Home Health ICD-9/ICD-10 Alert

Audits: 3 Tips Help Audit-Proof Your Diagnosis Coding

Coding for case mix is bound to leave your claims hanging under audit.

ZPIC audits are hitting home care providers hard. There's no time like the present to make sure your coding stands up under scrutiny.

Get to Know the Newest Auditors

Zone Program Integrity Contractors (ZPICs) are Medicare's new fraud contractors and they have been ramping up audits on home care providers throughout the United States.

While Recovery Audit Contractors (RACs) have mostly focused their reviews on hospitals, ZPICs have swooped in to cover reviews of smaller providers like home health agencies, hospices, and durable medical equipment suppliers.

ZPIC home care activity may be nationwide, but the most intense concentration of audits appears to be in Texas, Florida, and California. Agencies in the central Southwest, Northeast, and Atlantic states are also getting hit heavily -- plus agencies in Michigan, Ohio, and Kentucky.

Background: The **Centers for Medicare & Medicaid Services** (CMS) has awarded ZPIC contracts in three of seven zones it established. In zones not yet assigned ZPICs, the old Program Safeguard Contractors (PSCs) still function.

The three ZPICs are **Health Integrity** (Zone 4: Texas, Colorado, New Mexico, and Oklahoma), **AdvanceMed** (Zone 5: Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia), and **SafeGuard Services** (Zone 7: Florida, Puerto Rico, and the Virgin Islands).

And when a ZPIC strikes, the HHA under audit can be hit with astronomical extrapolated overpayment demands or payment suspensions. Be prepared by taking the following three steps.

1. Bone up on the Basics

Before you code your next patient, make sure you are up-to-date on the latest coding guidance. Know the source documents you must reference for each of the OASIS coding M items, says **Sparkle Sparks, MPT, HCS-D, COS-C,** with Redmond, WA-based **OASIS Answers**

You can familiarize yourself with ICD-9 basics by reading the most up-to-date version of ICD-9-CM Official Guidelines for Coding and Reporting. This will bring you up to speed on the rules everyone must follow when choosing primary and secondary diagnosis codes. Then make sure you know the most current home health and OASIS-specific coding instructions by reviewing the OASIS User Manual, Appendix D, published by CMS. These are additional requirements placed on home health coders by CMS. This is also the only place where you can find information related to how to choose codes for M1024 (Payment diagnoses) as well as other coding concepts that are unique to the home health environment.

Whether you are using a manual or software, make sure you know how to use it correctly, Sparks warns. The General Coding Guidelines require this, she says. For example, if you're using an ICD-9 coding manual, "swim upstream to verify codes," she suggests. Check for notes such as "Includes" "Excludes," and "use additional codes" in the various places that these notes can be found in the Tabular List. If you don't know how to use the coding manual as specified in the Coding Guidelines, you won't have all the information you need to assign the codes.

Tip: Make sure you are looking at both the Alphabetic Index and the Tabular List. Otherwise, you could miss something

that will make your coding wrong or incomplete.

2. Report Case Mix Codes Only When Appropriate

When it comes to case mix diagnoses, don't try to fit a round peg in a square hole, Sparks warns. One error Sparks often sees is the inappropriate use of a case mix diagnosis in one of the secondary diagnosis spots. Coders must check to make certain the secondary diagnoses they select meet the criteria for inclusion, she cautions.

Don't: When reporting secondary diagnoses on the OASIS, "'the last thing on your mind should be 'How can I get a case mix diagnosis in here?'" Sparks warns.

Before you list a secondary diagnosis make sure it fits one of two qualifications for inclusion, Sparks suggests:

1. The diagnosis should be addressed in the plan of care; or

2. You should have detailed documentation about how the diagnosis will impact the patient's care or change the way you're going to provide care.

For example: If you're providing aftercare for knee replacement surgery and the patient also has GERD, make sure the documentation shows how the GERD diagnosis will impact your patient's care. Otherwise, you shouldn't list GERD as a secondary diagnosis.

Red Flag: It's the case mix diagnosis codes that auditors will take the most notice of because the auditor's mission is to make sure that claims are paid appropriately, and case mix codes are an easy place for them to look for the money, Sparks says. To avoid coming out on the losing end of an audit, be absoloutely certain that you have the documentation to back up the case mix codes you include.

3. Don't Get Ahead of Yourself

One practice that can sink your agency's ship under audit? Coding before the admission packet even goes out, says home care consultant **Karen Vance, OTR** with **BKD** in Springfield, MO.

"The list of diagnoses and the sequencing must be based on the comprehensive assessment," Vance warns. When you code before the assessment is complete, auditors will likely assume that your coding is based on two things: the diagnoses coming from the referral source and the list of point and dollar-earning case mix diagnoses, she says.

To keep your claims in the clear, start with clinical reasoning and finish up with accurate coding, Vance says.

Note: Find the ICD-9-CM Official Guidelines for Coding and Reporting here: www.cdc.gov/nchs/data/icd9/icdguide10.pdf and the OASIS User Manual, Appendix D, published by CMS here: http://www.selmanholman.com/docs/Appendix%20D.pdf