Home Health ICD-9/ICD-10 Alert

ATTACHMENT D :TAKE A CLOSER LOOK AT ATTACHMENT D

Know where to turn when CMS gives contradictory advice.

The Centers for Medicare & Medicaid Services' December 2008 revisions to OASIS Chapter 8 Attachment D seem to have raised more questions than they have answered. Despite clarifications on some points, confusion lingers. Alleviate your uneasiness with these solid answers.

Check the History

Attachment D advises home health coders to code only unresolved diagnoses in M0230 and M0240, notes **Trish Twombly, RN, BSN, HCS-D, CHCE,** director of coding with Foundation Management Services in Denton, Texas. The revised Attachment D advises coders not to code diagnoses for resolved conditions that have no impact on the patient's plan of care. But what about history codes? History codes are resolved conditions, and the official coding guidelines advise that these codes are important and often required, Twombly says.Attachment D doesn't specifically mention history codes, she points out.

Bottom line: In cases where Attachment D contradicts guidance from the ICD-9-CM Official Guidelines for Coding and Reporting, you should defer to the coding guidelines, Twombly says.

For example: the American Hospital Association's Coding Clinic, which is recognized as official coding advice in the coding guidelines, states that you should list a code from the V10 (Personal history of malignant neoplasm) category to indicate the former site of a malignancy "when a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy."

The official coding guidelines also advise that history codes are acceptable on any medical record "regardless of the reason for visit."

Check the Documentation

Attachment D tells coders that they must have physician documentation before coding the diagnoses, but this conflicts with previous Attachment D advice as well as the OASIS Chapter 8 assessment strategies, Twombly says.

Attachment D also states that diagnosis information comes from the clinical assessment and the plan of care and that is in line with other CMS guidance in Chapter 8 of the OASIS Implementation Manual, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principle of Selman-Holman & Associates in Denton, Texas.

The admitting clinician uses all the available records to determine the diagnoses and verifies these diagnoses and conditions with the physician, Twombly explains.

"Physician documentation is often sketchy and not always an available resource for coding," Twombly says. "We can gather additional details from the patient, caregiver, and family and verify with the physician."

Sort Out These Scenarios

Coders everywhere have expressed frustration over the coding scenarios CMS included with the revised Attachment D. The example codes are frequently at odds with coding guidelines. Take a look at the following scenarios and Twombly's take on how they should have been coded.

Scenario 1: The patient sustained a left hip fracture resulting in an open reduction internal fixation (ORIF). Following

hospitalization, she went to a skilled nursing facility. She can perform non-weightbearing activity with supervised pivot transfers and requires a contact guard assist in and out of bed. CMS coded for this patient as follows:

M0230a: V57.1 (Other physical therapy) and

M0240b: 781.2 (Abnormality of gait).

The V57.1 code should be in M0230, provided therapy is the only discipline seeing the patient,

Twombly says. But abnormality of gait isn't the right code to list in M0240.

Once a patient has completed active treatment for a fracture and is receiving routine care during the healing or recovery phase, you should report the fracture with an aftercare code, Twombly says.

Also, if you know the underlying etiology for a symptom, you should code the etiology rather than the symptom, Twombly says. You should only list a symptom code like abnormality of gait if you don't know the underlying etiology. So the correct way to code for this patient is as follows, she says:

M0230a: V57.1 (Other physical therapy);

M0240b: V54.13 (Aftercare for healing traumatic fracture of hip); and

M0246: 820.8 (Fracture of neck of femur; unspecified part of neck of femur, closed).

Scenario 2: The patient had a total hip replacement due to osteoarthritis. She has a mildly exudated wound infection (staph aureus) with a partial separation of her surgical incision with IV antibiotics. Nursing and therapy have been ordered.

CMS coded for this patient as follows:

M0230a: 998.59 (Other postoperative infection);

M0240b: 041.11 (Methicillin susceptible Staphylococcus aureus);

M0240c: V54.81 (Aftercare following joint replacement);

M0240d: V43.64 (Organ or tissue replaced by other means; joint; hip);

M0240e: 715.35 (Osteoarthrosis, localized, not specified whether primary or secondary; pelvic region and thigh); and

M0240f: 781.2 (Abnormality of gait).

CMS didn't code for the dehisccnce, which should be sequenced before the infection code, Twombly says. Plus, using both an aftercare code and a complication code to describe the same wound is incorrect. An aftercare code shouldn't be used when the wound is complicated.

The scenario doesn't mention that the patient has osteoarthrosis in any other joint, so this condition should be considered resolved by the joint replacement and not coded, Twombly says.

And finally, CMS missed coding for the IV and antibiotics the patient is receiving.

To code correctly for this patient, Twombly suggests listing the following codes:

M0230a: 998.32 (Disruption of external operation [surgical] wound);

M0240b: 996.66 (Infection and inflammatory reaction due to internal joint prosthesis);

M0240c: V43.64 (Organ or tissue replaced by other means; joint; hip);

M0240d: 041.11 (Methicillin susceptible Staphylococcus aureus);

M0240e: 781.2 (Abnormality of gait);

M0240f: V58.81 (Fitting and adjustment of vascular catheter).

Another approach: If this were a superficial infection of the wound and external dehiscence, the aftercare of the joint replacement could still be routine, says Selman-Holman. CMS should have provided more clarification on this scenario because of the prohibition against coding an aftercare code when the condition is complicated. In this case, you would list the osteoarthrosis in M0246, across from the aftercare code because it is the underlying condition to the aftercare V code, she says.

Note: To learn more about how the OASIS Chapter 8 Attachment D revisions are impacting your agency, order the transcript or CD for the audioconference HHAs: Get Ready for Major Process Changes, presented by Twombly, by visiting www.audioeducator.com/industry_conference.php?id=1426.