Codify
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Diagnosis Coding: 11 TIPS FOR AVOIDING HIPPS DOWNCODING

Strategies for accurate coding -- the first time.

Don't throw up your hands in coding frustration. Use these tips to improve accuracy instead.

1. Understand the primary diagnosis.

Home health rules define primary diagnosis as "that diagnosis which represents the most important reason you're providing home care, the most acute diagnosis and that which justifies the intensity of service," instructs consultant **Pat Sevast** with **American Express Tax & Business Services** in Timonium, MD.

2. Don't just repeat the hospital diagnosis code. Clinicians still put acute fracture codes in M0230 and M0240, but they are not treating the acute fracture at home, even if the patient did not have the fracture repaired, stresses consultant **Melinda Ga-boury** with Nashville, TN-based **Healthcare Provider Solutions**.

3. Focus on the patient, not on the points. If you are in the home to manage new medications and fluid intake problems in a diabetic patient who developed congestive heart failure, the primary diagnosis is most likely the CHF (which gives you no points) rather than the diabetes (which gives you 17 points), Sevast illustrates.

4. Determine the purpose of home care. If you're providing catheter care for a patient with multiple sclerosis, more than likely you are not providing treatment for the MS, Sevast says. Even though MS gives you 20 points, "the purpose of home care in this episode may just be to deal with the Foley," she advises.

5. Know what kind of ulcer you're caring for. If you plan to code the primary diagnosis as diabetes with a manifestation code for the foot ulcer, "absolutely be sure you have documentation that it is a diabetic ulcer rather than a pressure ulcer or stasis ulcer," Sevast counsels.

6. Be sure your clinicians really understand how coding has changed. Before coding was connected with reimbursement under the prospective payment system, clinicians tried to keep coding as simple as possible. "We just wanted to get a valid code in there," Sevast remembers. But now that the primary diagnosis drives payment, it has become a focus in the search for fraud and abuse, she warns.

7. Code what you're treating, not what you think caused it. This distinction continues to be a problem for some clinicians, Gaboury stresses. Agencies may need to focus educational efforts on clinicians who still have problems understanding the new rules.

8. Read periodicals and attend more than one coding education session. Coding is complex and requires ongoing training to get it right, Sevast advises.

9. Audit claims before you submit them. You can audit your own claims for indicators of erroneous primary diagnoses, experts say. For example, with many neurological diag-nosesit would be unusual if there are very few nursing visits in comparison to aide visits, Sevast says, so you would want to look more carefully at those. And every time you code diabetes, "definitely make sure the focus of care is on the diabetes - such as a referral with diabetes as the reason, monitoring blood sugar and teaching diet," she explains.

10. Learn from your mistakes. Monitor the assessments of new nurses -- or those with higher numbers of coding mistakes -- until they demonstrate consistently correct choices for primary and secondary diagnoses, Gaboury suggests.

11. Ordernew books. Up-to-date coding books are essential, since codes change every year, experts warn. And this year,

for the first time, there will be no grace period for the transition to new codes that takes place Oct. 1. Have books available and training complete by Oct. 1 to avoid costly coding errors (see OASIS Alert, Vol. 5, No. 7).