

Home Health ICD-9/ICD-10 Alert

Coding 101: Looking to Boost Coding Accuracy? Here's How to Get the Clinical Documentation You Need

Are your agency's coding practices non-compliant?

The documentation you receive from your clinicians lays the foundation for the diagnosis codes you report. Inaccurate or incomplete documentation means your coding will be lacking and your agency's bottom line and care planning will suffer. Make sure your field clinicians know up-front what you need in order to select the most accurate diagnosis codes and you'll save time in the long run.

Establish these Diagnosis Documentation Basics

There are four main areas clinicians must cover to provide you the information you need to complete M1020/M1022.

The field clinician must understand how to select primary and secondary diagnoses so she can fill out the narrative portion of the OASIS diagnosis-related questions, M1020 and M1022, said **Annette Lee, RN, MS, HCS-D, COS-C**, with Redmond, Wash.-based **OASIS Answers** during the **OASIS Certificate and Competency Board's** 2011 Annual Conference in November. The clinician also needs to know how to sequence diagnoses. And finally, the clinician must assign the symptom control rating.

The primary diagnosis is that diagnosis most related to the plan of care, Lee said. This diagnosis is the chief reason for home care. Surgical codes and E-codes aren't appropriate in M1020, but V codes can be listed in some circumstances such as therapy-only episodes.

The secondary diagnoses include those conditions actively treated in the plan of care as well as those that may affect a patient's responsiveness to treatment, Lee said. Report comorbidities that existed at the start of care as well as those that have since developed in M1022, Lee said. Only diagnoses you expect to have an impact on patient progress or outcomes should be listed here.

Sequencing and symptom control are two different matters. For accurate sequencing, clinicians should list diagnoses in the order that best reflects the seriousness of the patient's condition and justifies the disciplines and services provided -- not by symptom control rating, Lee said. Symptom control rating describes the level of control for each diagnosis and is used for outcome risk adjustment purposes.

Fill in These Blanks

While clinicians generally fill in the OASIS items and do a thorough assessment of the patient, they don't always provide documentation of a good history and physical, says **Kristina Brown, RN, BSN, COS-C, HCS-D**, owner and executive director of **Advanced Home Care Coding** in Denton, Texas. This additional information is essential for the coder to see what is going on with the patient. Try to work with clinicians to establish a process that includes access to this information for each patient for whom you assign codes.

Problem: There are many agencies that don't require clinicians to list diagnoses for their patients, Brown says. Not only does this place a near-impossible burden on a coder trying to assign accurate diagnosis codes, it's also not compliant, she says.

The field clinician must understand how to select the primary and secondary diagnoses, and sequence them so she can fill out the narrative portion of M1020/M1022, Lee said. The coder can then fill in the numeric code. But, if the coder needs to manipulate the diagnoses, move them around or add a code, she must follow the agency correction policy and

work with the clinician.

Traing tip: The field clinician should be able to determine what the agency will be doing for the patient for the next 60 days and sequence the diagnoses based on the importance of each diagnosis to the Plan of Care, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas. "Sometimes field clinicians are stumped, though, because they don't know the basics of Medicare home health coverage." Agencies should begin with training on Medicare eligibility to improve care planning which will also improve the field clinician's selection of diagnoses.

Try a Coding Worksheet

Adding a communication tool between coders and clinicians can help improve accuracy and save time, says Brown. And a one-hour in-service during which coders and clinicians discuss what's needed for accurate ICD-9 code assignment can make a world of difference.

Establishing exactly what the coders need to know saves everyone time in the end because there's less need to go back to the clinician for more information on the back end, Brown points out.

When coders don't get the information they need, the agency misses out on the benefit of having dedicated coders, Brown says. Coders can only select diagnosis codes based on the information they have. Missing information means lower accuracy and less reimbursement.

Try this: Implementing a coding worksheet like the one on page 29 can streamline coder/clinician communication. Brown says. Even if your point of care system doesn't allow you to add forms easily, adding the information outlined on the worksheet to the chart via an addendum or clinical note will give coders what they need.

Bottom line: The OASIS doesn't always include all of the information a coder needs, Brown says. The coder should get some sort of additional communication whether it's through a coding worksheet, an email, or via some other method. And that communication should include the patient's diagnoses in the correct sequence along with the proper symptom control ratings.

Last word: The clinician should always review and approve the diagnosis codes the coder assigns, Brown says. Simply signing and not reviewing means the clinician doesn't learn from any changes the coder suggests or catch any issues with the coding.

For example: The code for gastroesophageal reflux disease (GERD) -- 530.81 -- is a case mix code. Some coders make the leap that if a patient is on medication for GERD, the code should be listed. But if the clinician doesn't document how the GERD relates to the plan of care, this puts the agency at risk of upcoding, Brown points out. Better communication and cross-checking between the coder and the clinician can prevent such errors.