Home Health ICD-9/ICD-10 Alert

CASE STUDY :REAP REWARDS WITH EXPERT SEQUENCING STRATEGIES

Open the lines of communication with your clinicians to improve diagnosis coding accuracy.

Taking a case management approach to diagnosis selection could gain your agency hundreds of dollars. Like most home health coders, **Jan McLain, RN, BS, LNC, COS-C, HCS-D,** with Adventist Health System Home Care in Port Charlotte, Fla. spends a majority of each day attaching codes to diagnoses submitted by admitting clinicians.

Two challenges: Clinicians don't always see the big picture in their diagnosis sequencing, McLain relates. And nurses can have a tendency to focus on the immediate task at the start of care and not consider disease and case management, she says. To assign and sequence the appropriate diagnosis for each patient, McLain follows these five steps:

1. Look at what the admitting clinician says is his focus of care and review the diagnosis codes and sequence that the admitting clinician selected.

2. Read the plan of care, review the orders, check the frequency of visits, look for any new or changed medications, etc.

3. Search through any referral or hospital information to which you can gain access.

4. Do a congruency review to compare the OASIS with the plan of care.

5. Follow up with the clinician to address any discrepancies found or questions.

McLain is offsite, so she communicates with the clinicians at Adventist using a Microsoft Excel-based congruency report/coding form that she emails.

Review Documentation and Ask the Right Questions

Looking closely at the medical record can raise diagnosis coding questions. And finding the answers may change your case mix points.

For example, McLain received a plan of care for a new patient with a new Foley catheter, and a new stage 1 pressure ulcer on the coccyx. The nurse had entered the following information on the OASIS.

• Attention to Foley;

• Attention to non-surgical wound;

• Pressure ulcer;

• Urinary incontinence;

• Skilled Nursing orders 2w1, 1w1, 1m2;

• M0190 syncope attack; and

• M0210 cerebrovascular accident (CVA) with weakness.

Reviewing the hospital documentation, McLain finds that this patient was fairly independent prior to fainting at church and was then diagnosed at the hospital with a cerebrovascular accident (CVA) with dominant side hemiparesis. The patient refused a rehab facility, saying she would do better at home. Her husband is active in the community with

minimal health concerns and the daughter lives right next door. The discharge summary from the physician states the patient was having some problems with depression but "should do well as her functional status improves."

The plan of care describes the tasks related to the diagnosis that the clinician provided but also lists goals to improve to "the previous level of function." Functional M0 scoring on the OASIS shows that this patient could get to the bathroom independently with or without a device, but for M0700 (Ambulation/Locomotion: Ability to SAFELY walk,once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces), the response for ambulation was a 2 -- Able to walk only with the supervision or assistance of another person at all times.

For this patient, the clinician has to teach how to take care of the new catheter and get a hydrocolloid on the pressure ulcer because the family doesn't know how to manage these items. Rather than looking ahead, the clinician's plan of care only covered the patient's initial need, McLain found.So, in a communication with the clinician, McLain asks these questions:

• Do you think this patient has any rehab potential from her CVA?

• Is there any anticipation of therapy services in the next 60 days?

• I noted two new blood pressure medications listed. Does the patient have a hypertension (HTN) diagnosis?

• Will the nurse be teaching about the CVA process, recovery process, etc.?

• What are the patient's (and the family's) goals for her recovery from the CVA?

• Will the Foley catheter be a permanent situation for ths patient?

The clinician responds:

• The patient has refused therapy now but said she would be "willing later; I am just so tired."

• The family is active and outgoing. States mom is just so "depressed since this has happened -- not like herself at all."

• The nurse did plan to teach about CVA recovery "if they asked any questions" and as the patient could not get to the bathroom, she felt the catheter would stay in.

• And yes, the blood pressure drugs were new but the patient had no history prior to this of a diagnosis of HTN. The nurse wasn't sure if the patient had HTN now, but the blood pressure at admission was 162/92.

After McLain's discussion with the clinician, the agency made an additional visit to the home. The admitting clinician also had a conversation with the referring physician's nurse and as a result, sent in additional diagnoses of new onset HTN, situational depression, late effect hemiparesis -- dominant side from the CVA, and therapy. The agency also received occupational therapy and physical therapy evaluation orders.

On the second visit, the patient says she wants the catheter out; she wants to get up and be able to go to the bathroom to use the toilet and take a shower instead of using the bedside commode (BSC) and taking a sponge bath while sitting on the BSC. "I want to live normally, not stay in this room all the time," she says.

Additional Information Makes Coding Accurate

Based on the revised information, the clinician sends McLain a new request to code the episode with these diagnoses:

• M0230a: 438.21 (Late effects of cerebrovascular disease; hemiplegia affecting dominant side);

• M0240b: 788.30 (Urinary incontinence, unspecified);

• M0240c: 401.9 (Essential hypertension, unspecified);

• M0240d: 309.0 (Adjustment disorder with depressed mood);

• M0240e: 707.03 (Pressure ulcer; lower back); and

• M0240f: 707.21 (Pressure ulcer stage I).

Catheter care: You could also list V53.6

(Fitting and adjustment of urinary devices) for this patient because it was present on admission -- even though the patient has requested for the catheter to be discontinued, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principle of Selman-Holman & Associates in Denton, Texas.

In this case, the clinician should teach the patient and family about the benefits of the catheter for the healing of the pressure ulcer and teach the patient that bladder retraining may be possible to reduce incontinence, Selman-Holman says. The catheter should remain in place until the therapy can improve the functional status as well as the strength of the peritoneal muscles.

But if you receive orders to discontinue the catheter, you may opt not to code the care of the catheter, Selman-Holman says.

Plan of care: The patient will receive the following care:

• Skilled nursing three times week one, two times week two, and one time week six including teaching disease process-recovery from CVA

• Physical therapy evaluation

• Occupational therapy evaluation

• Home health aide two times week two to assist with personal care and carry out the OT plan of care.

Consider the Big Picture

McLain suggests revising M0670 (Bathing. Ability to wash entire body) to a 4 -- Unable to use the shower or tub and is bathed in bed or bedside chair from 1 -- Able to bathe self in shower or tub independently based on the patient's documented status. This would increase reimbursement by $413.34 and would then be used in compare scores.

Plus, adding the new HTN diagnosis code will increase reimbursement by $401.82.

Bonus: Following through with your questions can help clinicians move from selecting codes by thinking about the task of the day to using a true case management model. As a result, OASIS scoring will be more accurately transmitted to the state. Coding chronic conditions is important to the overall plan of care and to the patient's quest for independence, McLain says. Once a patient has had a CVA, the chances of having another CVA are high. With this approach, outcome data is accurate and the patient should have the resources to improve.

Therapy Adds Points

And this is all before the therapist makes an observation and adds the therapy visits to the payment equation.

McLain checks back and finds that PT and OT made their evaluation visits within the OASIS time frame, so they are able to submit M0826 with 12 combined therapy visits.

As a result, the request for anticipated payment was sent for an additional reimbursement of $2,082.28. This would have been collected at final payment but with the clinician anticipating, using the OASIS 5 day window and a little coaching, the case flow increased for the agency and the overall RAP went from $1,810.63 to $4,708.07.