Home Health ICD-9/ICD-10 Alert

PART 2: END THESE NAGGING QUESTIONS -- NAIL DOWN WHEN TO REPORT RESOLVED DIAGNOSES AND E CODES

Keep sequencing accurate or risk reimbursement.

The ICD-9 coding guidelines advise against reporting resolved diagnoses that no longer impact care, but when exactly is a diagnosis considered resolved? And what about E codes -- you probably don't report them often, but do you know when and where you should? Our experts help with more of your questions in part two of this article series on tricky diagnosis coding situations.

Link Resolved Diagnosis to Current Care

In home care, you're often providing care for a patient after the initial condition has been resolved. You shouldn't code for a condition that's no longer present, but sometimes the resolved condition has a bearing on the current care you provide. What's the rule of thumb for reporting a resolved condition?

In general, deciding whether to report a resolved condition depends on whether the condition has a bearing on the current stay/plan of care, says **Ida Blevins, RHIA,** with St. John's Hospital Home Health Services in Springfield, IL.

With regard to resolved conditions, the official ICD-9-CM Coding Guidelines advise against reporting resolved conditions or diagnoses as well as status-post procedures from previous admission that have no bearing on the patient's current stay.

Instead, look to history V codes (V10-V19) to report the "historical condition or family history" if it "has an impact on current care or influences treatment," the guidelines advise.

Coding scenario: Your patient had pneumonia in the hospital. Now she is off antibiotics and no longer has respiratory symptoms. You will be providing teaching on pneumonia, but her symptoms are resolved and there are no treatments prescribed. How would you report the pneumonia in the next home care episode?

Answer: Report V12.61 (Personal history of pneumonia [recurrent]) for this patient, says **Jan McLain, RN, BS, LNC, COS-C, HCS-D,** with Adventist Health System Home Care in Port Charlotte,

Fla. The pneumonia symptoms are gone and the treatment is done. That makes the diagnosis "personal history," she says.

Mind this OASIS Nuance

As a seasoned coder, you know that the official coding guidelines and the OASIS don't always quite agree. Earning case mix points for a resolved condition brings up one such situation.

Appendix D of the OASIS User's Manual (Section D, 1) advises home health coders to "Code only those diagnoses that are unresolved. If a patient has a resolved condition which has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis, and should not be coded."

In other words, "You simply cannot list resolved diagnoses as a primary or secondary diagnosis (M1020/M1022), but the rules are a little different for completing item M1024," explains **Sparkle Sparks, MPT, HCS-D, COS-C,** with Redmond, WA-based OASIS Answers.

However: If you're reporting a case mix diagnosis that's been replaced by a V code, it's ok to report the resolved

diagnosis in M1024 -- but that's the only place it's ok to list a resolved diagnosis, Sparks says.

Why? M1024 (like M0245 and M0246 before it) was created to recoup points that could be lost by reporting a V code anywhere in M1020 or M1022, says Sparks. "This allows us to use V codes as primary or secondary diagnoses when it's appropriate (per the Guidelines) while not losing money to which we are entitled per the instructions outlined by CMS in the PPS Final Rule. We complete M1024 for reimbursement only," she says.

The diagnoses in M1024 are not reported on the claim, so the Official Guidelines for Coding do not apply, agrees **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of Selman-Holman & Associates in Denton, Texas.

For example: Your patient has had an appendectomy and you are providing routine aftercare. The code you would use as a current diagnosis is V58.75 (Aftercare following surgery of the teeth, oral cavity and digestive system, NEC), says Selman-Holman. The underlying diagnosis, appendicitis, is resolved and so you would not code it as a current diagnosis. However, you can report the appendicitis in M1024 next to the aftercare V code in order to receive the points and therefore increase your reimbursement -- because that diagnosis is a case mix diagnosis, Sparks says.

Bottom line: You should follow ICD-9 coding guidelines when determining what to report as primary and secondary diagnoses in M1020 and M1022 but follow OASIS guidelines when deciding what to report in M1024.

Set the Standard for E Codes

Another area of confusion for home health coders is when (and in what sequence) to report E codes when a patient's diagnosis is the result of an external cause. E codes don't offer any case mix points, but they do provide additional information about a patient's condition. With limited room on the OASIS for ICD-9 codes, some coders are reluctant to list E codes when they could be reporting reimbursement-garnering numerical diagnosis codes.

Most E codes aren't mandatory in home care, Selman-Holman says. But E codes should be used to show a poisoning caused by a drug or chemical or an adverse effect of a drug taken correctly, she says.

Coding scenario: Your patient is receiving skilled nursing, physical therapy, and occupational therapy for aftercare of a joint replacement of the knee.

She has secondary diabetes not stated as uncontrolled, due to adverse effect of steroid use. She also has muscle weakness, exacerbated chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD). Skilled nursing will perform venipuncture for prothrombin time and international normalized ratio (PT/INR), teach and monitor coumadin effects, and perform dressing changes to the surgical site.

How should you sequence the E code in this scenario? Should you list it directly following the secondary diabetes, or can it be sequenced further down to allow for the more serious diagnoses that contribute to the focus of care?

Answer: When the guidelines advise you to "use an additional code," the additional code should be reported but that doesn't mean it must be the very next code listed, Sparks says. So, in the coding scenario above, it's perfectly fine to list the E code following the other diagnoses.

Another viewpoint: E code sequencing is a bit of a gray area in coding. The guidelines advise you which types of E codes to report for adverse effects and poisonings, but there is no direction as to how the codes should be sequenced. However, if you list the E code further down in M1022, it can cause confusion, Selman-Holman says.

For example, it might look like all the patient's conditions were caused by the situation the E code describes. Or that just the condition listed immediately above the E code was caused by the drug,

Sequencing Matters in Reimbursement

Proper sequencing is important on the OASIS because the diagnoses that make it into the six slots that make up M1020 and M1022 can impact the reimbursement your agency receives. "Often, we worry about the order in which we report

"other" or "secondary" diagnosis codes on the OASIS because those six code slots have the potential to increase our reimbursement," says Sparks. "But it's an artificial constraint due to OASIS."

The CMS instructions to home health coders from both Chapter 3 of the OASIS-C Guidance Manual, C-9; as well as Appendix D, D.3.b. advise coders to "Ensure that the secondary diagnoses assigned to the OASIS are listed in the order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided."

Establish Policy with E Codes

Be accurate and consistent with your E code reporting, coding experts advise. Although they do provide additional clarification related to the patient's condition, E Codes are not required in home care, Blevins notes.

She recommends that agencies establish an internal policy that follows the official ICD-9-CM guidelines for use of E codes. Following that policy will ensure compliance with consistency of coding and reporting, Blevins says.

Tip: E-codes may never be listed as the principal diagnosis.

Note: Read Part 1 of this series in the February 2010 issue of Home Health ICD-9 Alert and watch for Part 3 in our April issue.