Home Health ICD-9/ICD-10 Alert

Coding Tool: Cover Your Bases When Clinicians and Supervisors Clash Over Correct Coding

You know the scenario: The clinician codes a medical record one way, and her supervisor thinks it should be changed. We've got the lowdown on your legal -- and regulatory -- responsibilities for handling these adjustments.

Problem: "The cruel reality is that nurses were never taught coding in nursing school," says **Julianne Haydel,** president of Haydel Consulting in Baton Rouge, La. "Prior to [the prospective payment system], it wasn't such a big deal if coding was done incorrectly." Haydel cites the unique differences between home health ICD-9 coding and industry standards as a source of further complications when clinicians code.

Result: Brittle diabetics with wounds are being assigned primary diagnosis codes of diabetic ulcers instead of diabetes, while wound-care coding mistakes end up costing home health agencies enormous amounts of money, Haydel says.

Solution: Handle any necessary changes just like you would handle any other change to the medical record, says **Elizabeth Hogue,** a Burtonsville, Md.-based healthcare attorney. "That is, the clinician who coded should draw a line through the incorrect code, write the word 'error,'and sign and date it with the date on which the clinician takes this action. The clinician could also enter the correct code at the same time," she says. Hogue warns that this process may require clinicians to make extra trips to the office -- a time-consuming endeavor.

Consider attaching a memo saying, "Coding corrected for this reason," says **John Gilliland** with Gilliland & Caudill in Indianapolis. He recommends having something more concrete than a Post-it note to explain the change. "Don't erase, just cross out," he adds. And documenting who made the change and why is key.

Alternative: There is nothing wrong with having the clinician consult with a coding expert, but in the long run, it is the clinician who will be responsible for the ICD-9 code. She's also the one who can answer all the different questions about the codes, Haydel says. She recommends that agencies use expert ICD-9 training programs to educate their clinicians -- a one-time fee that could result in literally hundreds of dollars saved per episode.

If the agency finds that certain clinicians are responsible for the majority of the coding errors, the agency should consider doing a quick in-service to train the identified clinicians in proper coding, Gilliland says.

Another option is for the agency to hire a certified coder to handle all the coding of medical records. When agencies have a certified coder, she should have the final say on the proper code, Gilliland says.

Bottom line: From a legal perspective, it is the agency's responsibility to code correctly, and if someone -- a biller, trained coder or supervising clinician -notices or believes there to be errors, these errors need to be followed up on and corrected, Gilliland says.