Home Health ICD-9/ICD-10 Alert

CODING 101: Double-Check Documentation or Risk GERD, Low Vision Downcoding

Case mix diagnoses bring claim scrutiny.

Auditors are looking closely at claims with gastroesophageal reflux disease (GERD) or low vision diagnoses. Keep a sharp eye on your documentation to ensure it contains the essentials required to earn reimbursement for these case mix conditions.

GERD and low vision have been problematic diagnoses for a while, says **Judy Adams, RN, BSN, HCS-D, COS-C,** president and CEO of Adams Home Care Consulting in Chapel Hill, N.C.

Watch for Impact on Plan of Care

You should never list a diagnosis unless your documentation shows its impact on the home health plan of care, Adams says.

Problem: 530.81 (Esophageal reflux) and 369.xx (Blindness and low vision) earn case mix points and the added reimbursement they bring draws extra scrutiny, Adams warns.

Consequences: When an auditor does not find GERD or low vision documented as actively affecting the plan of care, he'll downcode the claim, says **Trish Twombly, RN, BSN, HCS-D, CHCE,** director of coding with Foundation Management Services in Denton, Texas.

Watch for GERD Documentation Phrases

Many patients have GERD, a condition in which the patient regurgitates her stomach contents into her esophagus, but you can only report it if your staff is addressing the condition, Twombly says.

Before listing GERD in a secondary diagnosis slot, make certain that the documentation demonstrates the care you must provide the patient as a result of this condition, Twombly says. For example, you might be providing teaching on a new diagnosis or treatment for the condition.

Documentation example: Documentation should give specific details about how your patient's care is impacted by their GERD. For example, "Patient is taking non-steroidal anti-inflammatory drugs (NSAIDs) for osteo-arthritis, but she hasn't been using them as directed because they kick up her GERD."

Clear up Low Vision Confusion

When coding for low vision, make sure you're also listing the diagnosis code for the condition responsible for the low vision, Adams says. For example, list 362.50 (Macular degeneration [senile], unspecified) along with the appropriate code from the 369.xx low vision category if macular degeneration caused your patient's vision trouble.

The medical record must include the details regarding your patient's low vision. For example, "patient has decreased visual acuity" or "decreased visual fields," Adams says.

The documentation must also demonstrate the impact the low vision has on the patient and her plan of care, Twombly says. How will the clinician address the low vision? Perhaps the patient needs someone to help fill her pill box. Or maybe you will be sending in an occupational therapist to help her with activities of daily living. Maintaining this level of detail will help protect your claims.

Mistake: The most common error related to a low vision diagnosis is basing your diagnosis code assignment on the patient's scoring vision partially or severely impaired on M0390 (Vision with corrective lenses if the patient usually wears them), Adams says.

If this is the only documentation you have of your patient's low vision, it's not appropriate to list a 369.xx code. M0390 does not address visual acuity; it addresses functional vision in the patient's environment.

You'll need to document all additional testing to support a diagnosis of low vision.

Mistake: There is a common misconception that if the patient cannot see or wears glasses then a low vision code is acceptable, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of Selman-Holman & Associates and CoDR-Coding Done Right in Denton, Texas.

However, the 369 category excludes correctable refractive errors. Nearsightedness, farsightedness, and astigmatism are examples of correctable vision and are not appropriate to justify the use of a 369 code, even if the patient needs new glasses.