OASIS Alert

Coding: Optimize Reimbursement With Correct Coding Choices

You may think coding is constantly mutating, but some things never change.

Using an incorrect diagnosis or coding assignment can cause all kinds of problems, instructed **Prinny Rose Abraham**, a coding expert with Minneapolis-based **HIQM Consulting**, in a recent teleconference sponsored by **Eli**. It may lead to the wrong case mix assignment, the wrong reimbursement amount or a delayed claim payment while the fiscal intermediary scrutinizes the clinical record. Downcoding will result if your record as a whole shows you weren't really providing the level of care for which you claimed a higher payment rate, she added.

When clinicians are trying to decide which conditions to code, they should remember the **Centers for Medicare & Medicaid Services** instructs that M0240 "should include not only conditions actively addressed in the plan of care but also any comorbidity affecting the prognosis, even if the condition is not the focus of any home health treatment itself," Abraham told listeners. "That's your acid test of what codes you need to include," she said.

Abraham offered these basic coding tips:

1. Primary diagnoses matter. This has not changed under the prospective payment system, Abraham said. As in the fee-for-service years, the primary diagnosis should be the condition most closely related to the plan of care. If you are seeing the patient to treat a diabetic leg ulcer, code the leg ulcer first and the diabetes second. But if you're coming in primarily to manage the diabetes, the order would be reversed, she explained. "Don't ever forget that the principal diagnosis must be related to the current plan of treatment," she advised. Code first the diagnosis that is most acute and requires the most intensive service. And always have the plan of care available when addressing coding questions.

2. Read chapter instructions. Unless you read the instructions at the beginning of a section in your coding book, you'll miss some of the official coding guidelines embedded there, Abraham warned. For example, the definitions at 710 will help you determine whether to use 715.89 (osteoarthrosis involving, or with mention of more than one site, but not specified as generalized; multiple sites) or 715.96 (osteoarthrosis, unspecified whether generalized or localized; lower leg). And the brackets in the tabular section of your book will indicate which are the appropriate fifth digits for a specific fourth digit.

3. Don't be afraid to query physicians. If you need more information about the diagnosis so you can code accurately and be paid correctly, don't be put off by the fact that physicians don't like queries. "Just pick your battles," Abraham suggested.

4. Diagnoses change. If you find your patients' diagnoses rarely change between the admission assessment and the recertification assessment, you should look more closely. Many times software automatically fills in the diagnosis on recert and the clinician forgets to ensure it is still accurate, Abraham warned.

To order Prinny Rose Abraham's coding teleconference, which reviewed FY 2004 coding changes, V and E codes and other coding strategies, go to http://codinginstitute.com/conference/tapes.cgi?detail=430 or call 1-800-508-2582.