OASIS Alert

Training: Correct These PPS Problems -- Or Pay The Price

Make sure your training program addresses these top mistakes.

Now that you're ending the third quarter under the new prospective payment system, it's time to come up for air and see where your training dollars should go next -- and where you're making costly mistakes.

Many home health agencies were overwhelmed back in January when the drastic PPS changes first went into effect, and some are still struggling with implementing the new rules, says **M. Aaron Little**, senior managing consultant with **BKD** in Springfield, MO.

Watch out for these top PPS implementation errors -- and if you're making them, try our solutions before you throw your hands up in frustration:

Error #1: Therapy Approach Throws Off Primary Diagnosis

Many agencies "are stuck on a few diagnoses they use for almost everything" when therapy is the primary service provided on the plan of care, says **Karen Vance**, supervising consultant with **BKD** in Springfield, MO.

Problem: The four most common diagnoses in home health are chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension (HTN) and diabetes mellitus (DM). However, few agencies list those diagnoses in M0230 as their primary diagnosis, choosing instead to list a "rehab" diagnosis such as gait abnormality or muscle weakness, Vance notes. Not only do agencies stuck in this rut wind up with limited patient documentation, they also curb patients' opportunities to receive well-rounded therapy.

Example: When a patient suffers from both COPD and CHF, the primary diagnosis is often listed as strengthening muscle weakness. Yet, the occupational therapy plan of care usually focuses on energy conservation techniques such as pursed-lip breathing and other oxygen-restoring activities that will help the patient budget her strength so that she is not too exhausted at the end of the day. The physical therapy plan of care includes adapting the environment to reduce the patient's chances of falling. The conditions this plan of care addresses more closely match the COPD and CHF than muscle weakness.

Solution: Rather than focus on secondary diagnoses, agencies should list in M0230 the primary diagnoses that cause those problems, Vance instructs. When you simplify the diagnosis, you fail to acknowledge the other work that goes into your care. For instance, when you focus only on strengthening work, you ignore time you spent training caregivers on safety and helping patients better manage their medications, she says.

Error #2: Number Of NRS Ordered Determines Add-On Payment

Despite many agencies' confusion, the non-routine supplies (NRSs) add-on payment "is solely derived from your responses on the OASIS assessment -- not a provider's estimated costs or ordered quantities," Little asserts.

Problem: Agencies want to bill for NRSs that they order for conditions they discovered after they completed the OASIS assessment. You may believe payers should reimburse the expense of buying supplies for conditions that patients had when they entered your care. However, billing for the supplies you realized you needed after the fact won't net you any more money for that episode.

Example: A patient is discharged from the hospital into your care. During your OASIS assessment you fail to notice that she has a skin ulcer in one of her body crevices. When you find the ulcer later in the episode, you realize the patient should've been scored into a higher supply severity level. You submit for reimbursement for those additional supplies,

but wind up paying for them out of pocket because the skin ulcer doesn't appear on the original assessment.

Solution: The difference between a Level 1 severity and a Level 6 severity amounts to potentially hundreds of dollars in lost NRS reimbursement, Little notes. You can't recoup those losses if your original assessment overlooked a serious condition. Your best bet is to thoroughly evaluate patients for wounds, sores or other conditions that require higher supply level.

Error #3: Relying Only On Patients Or Providers For Episode Timing

One of the biggest problems facing agencies these days is "misunderstanding how they should research episodes to appropriately answer M0110," says **Melinda Gaboury**, CEO with Nashville, TN-based **Healthcare Provi-der Solutions**.

Problem: Agencies must decide if an episode is early, later or adjacent -- whether the subsequent or adjacent episode takes place at one agency or across multiple ones. That means you may need to know about a patient's home health services as far back as two episodes ago -- or longer.

Solution: Your episode-timing research could net you better payment, Gaboury says. CMS pays agencies more for third or later episodes, even though the industry argues that initial episodes require more administrative and diagnostic work.

Tips: You should check the Common Working File, ask the patient about his previous episodes and consult his attending physician to get a thorough understanding of the patient's history. Relying on only one source of information could lead you to wrongly conclude which episode you're billing for.

Lesson Learned

As always, the more educated your management team is, the better able they'll be to spot and correct mistakes, Little says. "If management doesn't have a clear understanding of the changes, it will be difficult for the rest of the agency to learn and adapt," he cautions.

Solution: At least once every few months, assemble your management team, including top management and at least one representative from each department (clinical, financial, billing, IT, etc.), for a general review of the changes included in the PPS refinements final rule. Outline where your agency is struggling and brainstorm ways to overcome those problems.

Resource: Your management team may also benefit from attending educational sessions such as those offered by **Eli**, Little points out. You can learn more about **Eli's** audioconferences at http://www.audioeducator.com.