THE DEVIL’S IN THE DETAILS
SURVIVING WITH YOUR
CLINICAL DOCUMENTATION

Home Care Association of Arkansas
Annual Meeting
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It arrives in the form of a letter...

Terminology & Types of Pre/Post Payment Audits

- ADR: Additional Documentation Request
  - Pre payment
  - Intent is pre payment review and request for additional documentation
  - Probe Edits
- RAC: Recovery Audit Contractor
  - Intent is the recovery of funds
  - Post Payment
- ZPIC: Zone Program Integrity Contractor
  - Intent is Fraud Detection
  - Post Payment

Terminology & Types of Pre/Post Payment Audits

- CERT: Comprehensive Error Rate Testing
  - Identification of Error Rate in PPS Payments
  - Focused edits
- MIC: Medicaid Integrity Contractor

ADR

- Pre-Payment review
- May be probe edit based/triggered
- HIPPS Codes
  - J11 Palmetto 1BGP*, 2CGK*
- Coding
- Face To Face
- 30 days to respond
- What happens if you do not respond in time?
### RAC

**Recovery Audit Contractor**
- Post Payment Review
- Identification of Over & Underpayment
- 4 Regions, 4 Contractors initially review claims depending upon region
- 30 days to respond
- What happens if you do not respond?
- What about denial rate?
- Extrapolation

### ZPIC

- Post Payment
- Focus is potential for fraud
- Billing trends
- Office & Patient on site visit by contractor
- Initial response to request period
- Episodes requested may vary. May need to provide multiple episodes.
- What if you don't respond?
- Extrapolation
- Implications of denials

### What they want...

- Certification & POC
- ALL physician orders
- F2F if patient admitted after 4/1/2011
  - Even if a recertification episode
- Med lists
- All clinical notes (ALL disciplines)
- Flow sheets
- Intake and ALL referral documents
- All therapy evaluations in addition to notes
- Discharge summaries
- OASIS documents
- List of all staff, physicians and others who provided care during episode
- Signature Validation

### And then you wait...

### So what do you do in the meantime?

- Evaluate your risk & practices
- Focused Self-Audit
- Identify other at-risk episodes
  - F2F processes
  - LOS Issues
  - Coding issues
- Review agency practices

### So what do you do in the meantime?

- If the patient had “visitors,” try to determine what was asked and what was told to the visitor.
  - May be discharged patients so may not be able to determine.
- What are your patients’ knowledge deficits regarding what your agency does for them?
- What are your patients’ knowledge deficits regarding eligibility for homecare, i.e., what homebound means?
Interview the Patients

☐ Get statements from the patients regarding any visitors they may have had.
  - Witnessed or notarized
  - Ask questions regarding homebound
  - Ask questions regarding their need for skilled nursing and therapy.

Strategies

☐ Make a copy of each chart in question (don’t forget front and back), then number the pages of the copy as you compare to the original.
  - Now make another copy of your now numbered copy.
  - Electronic copies
  - Keep an exact copy of what you send.
  - Determine if those patients have had any visitors.

Tell Them Why the Patient is Homebound...

☐ The ZPICs’ definition of homebound is narrow.
  - Considerable and taxing effort

Tell Them Why the Patient Needed Skilled Nursing

☐ What is the skill?
  - Observation and assessment is not just assessment (reasonable potential for change)
  - Teaching
    ■ Is the teaching related to the patient’s injury or illness?
  - Direct Care
    ■ Follow the orders!!

Tell Them Why The Patient Needed Therapy

☐ The therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record.
Tell Them Why The Patient Needed Therapy

For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.

Tell Them Why The Patient Needed Therapy

Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

Tell Them Why The Patient Needed Therapy

The skills of a qualified therapist are needed to restore patient function:

- To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.

- Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.

You Don’t Want the Therapy To Fall In This Category

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition. However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.

