant side hemiparesis. The patient refused to go to a rehab facility, saying she would do better at home.

Her husband was active in the community with minimal health concerns and the daughter lived right next door. The discharge summary from the physician stated the patient was having some problems with depression but "should do well as her functional status improves."

Original plan of care: A plan of care describes the tasks related to the diagnosis that the clinician provides but also lists goals to improve to "the previous level of function."

For this patient, the clinician had to teach how to take care of the new catheter and get a hydrocolloid on the pressure ulcer because the family didn't know how to manage these items. Rather than looking ahead, the clinician's plan of care only covered the patient's initial need, McLain found.

Question Initial Information To Discover Missing Puzzle Pieces

In a communication with the clinician,McLain asked these questions:

• Do you think this patient has any rehab potential from her CVA?

• Is there any anticipation of therapy services in the next 60 days?

• I noted two new blood pressure medications listed. Does the patient have a hypertension (HTN) diagnosis?

• Will the nurse be teaching about the CVA process, recovery process, etc.?

• What are the patient's (and the family's) goals for her recovery from the CVA?

• Will the Foley catheter be a permanent situation for this patient?

The clinician responded:

• The patient has refused therapy now but said she would be "willing later; I am just so tired."

• The family is active and outgoing. States mom is just so "depressed since this has happened -- not like herself at all."

• The nurse did plan to teach about CVA recovery "if they asked any questions" and as the patient could not get to the bathroom, she felt the catheter would stay in.

• And yes, the blood pressure drugs were new but the patient had no history prior to this of a diagnosis of HTN. The nurse wasn't sure if the patient had HTN now, but the blood pressure at admission was 162/92.

Result: After McLain's discussion with the clinician, the agency made an additional visit to the home. The admitting clinician also had a conversation with the referring physician's nurse and as a result, sent in additional diagnoses of new onset HTN, situational depression, late effect hemiparesis -- dominant side from the CVA, and therapy. The physician provided occupational therapy and physical therapy evaluation orders.

On the second visit, the patient said she wanted the catheter out; she wanted to get up and be able to go to the bathroom to use the toilet and take a shower instead of using the bedside commode and taking a sponge bath.

Revised plan of care: The patient will receive the following care:

• Skilled nursing three times week one,two times week two, and one time week six including teaching disease process-recovery from CVA

• Physical therapy evaluation

• Occupational therapy evaluation

• Home health aide two times week two to assist with personal care and carry out the OT plan of care.

Bonus: Following through with questions helped the clinician move from selecting codes by thinking about the tasks of the day to using a true case management model. As a result, OASIS scoring will be more accurate.

Use Additional Information To Boost Coding Accuracy

Based on the revised information, the clinician sent McLain a new request to code the episode with these diagnoses:

• Primary diagnosis: 438.21 (Late effects of cerebrovascular disease; hemiplegia affecting dominant side);

• Other diagnosis b: 788.30 (Urinary incontinence, unspecified);

• Other diagnosis c: 401.9 (Essential hypertension, unspecified);

• Other diagnosis d: 309.0 (Adjustment disorder with depressed mood);

• Other diagnosis e: 707.03 (Pressure ulcer; lower back); and

• Other diagnosis f: 707.21 (Pressureulcer stage I).

Upside: Coding chronic conditions is important to the overall plan of care and to the patient's quest for independence, McLain says. With this approach, outcome data is accurate and the patient should have the clinical resources to improve.

Catheter care: You could also list V53.6 (Fitting and adjustment of urinary devices) for this patient because it was present on admission -- even though the patient has requested for the catheter to be discontinued, says **Lisa Selman-Holman**, consultant andprinciple of **Selman-Holman & Associates** in Denton, Texas.

In this case, the clinician should teach the patient and family about the benefits of the catheter for the healing of the pressure ulcer and teach the patient that bladder retraining may be possible to reduce incontinence, Selman-Holman says. The catheter should remain in place until the therapy can improve the functional status as well as the strength of the peritoneal muscles.

But if you receive orders to discontinue the catheter, you may opt not to code the care of the catheter, Selman-Holman says.

Add To Your Bottom Line With Additional Diagnoses

Adding the new HTN diagnosis code will increase reimbursement by $401.82. Revising the bathing OASIS item to reflect the patient's actual condition will increase reimbursement and allow the patient the opportunity to show improvement during the episode, McLain points out.

And this is all before the therapists make their evaluations and add the therapy visits to the payment equation.

McLain checked back and found that PT and OT made their evaluation visits within the OASIS time frame, so they were

able to predict 12 combined therapy visits.

Bottom line: The cash flow improved for the agency as the episode payment went from $1,810.63 to $4,708.07. By fully using the OASIS 5-day window plus good communication between the clinician and coder, the request for anticipated payment (RAP) in this case was submitted with an additional reimbursement amount of $2,082.28 over what would have been submitted on the first try.