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OASIS Alert

Reimbursement: Why Certified Coders Could Save Your Bottom Line

7 strategies for PPS success.

You could be losing money under the revised home health prospective payment system by ignoring factors you can control.

The dramatic changes in payment since January have agencies searching for what issues to focus on first. There are good points to pay attention to, as well as challenges, said **Betty Gordon** with **Simione Consultants** in West-borough, MA, speaking at the April **National Association for Home Care & Hospice's** March on Washington conference.

Bad news: The complexity of the new prospective payment system makes it harder for financial managers to predict how much an episode will pay, Gordon said. Rules are much more complicated. It will be difficult for agencies to know whether their answers to M0110 have been corrected or even if the Common Working File is correct, she noted.

Good news: This takes the pressure off clinicians to manipulate the system. And the PPS refinements reward OASIS accuracy, she said.

New Emphasis Requires New Staffing Approaches

Because the new PPS rewards the best assessment possible, focus on ensuring your OASIS assessments are accurate, consistent and complete, Gordon advised. Documentation must be in the record to justify the way the clinician scored the OASIS. "Think of OASIS as a book or a story that all has to fit together," she added.

Correctly answering M0230 and M0240 (Diagnoses and severity index) plus M0246 (Case mix diagnosis) are the biggest challenges under the new PPS, according to Gordon. Many people didn't even pay attention to secondary diagnoses in the past, but now these are an important component in the reimbursement calculation, she said. This is an area for potential problems if not done properly.

Look To An Expert

Having a home care coder and having people familiar with coding reviewing OASIS accuracy is more important than ever, Gordon advised. "In 2006 and 2007, many agencies had the nurse doing the assessment also do the coding and the sequencing of codes. That is no longer possible under the new PPS system," Gordon cautioned.

Coding is a complicated skill and to be successful, an agency needs to use someone who is skilled in coding, knowledgeable about the coding conventions and aware of the rules and regulations about how you code, Gordon said. Use a certified coder to be sure you are accurate on this important part of reimbursement. The investment is worth it, she stressed.

What to do: Take a look at who is responsible for coding and decide whether you want to change that, recommends consultant **Regina McNamara** with **Kelsco Consulting Group** in Cheshire, CT. Once you have primary and backup coders, send them to get specialized coding training, she urges. Have them continue to keep up with all the coding changes as they occur, Gordon reminded listeners.

Strategies To Keep Your Agency Afloat

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Operational strategies could be what determine your success or failure. The first step is to stay on top of adjustments made to the reimbursements and whether those adjustments are correct, Gordon said. This is especially true in light of all the payment glitches that still plague the **Centers for Medicare & Medicaid Services'** payment software.

Track therapy visits to quickly identify any sudden changes in practice patterns. If your therapy utilization spikes or falls under the PPS refinements, get ready for intense scrutiny, says physical therapist and consultant **Cindy Krafft** with Northampton, MA-based **Fazzi Associates**.

The non-routine supplies reimbursement is a positive change, but you will need good in-ternal processes to receive your earned reimbursement, Gordon advised. You will need to have supplies on your orders and on your claims, as well as systems for tracking them by individual patient. Other strategies Gordon suggested:

1. Educate staff on how to achieve OASIS excellence. Make sure staff understand how crucial OASIS accuracy is to your agency's success. One inaccurately scored item could cost you hundreds of dollars in lost reimbursement. Regular testing of clinicians will show you what training each needs to improve accuracy (see chart, p. 67).

2. Beware of later episodes. Increased reimbursement for later episodes may lead to scrutiny of chronic patients. Be sure they need skilled care and that you document it carefully.

3. Target secondary diagnoses. Train staff to focus on the patient's history and physical to be sure you capture secondary diagnoses -- even those you are not treating. Look for diagnoses you need to address in the plan of care or those that influence the patient's prognosis or rehabilitation potential.

4. **Consider your policy on wound care patients.** Under the old PPS, the lack of reimbursement for supplies may have made it difficult for you to accept complicated wound care patients without losing money. The new reimbursement structure may change that equation.

Opportunity: Consider using specialty staff for wound care now that reimbursement is appropriate for the care needed, Gordon suggested.

5. Ramp up record review. More than ever, your reimbursement depends on the documentation supporting the OASIS answers and the care you're providing. Use record review to ensure that is happening.

6. Coordinate for accurate RAP payment. Your request for anticipated payment provides the first chunk of the expected episode reimbursement. To keep the cash flow manageable, you need staff to coordinate on whether an episode is early or later (M0110) and on how many therapy visits the patient needs (M0826).

Best bet: Aim to have the therapist evaluate the patient, decide on the number of visits required and get an interim order within the five days you have to complete the OASIS. The number in M0826 must match the number of therapy visits on the plan of care, Gordon reminded listeners. So if by the end of the five day period you have orders only for a therapy evaluation, you can only answer "001" on M0826 and will qualify only for the lowest therapy threshold for the RAP payment. If the therapist later gets an order for 12 visits, you'll need to wait until the final claim for that reimbursement.

7. **Claim supplies on LUPAs.** Even though CMS doesn't pay for supplies for a low utilization payment adjusted episode, if you use supplies, put them on the claim, Gordon urged. This will give the industry data to argue for a supply reimbursement for LUPAs.

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