Probe Edits

- Whole episode
  - Homebound
  - SOC 04/01 or later F2F
  - Lack of medical necessity
- Take Down to a LUPA
  - Lack of medical necessity (1w9, 5 visits per episode)
- Denied Therapy Visits
  - Measurable?
  - Reassessments and Re-evaluations
### The Appeals Process

**5 Levels to the Medicare Claims Appeal Process**
- Redetermination (MAC)
- Reconsideration (QIC)
- Hearings before ALJ
- Review by Appeals Council
- Judicial Review

**MUST file appeal to STOP RECOUPMENT of funds**

### The Appeals Process

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1. Redetermination | 120 days to submit appeal  
General timeline for decision is 60 days  
Attach any ADDITIONAL supportive documentation (do not resubmit entire claim information) |
| 2. Reconsideration | 2nd level appeal  
Performed by Qualified Independent Contractor (QIC)  
Independent review of initial and redetermination  
Monetary threshold not necessary  
File within 180 days of redetermination decision  
60 day decision OR will notify of appeal to ALJ rights |
| 3. ALJ Hearing | 3rd level appeal  
Requires minimum monetary amount in dispute  
Video teleconference or phone  
All party notification  
Decision within 90 days of request |
| 4. Appeals Council Review | 4th Level Appeal  
No minimum $ threshold  
Request within 60 days of ALJ findings  
Generally issue findings within 90 days |
The Appeals Process

- U.S. District Court- 5th Level Appeal
- Minimum $ Threshold required
- Must file request within 60 days of Appeals Council decision

Complex Medical Review

- "Providers/suppliers who show a pattern of failing to comply with requests for additional supporting documentation for any claims submitted to CMS may be subject to complex medical review for all claims."
  - Medicare Program Integrity Manual, 3.7
- Based on pattern of noncompliance
- Pre and/or Post-payment
- Results in Progressive Corrective Action (PCA)

Progressive Corrective Action Decision Tree

- Minor—0-33% Claim Denial Rate (CDR)
  - Remove from medical review unless this is a second probe or egregious behavior
- Moderate—34-66%
  - Education
  - Review resumes
  - May request CAP

- Major—67-100%
  - Education
  - CAP
  - Resumes
  - Additional actions may include
    - Postpayment sampling for overpayment projection
    - Referral to ZPIC
    - Referral to RAC
    - Referral for program exclusion
    - Suspension of payment and/or civil penalty
    - Withholding of payments

Then You Get Your Results

- Dates of Service: 06/03/07 - 09/24/09
- Claim Payment Dates: 09/07/07 through 10/09/09
- Claims Error Rate: 95.6%
- Number of Claims Reviewed: 69
- Number of Claims Allowed: 3
- Number of Claims Reduced: 0
- Number of Claims Denied: 66

ZPIC Letter
The claims sample of 69 has been extrapolated from the entire number of 1,563 claims in the universe. This has yielded a total overpayment of $8,149,387.00.

Actual alleged overpayment $300,000+

Three out of sixty-nine claims were allowed because documentation supported that the beneficiary was homebound, that skilled services were billed appropriately and were medically necessary according to Medicare guidelines.

Fifty-nine of the sixty-six denied claims were denied because the documentation did not provide sufficient information to support that the beneficiary met homebound criteria and the criteria for reasonable and necessary skilled services.

Seven of the sixty-six denied claims met homebound criteria but were denied because the documentation did not provide sufficient information to support that the beneficiary met the criteria for reasonable and necessary skilled services.

Five of the sixty-six denied claims included skilled services that were not in compliance with physician’s orders.

Forty of the beneficiaries were interviewed. Twenty-five were found to not be homebound at the time of the episode. Nine were felt to be homebound by the nurse/investigator team but documentation did not provide sufficient information to support this finding.

Should your Medicare and/or Medicaid claim submission patterns remain aberrant despite our educational efforts, the following actions may be taken against you: exclusion from the Medicare and/or Medicaid programs under 42 USC §1320a-7; imposition of civil monetary penalties pursuant to 42 USC §1320a-7a; and or the withholding of future payments as authorized by 42 CFR §405.371.

So what do you do in the meantime?

- Audit your charts—do it yourself OR have a 3rd party do it.
- What are your risks?
- Keep an eye on the DDE for denials showing up there.

Bases of Decision—Valid

- Not homebound
- Not medically necessary to treatment of illness or injury
- Physician’s certification absent
- Physician’s F2F documentation absent/insufficient
- Claims made prior to signature of physician on orders, Prior to receipt of F2F
- Nursing not intermittent
- Quality data not transmitted
Bases of Decision

- No treatment or regimen change within 14 days of start of care

(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient’s Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Changed Medical Regimen Diagnosis</th>
<th>ICD-9-CM Code</th>
</tr>
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</table>

- NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

Homebound?

- The clinicians did not provide patient specific details related to the beneficiary’s physical limitations that prevent her from leaving her home. The Physical Therapist documented the beneficiary’s functional status as independent in standing, weight-bearing and transfers; supervised ambulation with assistive device; independent in wheelchair brakes and footrests; and primarily independent in personal hygiene and dressing activities.

Uh-oh!!

- A general finding across the medical records was the use of standardized text for orders, treatment plans, and skilled nursing notes. The text was vague and did not describe the individual beneficiary’s health status, limitations, or needs. For example, the preprinted, standardized text used for the check box denoting that a beneficiary is homebound contains the phrase “taxing effort to leave home.”

Uh-Oh!

- Documentation in the record fails to explain “taxing” or to describe the level of effort required to leave home. According to Medicare guidelines, there must be “inability to leave home and, consequently, leaving home would require a considerable and taxing effort.” Simply stating “taxing effort” does not explain the functional or physical limitations that define the taxing effort preventing the beneficiary from leaving the home.

OK...so maybe it’s too late to do anything proactive...

- Use the experience to improve your processes and patient care.
- Change Processes
- Educate Staff
- Implement new patterns for documentation
- QA processes/review

About those visitors...

- Take the opportunity to educate your patients/caregivers about the benefits of home care, how it works and what homebound is!!
- Do your patients understand the home health benefit? Should be explained at the SOC.
Strategy For Improvement

- Have a chart auditing ‘party’
  - ALL Staff should get involved
    - 485—verify every order on 485 was performed during episode—bet you will be surprised (and not pleasantly!)
    - Skilled notes—verify a reimbursable skill provided on every note, no repetitive/unnecessary teaching
    - Physician’s orders—verify order for every task performed, frequency, updated
  - F2F review
  - Verify homebound statements

Common Bases for Complete Denial

- Easily cited as insufficient
  - Clinical data scarce
  - Homebound scarce
- Miscellaneous and numerous versions of forms confusing to doctors.
- Medicare has proposed a clinical template

Face to face

- Need to be SPECIFIC
  - “The patient requires the assistance and supervision of another to ambulate safely at all times due to high risk for falls/multiple recent falls.”
  - “The patient requires the use of portable oxygen and absences are limited to short term due to respiratory insufficiency and risk of complications.”

What about in the F2F

- PHYSICIAN must sign AND date prior to billing final claim for episode
- HIPPS code on the OASIS does not match the HIPPS code on the claim
- No OASIS transmitted prior to claim
- Documentation errors not corrected appropriately.
### Documentation Principles

- Medicare, other payors and state practice acts require that all relevant documents and entries into the medical record occur at the time the services are rendered.

### True Corrections

- Corrections to the medical documentation when actions were actually performed.
- It is always wrong to falsify documentation to indicate some action was taken that was indeed, not taken to avoid survey deficiency or to upcode in order to garner more funding when the patient’s actual condition does not warrant the option or code chosen.
  - “Uhhhh...you documented that the patient goes to the grocery store every day by themselves. You need to change that.”

### Falsification

- Falsification of documentation while typically not done maliciously can happen due to a lack of knowledge of the rules. Some types of changes that constitute falsification are: Creation of new records when requested, back-dating, post-dating, and pre-dating entries, writing over, or adding to documentation without following the formal guidelines.
- Falsifying documents is considered a felony offense and can carry some large penalties.

### Principles of Document Correction

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Not delete but instead clearly identify all original content

### Types of “Corrections”

- An addendum is utilized to provide additional information that was not available at the time the original documentation was entered. This should bear the current date, and include a reason for the addition or clarification of information added to the medical record. This should be entered in a timely fashion.

- A late entry provides additional information that was originally omitted from the charted documentation. This entry will have the current date, and is added as soon as possible. This should only be done if the individual providing the information has total recall of the details in the added information.

- A correction is exactly as it sounds. For example, the record noted ‘right’ when it should have stated ‘left’. When making a correction, you should never write over the original entry. Instead, you should strike out the original entry with a single line allowing the original information to still be legible. Sign and date the strike out.

http://apfsbilling.com/2013/08/making-corrections-to-medical-records/
When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Do not scribble over the writing to obscure what was originally written.
Do not attempt to erase.
Never use white-out. It is important that the original record remain legible for medicolegal reasons.
Resist the temptation to write “ERROR” or attempt to explain the error in the documentation.

Medical record keeping within an EHR deserves special considerations; however, the principles remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:
- Distinctly identify any amendment, correction or delayed entry, and
- Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

Why Does Documentation Matter?
- CMS Requirements (CoPs)
  - Homebound status
  - Medically reasonable and necessary
  - Intermittent skilled care
- Reimbursement support
- Legal considerations
- Interdisciplinary coordination

Homebound Requirement
- Pt has normal inability to leave home, leaving home requires considerable and taxing effort
- Absences must be infrequent and of short duration, or to get health care treatment
- Pt has illness/injury that restricts ability to leave home except with aid of supportive devices (crutches, cane, w/c, walker), use of special transport, or assist of another person
- Leaving home is medically contraindicated
Homebound Status

- May use check boxes with CMS criteria
  - Requires assistance for all activities
  - Taxing effort to leave home
  - Severe SOB, SOB w/exertion
  - Unable to safely leave home unassisted
  - Leaving home is medically contraindicated
- Must add narrative requirements
  - Support check box statements
  - Must include details specific to patient visit
  - Avoid repetitive statements

Homebound Specific Details

- Requires assistance for all activities
  - Requires assist of one with transfers on/off toilet using gait belt and assistance with toileting hygiene, clothing
  - Requires hands-on assist of 1-2 people to negotiate seven steps in/out of home
  - Wife must remind patient to use walker for ambulation
  - Daughter must set up med planner and remind patient to take meds on time
  - Choreworker prepares meals, leaves by patient’s chair
  - PT plan of care includes gait training with crutches as pt currently unsafe with use of device w/o assistance

- Taxing effort to leave home
  - Requires assist of daughter to go to physician appointments, riding in car causes severe back pain partially relieved by Percocet, on return home patient has to rest in bed due to pain and exhaustion
  - Able to ambulate short distances in home with walker, but requires wheelchair and assist of one to leave home. POC includes PT for gait training with walker and transfer training in/out of wheelchair, safety measures to lock w/c
  - Pt went to doctor appt yesterday and refuses PT visit today since too tired and still in bed

- Severe SOB, SOB w/exertion
  - Ambulates using walker, dyspnea with walking 8-10 ft and must stop to rest
  - Patient must stop to rest and catch her breath during dressing activities, takes almost an hour to complete sponge bath and dressing
  - Requires assistance with meal prep, must stop and rest while eating meal due to dyspnea
  - SOB while talking, must pause during conversation to catch her breath

- Unable to leave home unassisted
  - Patient requires supervision to leave home due to mental status, confusion and forgetfulness
  - Patient needs assist of one and use of wheelchair to get to physician appointments
  - SN called Para-quad and set up handicapped assisted van to transport patient to physician appointment
  - POC includes PT for gait training and strengthening as patient must be able to walk 150 ft to ALF dining room

- Leaving home medically contraindicated
  - Pt cannot leave home w/out respiratory barrier due to risk of infection while on chemo
  - Pt at high risk for infection/complications due to long-term steroid treatment for repeated asthma exacerbations, hx of recurrent pneumonia
  - Pt under physician order to keep LLE elevated at all times due to DVT
  - Pt NWB on RLE due to explantation right knee prosthetic joint for infection
Reasonable and Necessary

Care must be consistent with nature and severity of patient’s illness/injury and accepted standards of practice.

Consider condition of patient at time services were ordered and reasonable expectation of appropriate treatment for illness/injury during certification period.

Reasonable and Necessary Examples

- Type II Diabetes 4 years, recent UTIs and high blood sugars, no med changes
- TKR, 10 days in SNF, now home
- Parkinsons w/ increase in falls, med changes
- Alzheimers, more confused, now needs reminders for ADLs, increased difficulty feeding self, recent choking and risk for aspiration
- Tripped and fell, infected partial thickness wound on arm

Skilled Care Requirement

- Based on objective clinical evidence regarding patient’s individual need for care.
- Care must be provided by professional nurse or therapist to be safe and effective.
- Skill can be determined by:
  - Complexity of the care
  - Condition of the patient
  - Accepted standards of practice

Skilled Care Interventions

- Observation and assessment
- Management and evaluation of the care plan
- Skilled teaching
- Medication administration/treatment
- Catheter care
- Wound care
- Psychiatric treatment
- Skilled therapy services

Reasonable & Necessary

And if you were a medical reviewer...

