Home Health ICD-9/ICD-10 Alert

Give Your Documentation a Check Up

A good rapport with clinicians in the field can help secure your coding.

It's not the diagnosis codes that will sink your ship under audit, says **Tricia A. Twombly, BSN, RN, HCS-D, CHCE,** senior education consultant and director of coding with **Foundation Management Services** in Denton, Texas. Instead, it's poor documentation that can pull you under.

You can only code depending on the quality of the data you're given, Twombly says. The clinician conducting the OASIS assessment is an investigator, and it's her investigative notes that create the record you need to code from.

Example: Suppose the nurse conducting an assessment finds that her patient is taking little blue pills, Twombly says. When asked, the patient tells her they are for congestive heart failure (CHF). Provided she sees the patient as a reliable source, she now has a diagnosis that may be pertinent to the plan of care.

But she must link that CHF diagnosis with the care your agency provides in the documentation she creates -- especially the narrative in the start of care or recert assessment. A good narrative describes what the clinician is doing about the diagnoses listed in M1020 and M1022.

If the nurse were to simply list CHF as the principal diagnosis, and the coder in turn added 428.0 (Congestive heart failure, unspecified) in M1020 without any detailed documentation, your agency could face an unpleasant audit.

Tie Diagnoses to Care

Suppose your CHF patient's chart was pulled for audit, but there were no notes about this diagnosis in the narrative or in the daily visit notes. Even having a goal or intervention related to the CHF is no safeguard if the documentation doesn't show you taught on diet to help keep the CHF in check, on medication interaction that may occur between the patient's CHF medication and his hypertension medicine, on edema, and on the disease process. Such documentation helps to ensure that the diagnosis stands up under scrutiny.

Ideally, the documentation should act as little breadcrumbs that lead the auditor along a trail, Twombly says. Documentation that shows how the patient was admitted for CHF, followed by a narrative that includes a goal related to the CHF, and then visit notes that show how the nurse addressed that goal will keep your claims secure.

Use Care when Sequencing

When it comes to sequencing diagnoses, the **Centers for Medicare & Medicaid Services** have very strict guidelines regarding what is appropriate to list as a principal diagnosis in M1020, Twombly cautions. You can't just tick off a box that your patient has CHF.

Your documentation must demonstrate why this diagnosis is the chief reason your patient is being admitted to home care. This should include a description of why the diagnosis is the main reason and what you'll be doing about it.

The secondary diagnoses you report must be pertinent to the plan of care and documented in the narrative as well, Twombly says.

Keep Communication Lines Open

As a coder, you can't code what isn't documented. If you're working from documentation provided by clinicians in the field, it's essential to establish a rapport, Twombly says. If documentation is lacking, try taking this approach: "CHF is

listed as a diagnosis for this patient, but I don't see it in the documentation. I need you to augment the documentation to show what you did out there today."

Example: Suppose you are reviewing the documentation and notice that the patient is on anemia and asthma medication. These disease processes could affect the plan of care, but the documentation doesn't go into any details. You could contact the clinician and say "We see the patient is taking anemia and asthma medications. I know you must have taught on this, but it's not in the documentation. Would you like to query the physician as to why?"

The clinician may say no, but usually she'll be grateful that you noticed the details, Twombly says. This gives her an opportunity to amend the documentation and plan of care to illustrate the care she has provided more fully.

Bottom line: Clear and easy communication between clinician and coder allows you to clarify any necessary details for a specific code, says home care consultant **Karen Vance, OTR** with **BKD** in Springfield, MO.