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Home Health Coding and OASIS Expert

PPS: CMS Has An Eye On Your Insulin Injection Visits

Thorough assessment documentation and diagnosis coding are essential to supporting your claims.

The case mix points you receive for patients with diabetes took a hit this year, but that may not be the end of your struggle securing reimbursement for these patients. Your OASIS responses are one key to safeguarding your claims.

The **Centers for Medicare & Medicaid Services** is devoting some heavy scrutiny to claims for insulin injections following a report from the **HHS Office of Inspector General** in 2013. The OIG found fraud and abuse problems related to claims containing diabetes diagnoses and outlier payments for insulin injections.

The OIG's report concluded that some home health claims for insulin injections were unnecessary because the patient was physically and mentally able to self-inject.

Remember: Coverage for visits that are for the sole purpose of insulin injections is limited to:

- Patients who are physically or mentally unable to self-inject and
- When there is no other person who is able and willing to inject the patient.

These patients are also exempt from the requirement for intermittent care because they have a daily need for the injections, said **Judy Adams, RN, BSN, HCS-D, HCS-O, with Adams Home Care Consulting** in Asheville, N.C.

Protect Your Claims

CMS fears that home health agencies are furnishing visits for insulin injections that aren't medically necessary, according to the 2015 prospective payment system final rule. CMS worked with a contractor to come up with a list of the diagnoses that would help prove a patient's eligibility for insulin injections. The list contains nearly 165 diagnoses.

Ironically, many of the diagnoses in the list that supports the need for insulin injections are among those recently removed from the case mix list. "It's almost like CMS was saying 'If you didn't identify this diagnosis as a need for resources, we're going to take resources away from it. We know you'll start using these diagnoses to support coverage, but we're not going to give you extra coverage for them," Adams said during the recent **AudioEducator** audioconference Are you ready for the 2015 Home Health PPS Changes?

To support your claims for daily insulin injections you'll need to do three things: assess your patient's ability to self-inject, document the findings of your assessment, and code for the conditions that support your patient's need for skilled care to provide the injections.

Assess **Ability:** Incorporating an assessment tool that checks for the ability to self-inject will help you to both weed out inappropriate patients and back up the need for this service for those patients who truly require the assistance.

There are several reliable and validated assessment tools that can measure a patient's ability to self-inject, Adams said. These tools assess the individual's:

- Cognitive status
- Functional status
- Behavioral status
- Ability to perform activities of daily living (ADLs)
- Ability to inject independently
- Ability to recognize and deal with hypoglycemia

- Ability to recognize the possibility of dosing errors

Documenting the findings of your assessment is vital to protecting your claims. The old saying "if it's not documented, it didn't happen" goes double when you're only providing a single service. If the record doesn't show the need for a skilled service, it's doubtful you'll get paid for providing it.

Code thoroughly: In an analysis of 2012 claims data, CMS looked at claims and OASIS assessments likely to be associated with insulin injection assistance. It studied episodes with a diabetic condition as the principal diagnosis on the claim, Medicare Part A or Part B enrollment for at least three months prior to the episode and during the episode, and three episodes with at least 45 skilled visits. It found that more than half of the 49,100 episodes that met these parameters had a principal diagnosis of 250.0x (Diabetes mellitus without mention of complication).

"Clinically, this code generally means that the diabetes is being well-controlled and there are no apparent complications or symptoms resulting from the diabetes. Diabetes that is controlled and without complications does not warrant intensive intervention or daily skilled nursing visits; rather, it warrants knowledge of the condition and routine monitoring," CMS said in the 2015 Home Health PPS final rule.

Do this: A diabetes code alone won't support your patient's need for help with injections. Be sure to include the diagnosis codes that best describe the conditions that make your patient eligible for this service. See the sidebar above for a breakdown of the types of codes CMS hopes to see for these patients.

Note: Order a recording or transcript of Are you ready for the 2015 Home Health PPS Changes? here: www.audioeducator.com/home-health/home-health-pps-coding-updates-01-15-2015.html. Read the details about CMS's concerns in the final rule, starting on page 64 here: www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf.