OASIS Alert

Reimbursement: Use These 5 Tips To Make Your

Here's how to get up to speed on crucial documentation strategies.

Wound care is expensive for home health agencies both in time and supplies -- so don't let needless denials eat up the money you've earned.

It's not enough to assess the wound accurately and provide appropriate care. Your documentation also must support the OASIS assessment and visits provided, experts agree. Use these strategies to avoid denials:

• **Be prepared for medical review.** Ac-curate and complete documentation is crucial for the medical review process. To prevent denials, clinicians should use a standardized tool for both the initial assessment and weekly follow-up on each wound, regional home health intermediary **Cahaba GBA** recommends.

Focus on providing good descriptive documentation. Include in your wound care record the wound type and location, shape and measurements, description of the wound bed and surround-ing tissue and any drainage noted, Cahaba says on its Web site. Clinicians should use a standardized tool for both the initial assessment and weekly follow-up on each wound, the RHHI recommends (for example, see PUSH tool, Vol. 9, No. 1, p. 7).

• **Put information where it counts.** Be sure records of your ongoing assessment and care are part of the medical record visit notes. Note wound interventions in the plan of care, not just on a wound care sheet or log, advises **Gail Robinson** with **Boyer & Associates** in Brookfield, WI. The OASIS assessment, plan of care and visit notes should be consistent, Cahaba instructs.

• **Use photographs to document wounds.** Photographs let providers communicate clearly with each other and provide the most reliable documentation for medical, legal and reimbursement purposes, experts say. Taking a photo of the wound at start of care provides a baseline for measuring outcomes.

As a risk management tool, agencies should take photos of wounds before a patient is transferred to a different care provider, whenever there is a change in the wound condition and every two weeks even if there is no change, advises Burtonsville, MD health care attorney **Elizabeth Hogue**.

Smart idea: Use adhesive tape or labels to include the patient's name, the wound location and the date on which the photo is being taken in the actual picture you are taking. This method allows you to prove the accuracy of the picture. Include the photo in the patient's permanent record. If you use a digital camera, print out the photo so it can be added to the chart.

Protect yourself: Don't expect the picture to tell it all. Remember to provide the other documentation a photo doesn't cover, such as depth and circumference of the wound, any tunneling present, the type of tissue and the color, odor and amount of any discharge.

• **Document any interdisciplinary education or care you are engaging in.** If you are working with a dietitian to improve a patient's nutrition, a physician to ensure certain aspects of her blood chemistry are in good ranges, or a diabetes care manager to help the patient manage her blood sugars better, include these details in the record.

• **Document why the service you are providing is skilled.** Skilled nursing can be required to observe and assess the wound and to teach the family to care for the wound, the **Centers for Medicare & Medicaid Services** instructs in CMS Medicare Benefit Policy. Be sure to document the medical necessity for observation and assessment in the record to avoid downcoding.