Home Health ICD-9/ICD-10 Alert

CODING UPDATE ~ Keep Your Coding Compliant With The Latest OASIS Changes And Answers

Clarification from the Centers for Medicare & Medicaid Services may mean extra work for coders.

The August release of new OASIS instructions and Q&A means some big changes for home health. Find out what will impact coding, and which changes you don't need to worry about.

Don't Sweat This Severity Rating

The **Centers for Medicare & Medicaid Services** revised the OASIS User's Manual in June -- when the new version became available in mid-August, home health staffers found 50 pages of changed instructions in Chapter 8 alone.

But some of those changes were made in error, CMS announced. For example, of particular interest to coders, M0245 was revised to include a severity rating.

CMS advised the **National Association for Home Care & Hospice** (NAHC) that "when revising Chapter 8, it had no intention of revising any of the OASIS items. Home health agencies and software vendors should ignore the severity ratings when implementing other Chapter 8 changes," according to the Aug. 28 NAHC Report.

CMS plans to review the revised manual for other errors and publish a corrected version "as soon as one is ready," the NAHC Report says.

Heed This Advice On Manifestation Corrections

CMS responded to 47 questions posed by the **OASIS Certificate & Competency Board** (OCCB) in mid-August. The answer to the board's question about M0230/240 may change the way you work.

Pop quiz: During an audit of a start-of-care assessment, your auditor finds a manifestation code listed as primary. The matching etiology code isn't reported. Can your agency consider this a technical error and have your coding expert correct the codes to follow ICD-9 guidelines for multiple coding?

Answer: Not without the assessing clinician's consent, CMS says. Determining primary and secondary diagnoses is the responsibility of the assessing clinician in conjunction with the physician, CMS says.

If a clinician identifies a manifestation code as primary and reports it in M0230, it's not acceptable to simply move this diagnosis down to M0240 and add the etiology code dictated by mandatory multiple coding in M0230, CMS says. This change is not a technical correction because you're adding a diagnosis, CMS explains. So, the assessing clinician must be contacted and agree.

When a manifestation code is listed as primary, the coding specialist and the assessing clinician need to discuss the situation. If the clinician agrees with the coder that the sequencing of the diagnosis codes needs to be changed for more accurate reporting, agency policy can determine how and by whom the change is made, CMS says.

Get Consent In Writing

Before this clarification regarding mandatory multiple coding corrections from CMS, agencies may have felt comfortable allowing their coding experts to make technical error changes to coding, says **Sparkle Sparks, MPT, HCS-D, COS-C,**

with Redmond, WA-based **OASIS Answers.**

Coding scenario: The assessing clinician's primary focus of care is the patient's diabetic ulcer. However, the clinician lists the ulcer code, 707.1x (Ulcer of lower limbs, except decubitus), in M0230a as the primary diagnosis because she doesn't understand etiology/manifestation coding.

While the ulcer may be the clinician's focus of care, according to coding guidelines, the diabetes diagnosis, 250.8x (Diabetes with other specified manifestations), should come first in M0230a, followed by the manifestation code 707.1x in M0240b. But before you code for it as such, you must have the knowledge and consent of the assessing clinician, Sparks warns.

While the assessing clinician in this scenario would most likely list diabetes as a diagnosis in one of the M0240 slots, you still should not reorder the diagnoses without the clinician's approval, Sparks says. "CMS is telling us that we can't go in there and make coding corrections without the knowledge and consent of the assessing clinician," she says.

Try this: Your agency needs to have a mechanism in place to record that they are complying with the instruction to get the assessing clinician's approval of any coding changes, Sparks says. The only way to prove that you are following the correct procedure is to get that acknowledgement and consent in writing and have it somewhere as part of the record, she says.

The best method is to have the clinician make the changes by marking directly on the form or in the electronic record, dating and initialing, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of **Selman-Holman & Associates** in Denton, TX. If that isn't possible, then many agencies use a form to make a record of any OASIS corrections, she says. Whether the clinician signs the agreement or the agreement is documented by the coder, that form has to be kept with the medical record, she says.

Note: Read the full CMS OCCB Q&A document here: www.oasisanswers.com/downloads/CMS_OCCB_Q&As_July_2006.pdf.