Home Health ICD-9/ICD-10 Alert

Coding 101: DON'T FALL INTO OPEN WOUND AND DEBILITY CODING TRAPS

Learn when trauma codes aren't appropriate.

Before you code tricky wound and debility scenarios, take time to think them through--or risk denials.

If you automatically report a trauma code when you receive a referral for an open wound, you may be exposing your organization to denials. You may also be jeopardizing claims by reporting general weakness and debility codes when they are inappropriate.

Experts cite these specific coding errors as top reasons for frequent denials: reporting 870-897 when a wound wasn't caused by trauma and reporting non-case mix codes 780.79 (Other malaise and fatigue) and 799.3 (Debility) with 10 or more therapy visits.

Watch 'Open Wound' Designation

Don't be misled by the "open wound" terminology in the referral, because this can lead you to use a trauma code when it is inappropriate. "Hospital referrals often refer to a wound as an 'open wound,' regardless of the cause," says **Judy Adams RN, BSN, HCS-D** with Charlotte, NC-based **LarsonAllen Health Care Group**.

To code wounds, identify the correct wound type and then select the code that matches that wound type, advises Adams. Think about the cause of the original wound and code a trauma wound only if the original cause of the wound was trauma. Don't rely solely on referral information, and be sure to assess and review additional medical record documentation, she warns.

Example: You may have used 879.2 (Open wound of abdominal wall, anterior, without mention of complication) for a patient who was referred to home health for aftercare of an abdominal surgical wound.

Instead, the correct codes in this situation could include V58.75 (Aftercare following surgery of the digestive system) for care of an uncomplicated postoperative wound for a colectomy or, if the wound is infected, 998.59 (Other postoperative infection) with an additional code for the infectious organism, if known, suggests Adams.

Heads up: Listing general weakness or debility codes in cases where you will be providing 10 or more therapy visits can endanger your claim.

Neither 780.79 (Other malaise and fatigue) nor 799.3 (Debility) is accepted by fiscal intermediaries as a "medically reasonable and necessary diagnosis to support skilled rehabilitative physical therapy services," warns Adams. "Since both of these diagnoses relate to non-specific conditions ... they generally do not have a significant potential for rehabilitation."

These diagnoses are more appropriate in situations where the therapist will spend a very limited number of visits teaching the client or caregiver a home exercise routine to help increase endurance after the flu or pneumonia, explains Adams.

Example: An elderly patient who recently had an episode of flu was referred for PT because of increased weakness. The evaluation indicated that the patient had general weakness but didn't document any strength measurements. Code 780.79 was selected as the primary diagnosis and the therapist provided two visits a week for five weeks for gait and

therapeutic exercises.

After five weeks, the patient showed no indication of any appreciable progress so the claim was denied as not medically reasonable and necessary. Moreover, intermediary **Cahaba GBA** warns that the 780.79 diagnosis doesn't support skilled physical therapy services. "The problem here is primarily one related to coverage of medically reasonable and necessary services," says Adams.

Fine Tune Record Keeping to Squelch Denials

To learn from past mistakes and prevent future denials, implement standard record-keeping and audit practices to ensure your claims are approved, experts say.

Keep notes: Use a log to track denials and down-coded claims, advises Adams. For instance, use this record to identify trends such as denials for debility codes with 10 or more visits.

Protect yourself: "A denial can only be prevented if the clinical staff have properly documented and coded the medical information and the billing staff have taken steps to ensure that what was billed agrees with the documentation," says consultant **M. Aaron Little** with **BKD** in Springfield, MO. Conducting pre-billing audits on all episodes is the best way to prevent denials for errors such as open wounds that might be miscoded as trauma.

Little advises that these audits should include verifying that:

- all documentation has been received;
- all documentation has been appropriately signed and dated; and
- information coded on the claim is consistent with the medical record documentation.

Hidden trap: Don't rely on an integrated software system to pull information to a claim. Human error is still a problem here, warns Little.

Example: Check that the wound diagnoses coded on the claim match the diagnoses reported on OASIS.

Once you've uncovered a trend in your denials, be sure to follow up with training for the appropriate staff. A comprehensive audit strategy helps identify the departments and personnel where coding errors are originating and indicates what specific additional education staff need to help prevent future errors, says **Dio Namocatcat, HCS-D, CPC**, senior medical coder and consultant with **Visiting Nurse Regional Health Care Systems Inc.**

Tip: Designate a staff member who is responsible for keeping up to date on coding information and regularly shares this information with coders, advises Adams.