Eli's Rehab Report

Home Health Therapy Audits: Does Your Documentation Land Your Claims On The Rejection Pile?

Tip: Evade downcodes and denials by watching out for these mistakes.

For therapy only homebound patients, OASIS documentation determines the patient's need for skilled services. Avoid putting your reimbursement at risk by keeping a close watch on your responses especially with regard to locomotion, ADLs and IADLs.

Know What The Auditors Want To See

When auditors review home health charts they look for documentation of the plan of care, the patient's eligibility, homebound status, orders, and skilled need, says **Sharon Litwin, RN, BS, MHA** with **5 Star Consultants** in Camdenton, Mo.

Home health agencies are seeing denials in claims where the functional domain section of the OASIS shows a patient is independent, Litwin said during the recent **Eli**-sponsored audio conference Building a Strong Foundation in Homecare. If you're reporting a lot of "1s" and "0s" in ADL and IADL items M1800 through M1910 indicating a fairly independent patient, "you'd better be able to document that this patient is homebound. Because by OASIS scoring, they may not be, and they may not have skilled need either," Litwin tells Eli.

Auditors look for objective terms such as "a taxing effort" and hope to match them with functional questions on OASIS, such as shortness of breath, pain, balance, ADLs, and IADLs, Litwin said. When there's not a good match, you can expect downcodes and denials.

And if the auditor sees documentation indicating that your patient does occasionally go on outings, it's important that you also document that it was a taxing effort and why, Litwin said. Otherwise, you are bringing the patient's homebound status into question.

Terms such as "considerable and taxing effort" and "dyspnea upon exertion" are not enough to indicate the patient is homebound, 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. And checkboxes for indicating homebound status haven't worked in a long time, she says. "Homebound must be linked to the patient's injury or illness."

Just checking the right boxes on the OASIS functional items isn't enough to withstand audit scrutiny, either, Selman-Holman says. Your clinical documentation must support those answers.

Mistake #1: No Indication Why You're Seeing The Patient

When reviewing charts, "about 20 percent of the time, I have no idea why a patient is being admitted to home care," said Litwin. "You want to tell a story in your chart, but you don't want it to be a mystery novel," she said.

Thorough, specific, and accurate OASIS responses and documentation are vital if you hope to to secure appropriate epsiode payment and avoid denials. A strong narrative paragraph at the end of the OASIS can pull the story together, Litwin says. "The clinician can say what the skilled need is, what disciplines they need, why they are homebound and then write a short 'report.'" You can also send this narrative to the physician who needs a report and it can help with completion of the face-to-face.

Try this: Complete the OASIS in a manner where you see the patient answering the questions rather than just asking

him to answer questions, Litwin said. Have the patient walk around, take off his shoes and socks to check for wounds, pulses, and color. Then have him put them back on.

"If you ask a patient about her lower body dressing, she may say she's fine, but ask her to demonstrate and it may be another story," Litwin said. "You don't even have to ask the question if you see it during assessment."

Mistake #2: Documentation and OASIS Don't Match Up

When reviewing an OASIS, auditors look at all the M items. If they don't match up or are inconsistent and if the narrative documentation doesn't match up, "that could really nail you," Litwin said. Inconsistency could indicate a lack of coordination of care, incorrect OASIS responses, or that someone in the office is changing scores, she said.

Exception: You can expect inconsistency sometimes because different items have different timeframes and instructions. For example, a patient could be a "3" on ambulation and still be a "0" on toileting transfer because the "0" response indicates with or without a device. He may need someone to be with him at all times to ambulate, but use a wheelchair to get to the toilet. "In the case of that inconsistency, I would expect documentation to explain the situation and the patient's functional limitations," Selman-Holman says.

An example of an error: OASIS item M1860 □ Ambulation/Locomotion is scored 4 □ Chairfast, unable to ambulate but is able to wheel self independently, but the home health aide documents that the patient walked to the bathroom with assistance that same day. You'll only select response "4" for Ambulation/Locomotion if the patient isn't ambulatory at all.

Remember: The comprehensive assessment documentation and your OASIS scores must paint a true and consistent picture of your patient, Litwin cautioned. The Centers for Medicare & Medicaid Services (CMS) "sees the patient through these scores and all other documentation."

Note: Order a recording of transcript of the audio conference Building a Strong Foundation in Homecare here: www.audioeducator.com/home-health/building-strong-homecare-foundation-12-02-2014.html.