- “All systems WNL”
- “Assessment reveals no concerns”
- “Patient reveals no concerns.”
- Parameter “Call doctor for BS <40 or >400.”
- “No change from last assessment.” (even when this clinician didn’t see the patient last assessment).
Home Health Resource Group

- OASIS is the basis for payment
- HHRG produced through grouper software
  - Determined by 25 OASIS items
  - Three domains
    - Clinical Severity
    - Functional Status
    - Service utilization
- 45 HHRGs; 153 case mix weights
  - C1F1S1 to C3F3S5 for four different equations

Case Study: Mr. Shelton

- Referral for SN, PT, OT for post-op care following gall bladder surgery
- SOC visit made = Early episode
- Orders for 6 PT and 5 OT visits, total of 11 therapy visits
- Comprehensive assessment with OASIS items completed

Mr. Shelton

- Recovering from gall bladder surgery (no full epithelialization yet), other dx: CHF exac during hospitalization, type 2 diabetes (takes insulin), blindness; scores on OASIS data items:
  - M1200 = 2
  - M1242 = 2
  - M1342 = 3
  - M1400 = 2
  - M2030 = 1
  - M1810/1820 = 1
  - M1830 = 2
  - M1840 = 2
  - M1850 = 2
  - M1860 = 2

Aftercare for gall bladder surgery, CHF, diabetes and blindness

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Points</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020(a)</td>
<td>AC following surgery GI</td>
<td>V58.75</td>
<td>575</td>
</tr>
<tr>
<td>M1022(b)</td>
<td>CHF exac.</td>
<td>428.0</td>
<td>(3 pts)</td>
</tr>
<tr>
<td>M1022(c)</td>
<td>DM II</td>
<td>250.00</td>
<td>(2 pts)</td>
</tr>
<tr>
<td>M1022(d)</td>
<td>Blindness</td>
<td>369.4</td>
<td>(3 pts)</td>
</tr>
<tr>
<td>M1022(e)</td>
<td>Insulin use</td>
<td>V58.67</td>
<td>(0 pts)</td>
</tr>
<tr>
<td>M1022(f)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Clinical Severity**

- Diagnoses = 8 pts
- Vision = 1 pt
- Surgical wound status = 4 pts
- Dyspnea = 2 pts
- 15 clinical points

**FUNCTIONAL DIMENSION**

- M1810 or M1820 (Dressing upper or lower body) = 2, 4, 2, 2
- M1830 (Bathing) = 2 or more
- M1840 (Toilet transferring) = 2 or more
- M1850 (Transferring) = 2 or more
- M1860 (Ambulation) = 1, 2 or 3
- M1860 (Ambulation) = 3 or more

8 functional points

**Review Identified Problems**

- No supporting documentation of any vision deficits to verify blindness
- Down code blindness dx, M1200 to 0
- Surgical wound is described as “early granulation” with no s/s of infection
- Down code M1342 to 2

HHRGC = C3F3S5
### Effect on HHRG

<table>
<thead>
<tr>
<th>Before Review</th>
<th>After Review &amp; Down code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blindness = 3 pts</strong></td>
<td><strong>0 pts</strong></td>
</tr>
<tr>
<td><strong>M1200 = 1 pt</strong></td>
<td><strong>0 pts</strong></td>
</tr>
<tr>
<td><strong>M1342 = 4 pts</strong></td>
<td><strong>Total clinical points</strong></td>
</tr>
<tr>
<td><strong>Total clinical points</strong></td>
<td><strong>7, now a C2</strong></td>
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### Review Identified Problems

- Description of bathing ability notes pt needs help in and out of shower, but no mention of any other assistance needed or safety concern getting to and from bathroom or bathing
- Ambulation is independent w/walker
- No description of why pt uses BSC instead of toilet – inconsistent with his ability to get to bathroom for shower

**Down code M1840 to 1**

### Effect on HHRG

<table>
<thead>
<tr>
<th>Before Review</th>
<th>After Review &amp; Down code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1840 = 2 pts</strong></td>
<td><strong>0 pts</strong></td>
</tr>
<tr>
<td><strong>Total functional points 8, a F3</strong></td>
<td><strong>Total functional points 6, now a F2</strong></td>
</tr>
</tbody>
</table>

### Review Identified Problems

- PT made 6 visits as ordered, all the documentation met skilled and medically necessary requirements
- OT made 5 visits as ordered, but the documentation reflected goals met at visit 3 and did not support medical necessity for the last two visits

