Home Health ICD-9/ICD-10 Alert

CODING COMPLIANCE: RETHINK YOUR ADMISSION AUDIT STRATEGY TO SAVE TIME AND MONEY

Case conferences increase both your accuracy and your efficiency.

Conducting admission audits can be a lonely and time-consuming process, but when you gather staff around for a case conference, accurate coding isn't the only benefit.

Admission audits can safeguard your claims in an environment where your fiscal intermediary can easily edit for and catch coding misssteps. If you don't audit on the front end, you'll have to do it on the back end if your claim is returned to provider (RTP'd) says **Lynn Yetman, RN, MA, HCS-D, COS-C, CRNAC, LNC**, with Reingruber & Com-pany in St. Petersburg, FL.

Helpful: Admission reviews help provide consistency of information among all the admission documents and ensure there is documentation to support the OASIS responses selected, says **Rhonda Will, RN, BS, HCS-D, COS-C,** with **Fazzi Associates Inc**. in Northampton, MA.

Improve On The Old Way

Old way: In a traditional admission audit, the auditor reviews the documentation for the patient alone in her office. The auditor must review the chart, assessment and all of the other documentation to get a clear picture of the primary diagnosis. Then she must hunt down any additional information needed before she can go on to select the proper ICD-9 codes.

If she finds that the documentation isn't clear or complete, she has to track down the clinician for help in identifying the missing pieces of information. Then, she must make the necessary corrections and ends up with a bunch of correction documentation that needs to be signed, monitored for compliance and added to an audit tool.

Example: After completing a comprehensive assessment, the nurse lists a primary diagnosis of coronary artery disease for the patient, which would be coded with 414.0x (Coronary artherosclerosis). But, after an exhaustive review of the documentation, the expert coder conducting the admission audit finds that nursing and all three therapies have been seeing the patient due to a recent cerebrovascular accident.

The expert coder makes the determination that because the plan of care was really addressing the problems of the CVA, this is the more appropriate primary diagnosis. But to code for it, she'll need more information, so she leaves a message for the clinician to call to discuss the case.

Among other things, the expert coder needs to know how long ago the CVA occurred and whether the patient has been receiving continuous therapy since the CVA. If the patient has hemiplegia, the expert coder will also need to find out if it's spastic or flaccid and whether it is dominant side or non-dominant side. All this information needs to be included in the assessment for the coder to do her job.

Try A Case Conference Approach

New way: A more efficient way to audit each new admission is to hold a case conference, rather than conducting an admission audit, suggests **Karen Vance, OTR**, with **BKD** in Springfield, MO. Once the patient is evaluated and the plan of care developed, the ideal situation is to gather around everyone involved in the case and run through the OASIS data elements necessary for payment, she says.

Best practice: Determine which condition, symptom or diagnosis best explains the reason for home care, and then code for it. Once an agency gets past the learning curve, these conferences can be done quickly, says Vance.

Example: Everyone who has seen the patient has completed their evaluations and gathers for the case conference. The expert coder sits in.

During the discussion, as they move through the OASIS items, the expert coder discovers that the patient had a stroke three weeks ago which resulted in right-sided flaccid hemiplegia (his dominant side) and dysphagia. Not only is the patient receiving nursing care, but he is also receiving physical therapy, occupational therapy and speech therapy for rehabilitation after the stroke.

The expert coder concludes that the primary diagnosis of CVA, 434.91 (Cerebral artery occlusion, unspecified, with cerebral infarction), would be more appropriate. With the additional information provided by the discussion during the case conference, the expert coder can also assign the correct code for the hemiplegia, 342.01 (Flaccid hemiplegia, affecting dominant side) and dysphagia (787.2).

With the case conference approach, the person who is responsible for coding hears all of the discussion which will help determine the primary diagnosis and as an additional benefit, "during that same discussion, the clinical manager gathers information about how to manage the episode and the therapists learn what the primary diagnosis is," says Vance.

Hidden jewel: This opportunity for collaboration makes for more accurate data collection, plus it can be a time-saver. If any OASIS data needs to be changed, it can be corrected and initialed during the conference, notes Vance.