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Home Health Coding and OASIS Expert

Medical Review: Meet the New #1 Denial Reason: Lack Of OASIS Support

Diagnosis code sequence matters when it comes to accurate reimbursement.

Does your documentation support your OASIS M-item responses? If not, you could be setting yourself up for reimbursement delays and denials.

Palmetto GBA's medical review of high-therapy claims continues the trend of OASIS documentation errors edging out Face-to-Face issues as the chief reason for denials.

Palmetto reviewed claims with a HIPPS code of 5BHK*, processed Feb. 1 to April 15. 5BHK* are claims with the highest (20-plus visits) therapy category, mid-clinical score (2), the highest functional score (3), and a service severity rating of 1. It has a 2014 case-mix weight of 2.0230 the fifth-highest possible.

Of the 309 claims Palmetto reviewed in Florida, Texas, Illinois, Louisiana, and Mississippi, 84 had denials at least partly due to "Medical Review HIPPS Code Change/Documentation Contradicts M0 Item(s)," Palmetto says on its website. That compares to 73 claims that had F2F problems, according to the edit results.

However, the dollar impact of the two types of denials will differ, since entire claims are denied due to F2F while the M0 item reason generally carries downcodes.

In another probe medical review, Palmetto looked at Home Health claims for HIPPS code 5AGK* processed February 1April 30, 2014. These claims also fall into the highest therapy category, but with a low clinical score (1), a mid-functional score (2), and a service severity rating of 1, and is the seventh-highest case mix HIPPS code. Lack of supportive documentation was also a frequent cause of denials in this edit with documentation that contradicted OASIS responses on 69 of the 168 claims reviewed.

Know Why These Claims were Denied

Claims with lacking documentation in Palmetto's reviews received denial code 5CHG1: Medical Review HIPPS Code Change/Documentation Contradicts M0 Item(s) The documentation contradicts M0 Item(s).

"What this means is that, upon review of the documentation submitted, the documentation did not support some of the responses recorded in the Outcome and Assessment Information Set (OASIS)," says a Palmetto GBA spokesman. "As a result, the HIPPS code initially billed on the claim was recoded to the lower level, which resulted in a lower payment," he tells **Eli**.

For example: "Consider the case of a claim with a principal diagnosis of diabetes and a 'B' in the clinical severity domain (second position) of the HIPPS code. In reviewing the documentation, Palmetto found that the only skilled services provided were physical therapy visits.

"Therefore, when the OASIS entries for this claim were reviewed, and compared to the documentation submitted for review, the determination was that the principal diagnosis should not have been diabetes. When diabetes was removed as the principal diagnosis, the clinical domain of the HIPPS code then became 'A,' which resulted in a lower level payment," the Palmetto spokesman says.

Solution: When completing the OASIS, list the diagnoses in the order that best reflect the seriousness of each condition and support the disciplines and services provided, the Palmetto spokesman advises. "The principal diagnosis (M1020)

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should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care. Home health agencies should ensure that all OASIS items are answered accurately and correlate to the documentation in the patient record."

But agencies should continue to follow coding conventions and guidelines, cautions **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates** and **CoDR Coding Done Right** in Denton, Texas. "If Palmetto downcoded the diabetes because it was a therapy case but the primary reason for home care was documented as diabetic polyneuropathy or diabetic arthropathy, then a downcode is inappropriate."

Watch for these Claims Under Fire

"HIPPS codes 5BHK* and 5AGK* are understandably targets for claims investigation," says **Beth Johnson, MBA, BSN, RN, CRRN, HCS-D, HCS-O**, with **Johnson, Richards, & Associates**, in Brighton, Mich. "When PPS was originally proposed in CY2000, CMS expected that patients who had just been discharged from an inpatient-acute setting would require fewer therapy visits and only one 60-day episode of care as opposed to patients whose pre-admission location of care was a skilled nursing facility or the community. The '13th/19th visit rule' enacted with the Home Health PPS Final Rule of 2013 was an attempt to further ratchet down what CMS viewed as an excessive number of therapy visits being provided."

Be extra cautious with your documentation any time your agency provides more than 20 therapy visits during an episode, Johnson advises. "Documentation in every visit note must meticulously support skilled need, homebound status, medical necessity, and measurable progress toward specific patient-centered goals."

The Palmetto denials seem to indicate that either initial OASIS documentation or ongoing documentation contradict responses to the OASIS items that determine clinical and functional severity, Johnson says.

For example: When M1200 Vision is scored as "1" (Impaired vision) but M2030 Management of injectable medications is scored as "0" (Patient can safely manage all aspects of injectable medications independently), there is an inherent contradiction between these two answers, Johnson says. "A patient with low vision generally needs assistance in drawing up medications or adjusting pen dosing, checking for contaminants, site selection, or safe disposal of sharps."

"The functional items are some of the most difficult to answer because of the conventions to be applied namely ability, not actual performance and safety," says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates** and **CoDR Coding Done Right** in Denton, Texas. "The patient may be stumbling around, unsafe even with a walker, but the clinician may be reluctant to answer that the patient requires assistance to ambulate, especially when the patient lives alone. We come across these types of situations in OASIS review all the time."

Your patient may be ambulating (actual performance), but the question really asks at what level the patient is able to ambulate safely without regard to the presence of a caregiver, Selman-Holman points out. If the patient is unsafe at ambulating with a walker, then the answer cannot be a "2 Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces" when he is not safe.

"A patient that is safe walking with a walker doesn't require a high number of therapy visits. But if the patient is unsafe with a walker, then obviously he needs more therapy. It is quite common to find functional items answered inconsistently with each other and inconsistent with the amount of therapy to be provided," Selman-Holman says.

For a list of states affected by these medical review edits and stats broken out by region, see the articles at www.palmettogba.com/medicare click on "J11 MAC Home Health and Hospice" in the left column, then click on "Medical Review" in the left column and choose the "Results" tab below it. Choose the 5BHK results or 5AGK results articles in the right column.

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