Home Health ICD-9/ICD-10 Alert

Coding 101: Keep Low Vision Diagnoses from Clouding Your Claims

Steer clear of this OASIS/diagnosis coding assumption.

When your patient scores as having impaired vision on the OASIS, is it safe to assume you should list a 369.xx (Blindness and low vision) code for him? Make certain you know how diagnosis coding and the OASIS interact on this thorny issue.

Don't Wave a Red Flag

Ever since the 369.xx codes were added to the case mix list, they've triggered a second look when you list them at M1020 or M1022. Make certain you're not reporting these codes in error or you could wind up facing denials.

Problem: Like GERD and other diagnoses that became case mix in 2008, agencies are reporting 369.xx codes when the documentation doesn't support their use, says **Sharon Molinari, RN, HCS-D, HCS-O,** a home health consultant based in Henderson, Nev.

As a result, the Medicare Administrative Contractors have been giving claims that include these codes extra scrutiny. So you'll need to make certain your documentation backs up these diagnoses as appropriate.

One common mistake coders make with regard to the 369.xx codes is assuming that when M1200 □ Vision demonstrates impairment, that it's appropriate to report a 369.xx code. "OASIS item M1200 doesn't necessarily correlate with a 369.xx diagnosis," Molinari says. "You can't include a vision impairment diagnosis just because M1200 indicates a vision problem."

If the only documentation you have of your patient's vision impairment is his M1200 score, it's not appropriate to list a 369.xx code. Remember, M1200 doesn't address visual acuity; it addresses functional vision in the patient's environment.

To score a patient's vision as impaired for M1200, the clinician must document all additional testing that demonstrates the impairment, said **Ann Rambusch, MSN, HCS-D, HCS-O, COS-C, RN,** with **Rambusch3 Consulting** in Georgetown, Texas.

The documentation should include how the clinician measured the patient's vision, how she observed the impairment, and what the agency is doing about it, Rambusch said during the recent Eli-sponsored audioconference Coding and Documentation Vital to Your Home Health Claims.

But when should you report a 369.xx code? You'll need to meet three conditions first.

1. Get Physician's Diagnosis.

Reporting a 369.xx code should be based on a physician's diagnosis, Rambusch said. And you'll also need to list a code to describe the etiology of the vision impairment. For example, list 362.50 (Macular degeneration [senile], unspecified) along with the appropriate code from the 369.xx low vision category if the physician indicates that macular degeneration caused your patient's vision trouble.

It's not appropriate to list a 369.xx code for common refractive errors, Molinari points out. Instead, you would list one of these codes when your patient has visual impairment as the result of underlying etiologies such as glaucoma, retinopathy, macular edema not conditions like "near sightedness" or "astigmatism," she says

So, just because a patient cannot see or wears glasses doesn't mean you can report a vision impairment code. This is true even if the patient has a correctable vision problem and needs new glasses.

The medical record should include details describing your patient's vision impairment. For example, "patient has decreased visual acuity" or "decreased visual fields."

2. Identify How the Vision Impairment Impacts the Plan of Care.

The documentation should show how your patient's visual impairment impacts the plan of care. Some patients with a visual impairment and even blindness do fine and won't need interventions, Molinari points out. You don't always need to include a code for your patient's visual impairment, but when you do, you need to have a reason why low vision is impacting care.

For example, does the vision impairment prevent the patient from taking her medication correctly? Or is she having trouble performing activities of daily living due to her limited vision? Situations like these will have an impact on the plan of care.

3. Have an Intervention Directed at the Vision Impairment.

Before you list a 369.xx code, you should also have documented interventions that address the impact the patient's impaired vision has on her plan of care, Molinari says. How will the clinician address the vision limitations?

For example: Suppose the patient lives alone and 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.

Know the Reimbursement Impact

The 369.xx codes garner 3 points in all four equations, Molinari reminds. That can often increase the clinical dimension from C1 to C2 or from C2 to C3, which increases reimbursement. This is at the heart of why these diagnoses draw such scrutiny. The MACs look more closely at them because there is money that can be recouped.

Table 4: Case Mix Adjustment Variables and Scores for Blindness/Low Vision Codes