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Home Health ICD-9/ICD-10 Alert

Coding 101: Follow '10 Steps' To Prevent Denied Claims

Find out the first rule for diagnosis coding.

Faulty ICD-9 coding can derail your claims and decrease your agency's compensation -- especially under the 2008 prospective payment system.

That's because primary and other diagnoses in M0230, M0240 and M0246 combine with answers to other OASIS M0 items to produce case mix points for episode reimbursement. Learn how to use coding guidelines to choose the correct code.

Start With 10 Coding Steps

If you want to improve your diagnosis coding, look first at the introductory material in your ICD-9 coding manual. Here you'll find a good summary of "10 Steps to Correct Coding" to use as a guide when selecting diagnosis codes.

The most important step is to begin your coding search by consulting the alphabetic index, which is arranged by condition. Narrow your search using this index. Then cross-reference the codes using the tabular listings (Volume 1) and read the precise definition of your tentative code selections. The tabular listing provides additional information that will help you pinpoint the exact codes you need.

Example: Your patient has acute bronchitis and COPD. You look up bronchitis in the alphabetic index and find "bronchitis, acute or subacute, 466.0." If you don't look in the tabular list, you won't see the "EXCLUDES acute bronchitis with chronic obstructive pulmonary disease" notation, which points to the correct code for this patient: 491.22 (Obstructive chronic bronchitis, with acute bronchitis).

Play it safe: Never choose a code without referring to the ICD-9 index (Volume 2) first, then to the tabular section (Volume 1) for confirmation and specificity. Read any coding notes to assist in accurate assignment.

Don't stop too soon: Always report a diagnosis to the highest available and supportable specificity level. Use four- or five-digit codes when they are available. Never report a category (three-digit) or subcategory (four-digit) code when ICD-9 lists more specific codes under those headings. Thorough reporting ensures proper coding and timely payment.

Use as Many Codes as You Need

Strive to report ICD-9 codes that accurately and completely describe the patient's condition as supported by physician documentation. Using the physician's documentation as your guide, list on the OASIS assessment as many diagnosis codes as you need to. You have six potential payment slots on the new OASIS assessment, says coding consultant **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of Denton, TX-based **Selman-Holman & Associates**. But there is room for nine diagnoses on the claim that is transmitted to payers including Medicare.

Tip: Look for definitive diagnoses, says **Denae M. Merrill**, coder for **Covenant MSO** in Saginaw, MI. "'Rule out,' 'suspected,' 'probable' or 'questionable' are not codeable." There are provisions for these in the Official Coding Guidelines, but they do not apply to home care coding, Selman-Holman notes.

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Important: Never assume that a diagnosis applies. Make sure there is sufficient information in the medical record to support any ICD-9 codes you assign. If the documentation is unclear, always ask the physician for guidance.

Warning: Always observe the first rule of diagnosis coding: Only report a diagnosis supported by documentation, experts warn. Ensure that any diagnosis you assign is obtained through the OASIS strategies noted in Chapter 8 of the OASIS Implementation Manual to support your choices, Selman-Holman says. Never assign an ICD-9 code merely for the purpose of achieving payment. This is fraudulent and can result in serious financial and criminal consequences, as well as harm patient outcomes.

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