

Home Health ICD-9/ICD-10 Alert

Ensure Coding Success Under Revised PPS

Brush up on your manifestation coding skills to secure maximum reimbursement.

Is your agency ready for the changes that will affect you the most under the PPS revisions that take effect on January 1? One key to success is being as detailed as possible with your diagnosis coding. Follow our experts' five steps to make sure your agency succeeds under the new process.

1. Code all the diagnoses your patient has. Be thorough in your coding, **Jeff Lewis**, CEO of Baton Rouge, LA-based **Lewis Inc** advised listeners in an educational session at the **National Association for Home Care & Hospices'** October annual conference in Denver. Diagnosis coding skill will matter more than ever in 2008, but so will completeness. Agencies that meticulously code all the diagnoses can expect to receive diagnosis-based reimbursement in 20 percent more episodes than in 2007, Lewis found.

Good news: Most providers will get at least some improvement in diagnosis-based episode reimbursement next year, says Lewis. This is because more diagnoses receive case mix points in 2008. The better job you do using diagnosis codes to describe your patients, the more likely you are to receive the reimbursement you deserve.

Bad news: Agencies that got the most diagnosis-based payment in 2007 will be the biggest losers in 2008. Focusing only on coding the case mix orthopedic, neurological, diabetic and trauma diagnosis codes paid well in the past, but the payment is spread out over many more diagnoses next year, Lewis explained. And even last year's top diagnoses pay less in 2008. Diagnoses that added the most reimbursement in 2007 added \$950. The highest diagnosis-based added reimbursement in 2008 will be \$550, he said.

Only the codes you list in the first six diagnosis code positions in M0230 and M0240 "speak to [the **Centers for Medicare and Medicaid Services**]," Lewis said. CMS looks to these first six codes when considering reimbursement and risk adjustment, so be sure to put codes that count in these spaces.

2. Unlearn bad habits. Agencies should educate their staff to check for and change any bad coding habits they may have, says **Jun Mapili, PT, MAEd**, director of rehabilitation and coding supervisor for **Global Home Care** in Troy, MI. For example, coders should no longer report acute cerebrovascular accidents (CVA) 430-437 codes come January because they will be deleted from the lists of case mix diagnoses.

Silver lining: Late-effect of CVA codes such as 438.22 (Late effects of cerebrovascular disease; hemiplegia affecting nondominant side) bring points under the revisions.

3. Code to the highest degree of specificity. This is one of the keys to gaining maximum ethical reimbursement, Mapili says. You'll notice that most of the unspecified codes have been excluded from the list of case mix diagnoses, he says.

Example: You can gain case mix points for listing any code from the 414 (Other forms of chronic ischemic heart disease) category except 414.9 (Chronic ischemic heart disease, unspecified).

Nonspecific coding limits the usefulness of home health databases for future research into improving case mix measurement and other policy issues, Mapili explains. This is one of the reasons the case mix points for unspecific codes have been removed.

Note: See related article, Don't Jeopardize Your Claims With Unspecified Diagnoses, on page 93.

4. Know when to report the underlying cause rather than proximate cause. If your agency is providing multiple aspects of care, make sure you're not reporting a code that only illustrates one aspect.

Some of the long-term chronic conditions, such as paraplegia, only gain points if coded as primary (in addition to gaining points when combined with certain OASIS data items). Don't list a single aspect of care that requires more visits as primary when your agency is providing multiple aspects of care for the paraplegia -- the paraplegia should be listed first.

In other cases, while it is still important to code to reflect your plan of care, the sequencing of the diagnoses may not make a difference in payment. For example, currently if you are caring for a patient with Parkinson's disease and gait abnormality, you might be tempted to simply list 781.2 (Abnormality of gait). But if your care reaches beyond gait treatment to focus on multiple aspects of Parkinson's disease, you would be shortchanging your agency by listing only this symptom code, Mapili says. However, under the new PPS, whether or not the Parkinson's is listed first or as a secondary code in M0240, you can still gain case mix points if the patient has a toileting disability.

Look out: Come January, gait abnormality will only earn points if your patient is in an early episode and also has a pressure or decubitus ulcer.

5. Use manifestation codes. In certain cases, you must list more than one ICD-9 code to accurately report a condition, Mapili says. Often, this "multiple coding of diagnoses" involves both a disease and one of its manifestations.

Manifestation coding affects some of the case mix system's diagnoses, and some of the manifestation codes also carry points. But to receive points, the manifestation codes must appear in their proper sequence after the etiology. And you must also list all required digits for the code.

Coders who have gotten in the habit of listing 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled) and not reporting a code for any manifestations for their patients with diabetes are headed for trouble. These coders are not just losing money for their agencies but also risking denial in medical review for failure to document a potential skilled need such as diabetic neuropathy, Mapili says.

Medicare will be more particular about pairing the correct etiology with the manifestation, coding experts say. Even the fourth digit of the diabetes code will need to match up with the correct manifestation.

Some things never change: Although PPS brings many changes with it, the logic you should use to select primary and secondary diagnoses remains the same, Mapili says. You should still determine the primary diagnosis based on the condition that is most related to the plan of care.