Home Health ICD-9/ICD-10 Alert

CODING HOW-TO: AVOID UNDUE SCRUTINY BY KEEPING DIAGNOSES ACCURATE

A thorough billing audit process can save your agency time and money.

The diagnoses you report on your claims need to support the reason for delivering the service. This is especially true because the claim is the only thing that your fiscal intermediary sees; they don't see the OASIS or the plan of care, advises consultant **M. Aaron Little** with **BKD** in Springfield, MO.

Example: A claim had a primary diagnosis of diabetes and the HIPPS code reflects the points for diabetes. But reviewing the documentation shows the focus of the care is a venous stasis ulcer. The claim is coded incorrectly as 250.80 (Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled) followed by 454.0 (Varicose ulcer [lower extremity, any part]).

Warning: Venous stasis ulcers are not manifestations of diabetes so coding diabetes as the primary diagnosis is upcoding. If you submit a claim with an inaccurate diagnosis code, your intermediary could subject the claim to the increased scrutiny of a medical review, says Little. For example, your fiscal intermediary may have an edit in place for claims with a primary diagnosis of 781.2 (Abnormality of gait). If you submit a claim with 781.2 as primary when 719.7 (Difficulty in walking) is actually a more accurate code choice, your claim may be pulled for review.

Reporting inaccurate diagnosis codes will slow down your payment. It costs time and money as you provide additional requested documentation--and you may even have to go through an appeals process, Little warns. All this can be prevented if your agency simply makes certain that the diagnoses codes billed are accurate and agree with medical documentation.