OASIS Alert

Reimbursement: PROTECT REIMBURSEMENT WITH CONTINUED DOCUMENTATION

There's no doubt about it: Documentation can be a pain.

Then again, downcoded claims are even worse, and you could see plenty of those if you don't meticulously document your patients' pain throughout the episode.

OASIS item M0420 asks about the frequency of pain interfering with a patient's activity or movement, and reviewers are downcoding some home health agencies' claims when they initially respond that a patient does have hindering pain, according to a recent **Palmetto GBA** question-and-answer set.

A provider's patient indicates upon initial evaluation that he had pain on a daily basis, but the pain wasn't constant . "Points were given for M0420 relating to pain," one question begins. The agency hit a snag when it received notice from Palmetto that the intermediary was downcoding the payment category "due to lack of support in further documentation," the Q&A relates.

Another questioner notes that "agencies are reporting that they are receiving downcoding when a therapy-only case doesn't address pain on every visit note." Unfortunately, Palmetto's responses to the questions offer little to no real guidance, but experts agree it comes down to continuing documentation.

You should ensure that all your ducks are in a row and stay in a row when it comes to M0420, because your answer can add five points to the patient's case mix score. And if the RHHI looks askance at your documentation, you could face the dual headache of reduced reimbursement and going toe-to-toe with the intermediary.

The problems reported in the Palmetto Q&A seem to stem from inconsistencies between the initial assessment and the continuing documentation "either the issue wasn't addressed or it wasn't addressed properly in relationship to what was on the assessment for the pain," says consultant **Pat Laff** with **Laff Associations** in Hilton Head, SC. "You have to make sure your documentation is complete and reflects what's actually going on with the patient," Laff instructs. It must support what you've done in the past and what you plan to do in the future.

If you mark that a patient has pain interfering with daily life on the initial assessment, you must continue to address that pain on follow-up visits. "The [initial] assessment must reflect the status of pain as a functional limitation in light of the client's response with relief measure noted by the nurse in her notes. Subsequent visits must address the pain, relief measures with any changes noted as well as onset, duration, and rating scale consistently documented," says consultant **Beth Carpenter** with **Beth Carpenter & Associates** in Barrington, IL.

"Nurses can do a fabulous job of assessing the client initially and then not document sufficiently in subsequent visits," Carpenter notes.

To ensure the initial assessment is correct, nurses must use their eyes as well as their ears, Carpenter says. It's often not enough simply to ask the patient whether she has pain clinicians also must observe the patient's movement and look for other nonverbal signs of discomfort, she insists.

And the problem of continuing documentation isn't limited to M0420, Laff warns. "The same thing can ... relate to the need for home health aides, therapy, or any other services."