OASIS Alert

Therapy: Safeguard Claims with OASIS-Centered Therapy Documentation

You may have good assessment information, but do you know how to mesh it with the OASIS?

Your therapy visits are on CMS's radar, so demonstrating the medical necessity of these services is more important than ever. Therapists who make the effort up front to learn how to mesh their documentation with key OASIS data items will save time and help prevent lost reimbursement.

Therapists should include OASIS concepts in their documentation, says **Cindy Krafft, PT, MS, COS-C,** director of rehabilitation consulting services with **Fazzi Associates** in Peoria, Ill. Documenting things like when the patient is experiencing pain interfering with activities (M1242) or when he is dyspneic (M1400) will help support the need for skilled care. Yet often therapy documentation lacks this connection, Krafft says.

Don't Fear the OASIS

Fear and avoidance of the OASIS can lead to compartmentalization where the different disciplines look only at their individual piece of caring for the patient. But the outcome measures like improvement in ambulation, bathing, and transferring that result from OASIS data belong to all disciplines, Krafft says. "The whole team should know what's going on with your patients. If a patient is at risk for falls, it's important for therapy to know. They should know what's on the OASIS to provide the best care and mitigate risk."

Communication, collaboration, and documentation provide opportunities to all disciplines when they are done well, Krafft points out. For example, if therapy does gait training and works with the patient on improving her activities of daily living, the documentation should reinforce the medical necessity of this care.

Does the patient have dyspnea (M1400), interfering pain (M1242), incontinence (M1610), or pressure ulcers (M1306)? All of these OASIS items are important to include in therapy documentation. "Is a pressure ulcer relevant to therapy? Yes! If your patient has a stage III pressure ulcer on his backside, you need to get him up and mobile to promote healing," Krafft says.

Keep Documentation Meaningful

Physical therapy documentation gets scrutinized, Krafft says. One way for the record to stand up to this scrutiny is to make certain the documentation ties in what you're trying to accomplish with what you're doing. So often, documentation shows something along the lines of a patient with a goal of walking 200 feet. "Why does that patient have a goal of walking 200 feet? Why not document that the patient's goal is to be able to walk to where his medication is stored? Or the distance to the bathroom? Or to increase the speed with which he walks to the bathroom?" Krafft asks.

Therapy documentation should demonstrate that the care is measureable and meaningful. It must mean something to the patient -- and something meaningful functionally, Krafft says. "Patients don't say 'I want to walk 150 feet.' They say 'I want to be able to let my dog out,'" she says. The best therapy documentation connects the services you are providing with your individual patient's specific personal goals.

Familiarize Yourself with Data Items

Knowing the intent of each OASIS item, and the detail of each response, is critical for efficient use of your clinical reasoning to draw accurate conclusions, says occupational therapist **Karen Vance** with **BKD** in Springfield, Mo. You may have good assessment information, yet still be unaware of how to mesh it with the OASIS. By becoming aware of the

data items up front, you can save time and improve the value of your documentation, she says.

For example: Take OASIS items M1242 -- Frequency of pain interfering with patient's activity or movement and M1400 -- When is the patient dyspneic? Often the response at start of care (SOC) for these items is "Daily but not constantly," Krafft says. "Then therapy comes out and doesn't document pain interfering with anything or any evidence of dyspnea."

Often, the person filling out the SOC OASIS was educated about these items and their significance, but the therapist wasn't. As a result, no supporting documentation shows up in the visit notes or therapy assessment even though it's limiting a functional ability, Krafft says.

Then it looks like the assessing clinican picked the OASIS response for points or outcome scores. "Reviewers will assume you're doing it wrong," Krafft warns. The information included in your documentation should match beyond the SOC. Even if you don't personally touch the OASIS during the episode, you need to document how these items impact the patient's functional abilities.

Another example: OASIS item M1500 -- Symptoms in heart failure patients is completed at transfers and discharges, which can be done by therapists or nursing staff. Everyone must be able to account for this, Krafft tells **Eli**. You're giving a patient a final once-over. "What is the hand-off to the last person standing? How will they know the patient was symptomatic?"

Discharges can be done by someone who has never seen the patient before, Krafft points out. "We want to know who has heart failure, whether he's been symptomatic, and what your agency did," she says.

Mistake: Don't answer this item as if it's asking "What did I do?" and respond with "No action taken," Krafft warns. "It's not about you -- it's about we. What did we as an agency do for this patient?"

Writing therapy documentation that supports OASIS data items may sound daunting, but you shouldn't discount how much useful information you can gather during the course of your normal routine in conducting an assessment, Vance says. Observation and interview (with the patient and/or the caregiver) during a brief tour of the patient's usual routine can provide all the information necessary for most OASIS data collection.