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Home Health ICD-9/ICD-10 Alert

CODING 101: FOCUS ON THE BASICS TO AVOID THESE MISTAKES

Look at the whole patient before using aftercare codes.

Boost your accuracy rate--and avoid costly denials--by learning how to correctly use aftercare codes.

Many home care coders are learning coding on the job or piecemeal. Be sure you aren't making these mistakes, experts warn:

Mistake #1: Not using all possible digits. Correct coding requires that you code as specifically as possible. That means you should assign the most precise ICD-9-CM code to a diagnosis.

How to do it: Use the fourth or fifth digit when ICD-9 guidelines require it, says **Karen Marsh, RN, MSN**, president of **Kare-Med Consulting** in Jensen Beach, FL. Make sure you review the entire record when determining the codes to use, she says.

You can't justify a service with a four-digit diagnosis code when ICD-9 requires a more specific five-digit code to describe the patient's condition. If required digits are missing, your claim will be returned to provider (RTP).

Example: If you are coding for cervical cancer, you can't simply report 180 (Malignant neoplasm of cervix uteri) because three digits alone don't make a complete diagnosis. ICD-9 offers four-digit options, which you must use instead, such as 180.0 (... endocervix).

Pitfall: Don't assume what isn't in the medical record. If the medical record doesn't offer the information (such as anatomic region) that you need to be able to choose the most specific code, check with the physician for guidance. If the physician doesn't supply the information you need, choose an "unspecified" code, such as 180.9 (... cervix uteri, unspecified), rather than reporting 180 without a fourth digit or randomly choosing another fourth digit, Marsh says.

Watch out: Coding "cheat sheets" often don't list fifth digits, so you should always check your code choice in the ICD-9 manual. You also don't want to rely on unspecified codes too often. Payers are sure to reject claims that use truncated ICD-9 codes (shortened by dropping one or more digits after the decimal point). Nip RTPs in the bud by accurately reporting all possible digits.

Mistake #2: Using aftercare codes incorrectly. Use aftercare ICD-9 diagnosis codes when the patient is no longer receiving initial treatment for an injury or disease, but instead needs continued care for long-term results of the injury or disease or to complete the healing process, says **Karen Vance**, senior consultant with **BKD** in Springfield, MO.

Example: When a patient is admitted to home care following a fracture, rather than coding the initial fracture--which you probably aren't treating in the home--you should use an aftercare code, says coding consultant **Lisa Selman-Holman BSN, RN, HCS-D, COS-C**, with Denton, TX-based **Selman-Holman & Associates**. These could include the V54.1 codes for aftercare for healing traumatic fractures or the V54.2 codes for aftercare for healing pathologic fractures. Providers are to use the fracture codes only during active treatment of the fracture, and home care doesn't provide active treatment, she explains.

Look deeper: When you use an aftercare code, remember to also code the underlying medical diagnosis if it still exists, experts say. For example, a patient may be receiving aftercare following bypass surgery, but the surgery does not eliminate the underlying cardiovascular disease.

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Warning: Don't use an aftercare code if the treatment plan is focused on a current or acute disease or injury. You may be providing wound care following a toe amputation, but the real focus of care could be the patient's out-of-control diabetes.

Tip: Many versions of the ICD-9 manual will indicate whether you can report a V code as a primary or secondary diagnosis using the indicators "PDx" (primary) and "SDx" (secondary) next to the code descriptor. If the code has neither a "PDx" nor an "SDx" designation, you may use that V code as either a primary or a secondary diagnosis, according to ICD-9 instructions.

Mistake #3: Coding unconfirmed diagnoses. ICD-9 coding guidelines state that you shouldn't report "rule out" diagnoses except in an inpatient setting.

This avoids labeling a patient with an unconfirmed diagnosis, says **Carolyn M. Davis Hutt, CMA, CPC, CCP, CCS-P, CPHT, RMC**, reimbursement coordinator with **Oncology Hematology West** in Omaha, NE. Don't code diagnoses the doctor documents as "suspected," "probable" or "questionable" either, says **Denae M. Merrill**, **CPC,** coder for **Covenant MSO** in Saginaw, MI.

Pointer: Ask the physician to identify the specific diagnosis, if possible, so you know which diagnosis code you need to report.

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