Home Health ICD-9/ICD-10 Alert

Coding Procedures: Include 6 Essential Components for a Top-Notch Dx Coding Policy

Try a self-audit to prevent costly coding errors.

Creating an ICD-9 coding policy can help keep your claims flowing smoothly, but go into too much detail, and you're just stirring up trouble. Here's how to create a policy that will save your agency both time and money.

1. Begin at the beginning -- of your coding manual.

The first item your coding policy should include is a statement that your agency will adhere to the ICD-9-CM Official Guidelines for Coding and Reporting, found in the front of your coding manual, says **Trish Twombly, BSN, RN, HCS-D, CHCE, COS-C, HCS-O** director of coding with **Foundation Management Services** in Denton, Texas.

Warning: Not staying up-to-date with these standard rules can lead to trouble. In some cases, your manual may go to print before the annual guidelines update. Find the most recent version here: www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

For example: An addition in the 2011 guidelines for coding late effects, advises that "Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second."

"Exceptions to the above guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) **or the classification instructs otherwise**," the guidelines continue.

Without this instruction you might be confused by a note at new 2012 ICD-9 code 310.81 (Pseudobulbar affect). The instruction to "code first" mentions that late effect of traumatic brain injury (907.0) would be coded before the 310.81 code. That late effect code is usually coded after the condition produced, but in this case, you should follow the sequencing guidelines listed with the code itself.

Tip: The official instructions in the tabular list of your coding manual trump even the coding guidelines.

2. Flesh out your correction policy.

It's important to document who is doing the coding and how you make corrections, says home care consultant **Karen Vance** with **BKD** in Springfield, MO.

For example: Clinicians in the field must understand proper selection of primary and secondary diagnoses so they can fill out the narrative part of the diagnosis, said **Annette D. Lee, RN MS HCS-D COS-C,** with Redmond, Wash.-based **OASIS Answers** at the **OASIS Certificate and Competency Board**'s 2011 Annual Conference in November. Then an in-house coding expert can review the selections and fill in the numeric codes. But if she needs to change sequencing or add a code, she must follow agency correction policy and work with the clinician to determine which codes to list and in what order, she said.

Guideline: The **Centers for Medicare & Medicaid Services** (CMS) states that the assessing clinician must be the one to assign diagnoses, but that a coding expert can assist with proper sequencing and adherence to coding rules.

The Foundation Management Services coding policy requires both the expert coder and the assessing clinician to sign off on M1020, M1022, and M1024, Twombly says. This verifies that the clinician has determined these particular diagnosis

codes are pertinent for this patient and that the expert coder agrees the eligible codes are sequenced according to the coding guidelines.

3. Have an education plan.

Your coding policy should describe how coding staff will stay up-to-date and maintain their coding competencies.

Staying on top of changes is especially important with the recent PPS changes and the upcoming transition to ICD-10.

Key issue: Staying current on the coding rules helps to stave off mistakes. For example, under new PPS guidelines, you could lose out on reimbursement if you list 401.1 (Benign essential hypertension) and 401.9 (Unspecified essential hypertension) when a more specific hypertension code such as 402.x (Hypertensive heart disease), 403.x (Hypertensive renal disease), or 404.x (Hypertensive heart and renal disease) is appropriate for your patient.

In this case the coding guidelines haven't changed, but the PPS case mix diagnosis list has. The hypertension codes are still valid codes. But coders who have been incorrectly listing 401.1 or 401.9 when a 402.x, 403.x, or 404.x code would have been more accurate will negatively impact payment under the current PPS.

4. Establish your auditing process.

One of the best ways to prevent coding mistakes from impacting your reimbursement is to correct them before you submit a claim. Internal auditing can help make sure your coding is accurate before it starts costing your agency. Your audit process description should include the percentage of charts you'll audit for accuracy and how frequently you'll conduct audits, Twombly says.

5. Measure your coding accuracy.

Setting an expected accuracy rate gives coders something to work toward. If, for example, you require your coders to maintain a 95 percent accuracy rate with their coding, include this information in your policy, Twombly says. Meeting regularly with coders to go over their ratings can be helpful -- if you do so, be sure to include this information in your policy as well.

6. Stay up-to-date.

Keep your coding policy current -- don't let it get dusty. It's a good idea to meet periodically to make certain your policy is current, Twombly says. Staff at Foundation Management Services meet every six weeks to ensure their policy stays fresh and addresses any recent developments such as the revised PPS and the resulting changes that impact coding.

Waste of time: Don't write policies that are too specific, Twombly says. Indicating how you're going to code each particular diagnosis is time-consuming and doesn't pay off, she says. General policies that address the big-picture methods you use to keep your coding accurate are more useful and workable.