

Home Health ICD-9/ICD-10 Alert

Coding 101: Does Your Coding Policy Cover all the Bases?

Documentation cross-checks can prevent errors.

Establishing an ICD-9 coding policy helps ensure accuracy and consistency between coders. Make sure your agency's policy includes a plan to do at least the following:

1. Adhere to coding guidelines. The foundation of a solid coding policy is an acknowledgement that it is necessary to adhere to and follow all of the official coding guidelines found in the ICD-9-CM Official Guidelines for Coding and Reporting, at the front of your coding manual, says **Judy Adams, RN, BSN, HCS-D, HCS-O**, with **Adams Home Care Consulting** in Asheville, N.C. Part of following the guidelines includes a plan to code to the highest level of specificity and avoid non-specific codes whenever possible.

2. Check the documentation. Your coding policy should also acknowledge the necessity to obtain source documents from the physician's medical record, a hospital admission or discharge summary, or verification with the physician of diagnoses, Adams says. The policy should indicate that you have a plan to ensure that the diagnosis codes you report are consistent with the information in the medical record such as the comprehensive assessment and the medical record documentation, she says.

And, you should outline how coders will work in collaboration with clinicians to identify the most accurate diagnosis codes and sequence them to best reflect the seriousness of the patient's conditions to the home health plan of care. Ensure that the coding provides a complete "picture" of the patient and their need for services.

3. Make Corrections. You'll also want to document your procedure for correcting errors in the diagnosis codes, Adams says. To stave off errors, make sure your policy includes steps to ensure that diagnoses match on the assessment, plan of care and the billing form. And avoid including codes that will add payment case mix points when they are not supported in the plan of care or medical record as needing or receiving assessment, evaluation, treatment or otherwise have an impact on the patient's need for care, prognosis or rehabilitation potential, she says.

4. Maintain Quality. You should document your quality improvement plan as part of your coding policy. Do a quarterly sample record review to validate the accuracy and consistency of coding □ perhaps 5-10 records per quarter, Adams says. Ensure source documentation supports the diagnoses coded, codes are based on the medical record information, coding is consistent with the plan of care and the assessments, all codes are verified with the physician, and that coding follows the official guidelines, she says.

To check that codes are being assigned consistently by all coders, consider including a procedure to check the your agency's top 25 most reported diagnoses and how they are being assigned by all coding staff, says **Joan L. Usher, BS, RHIA, COS-C, ACE**, with **JLU Health Record Systems** in Pembroke, Mass.

5. Provide Education. Be sure to document the coder's role in educating staff about the general and chapter specific coding guidelines and use of diagnosis codes, Adams says. You should also outline how coding staff will stay up-to-date and maintain their coding competencies.