Home Health ICD-9/ICD-10 Alert

Reimbursement: AVOID COSTLY CODING DENIALS WITH THESE TIPS

Are these common errors tripping you up?

Your diagnosis coding errors are allowing regional home health intermediaries to keep money you expected to be paid. Here's what you must know to get the money your agency deserves.

For the three-month period from April 2004 through June 2004, **Palmetto GBA** reported a claims denial rate of 17.32 percent for its 16-state region. This denial rate translated into home health agencies losing a total of more than $190,000 thanks to medical review downcodes, according to the RHHI.

Although there are many reasons for medical review downcodes, one of the most common is errors in diagnosis coding, experts note. These could be errors in choosing the primary diagnosis, in sequencing the codes or in agreement between the codes selected and the documentation the clinician provides.

Failing to educate clinicians about the need to document in support of the diagnosis codes leads to downcoding, says consultant **Lynda Dilts-Benson** with St. Petersburg, FL-based **Reingruber & Co.**

Another major source of coding errors is new home health agencies just entering the market, reports **Rose Kimball** with Dallas-based **Med-Care Administrative Services**. These providers are subject to probe edits when they first open, but learning how to code accurately takes time. Consequently, these agencies receive a lot of denials in the beginning, she explains.

Home health agencies that expect clinicians to choose diagnosis codes also have significantly higher levels of coding errors, says Grand Rapid, MI-based consultant **Arlene Maxim** with **Healthcare Management Consultants**. "Learning how to code is a whole other profession," she says.

Once you receive a coding denial, your first step should be to track down the reason, says coding expert **Prinny Rose Abraham** with Minneapolis-based **HIQM**. Identifying the errors will show you what actions to take to prevent similar problems in the future.

Watch for: If you're experiencing significant denial rates, here are some of the most common problems experts find:

1. **Wrong primary diagnosis.** Remind coders to determine the most acute condition requiring the most intensive services. Don't simply use the diagnosis listed on the hospital referral.

2. **Coding the underlying disease.** Just because a patient has diabetes doesn't mean you always code that as the primary diagnosis, Kimball reminds coders. If you are addressing multiple aspects of the disease, then the diabetes may be the correct primary diagnosis. But if you are focusing your care narrowly, it isn't correct to code diabetes as primary just because "the acute problem was caused by diabetes," she warns.

   Similarly, diseases such as multiple sclerosis and Alzheimer's are often not the primary focus of care, even when they are present.

3. **Erroneous trauma codes.** Inexperienced coders often use trauma codes for surgical wounds and ulcers. Requiring an E code for every trauma code will help prevent this mistake, experts suggest. If the trauma code is accurate, there will be an E code explaining how it happened, Abraham says.

4. **Documentation doesn't support the code.** Supporting documentation is especially important if you choose a case mix code as the primary diagnosis. These codes increase the episode reimbursement and are especially likely to be scrutinized by your payer, experts agree.