**Down code therapy visits to 9**

### Effect on HHRG

<table>
<thead>
<tr>
<th>Before Review</th>
<th>After Review &amp; Down code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11 therapy visits</strong></td>
<td><strong>9 therapy visits</strong></td>
</tr>
<tr>
<td><strong>Service utilization</strong></td>
<td><strong>Service utilization</strong></td>
</tr>
<tr>
<td><strong>was a S5</strong></td>
<td><strong>now a S3</strong></td>
</tr>
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</table>

### Effect on Reimbursement

- Original episode was C3F3S5
  - $3435.94
- After review, MAC downcoded the episode to C2F2S3
  - $2399.85
- Incomplete/incorrect documentation and OASIS responses cost agency $1,036.09!
HHRG and OASIS

- Assess using appropriate techniques
- Choose accurate OASIS item response(s)
- Provide supporting information for the OASIS response in narrative documentation
- Make sure interventions are included in POC
- Visit note documentation:
  - Support for OASIS responses
  - Implement interventions, note effectiveness

To Recert or not to Recert?

- Still homebound?
- Continuing need for skilled services?
- Reasonable and necessary for home care?
- Diagnoses new or exacerbated?
- Revised plan of care?
- Reasonable progress toward goals?
- Outcome measures improved?
- Revised goals?
- Discharge plan?

To Recert or not to Recert?

- Patient had an MI 3 months ago, followed by a 4 vessel CABG. Home care has provided wound care to surgical incisions, which are now healed. SN instructed pt and wife in cardiac meds, how to check pulse and BP, diet, and s/sx to report. PT provided strengthening training and HEP. Patient continues to have unstable angina, wife gets anxious, calls 911 and insists pt go to ER, even though pt can state correct use of sublingual ntg, and angina is relieved on second or third tab.
- End of certification period – recert or discharge?

To Recert or not to Recert?

- Patient has a venous stasis ulcer on her left posterior calf, onset 8 months ago, wound clinic every two weeks. Same wound orders, ulcer slowly getting smaller, moderate amount serous drainage, no s/sx of infection present. Pt has venous insufficiency, emphysema, is a smoker and isn't quitting. SN has provided education on wound care, diet to promote healing, benefits of stop smoking, and s/sx to report. Husband is meticulous about doing dressing changes every other day, and they usually keep appts at clinic.
- End of fourth cert period - recert or discharge?

To Recert or not to Recert?

- Same patient with 8 month old stasis ulcer. She also has diabetes, blood sugars range 140-180 with an occasional >220. Lives alone, daughter does dressing changes since pt can’t reach the wound, inconsistent with q other day dressings, missed 1/3 of her clinic appts, wound 30% yellow slough, no s/sx infection. SN has taught pt/cg wound care, DM mgt, meds, and s/sx to report; both have stated understanding and have good recall, but don’t always comply with POC.
- End of fourth cert period – recert or discharge?

To Recert or not to Recert?

- Patient had a TKR two months ago, lives alone, incision healed and SN dc’d, PT providing therapeutic exercise, gait training and HEP instruction. Patient has pain but refuses to use meds except Tylenol, slow progress to quad cane in week 4, had a fall last week and has decreased walking and HEP since pain increased. Pt can demo HEP, but inconsistent with practice, able to ambulate 20-25 ft with cane but can’t negotiate front steps without help of at least one person.
- End of cert period – recert or discharge?
### To Recert or not to Recert?

- Patient with hospitalization 2 months ago for CHF, pneumonia, and generalized weakness. SN provided assessment and teaching on CHF management, meds, diet, and s/sx to report. PT provided exercises to increase strength, gait training with cane and HEP. Pt fell last week when he forgot to use his cane, skin tear on elbow treated with TAO and telfa.
- End of cert period – recert or discharge?

### To Recert or not to Recert?

- Patient with CVA, hemiplegia non-dominant side, mild expressive aphasia when tired. SN provided assessment, teaching on meds, diet, safety, s/sx to report, and PT/INR weekly. PT, OT and SLP provided exercises for deficits from CVA, pt achieved maximum potential, has HEP she performs with assist of husband. Pt will continue to require weekly PT/INR.
- End of cert period – recert or discharge?

### Interdisciplinary Coordination

- Opportunity to support medical necessity, homebound status and skilled need
- Information from all disciplines should agree
- Avoid contradictions between disciplines
- Follow up on problems identified
- Provide supporting education and assessment of effectiveness of interventions

### Questions?? Send to lisa@selmanholman.com
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