OASIS Alert

Diagnosis Coding: Avoid These 8 Common Coding Errors

If you're pressed for time when selecting codes for your home health patient, you may make an innocent mistake that will come back to cost you.

Query your computer and then check the record to see if you've made one of the following common coding errors, suggested **Prinny Rose Abraham**, speaking in a recent teleconference, "Advanced Coding for Home Health Services," sponsored by **Eli**.

1. Lack of specificity. Prevent future edits by learning to code to the highest specificity on file. People often code to the unspecified code out of habit, even when there is specific information available, Abraham said. There is a Medicare coding edit being used in some settings, though not yet in home care, she warned - but it could catch on: If the provider submits more than 20 percent of their claims with unspecified codes, the fiscal intermediary is supposed to contact the provider for "coding education."

2. Inaccurate neoplasm coding. Don't code neoplasms only from the index, Abraham warned. In the alphabetical list, you'll find neoplasm listed by anatomical site. But there are six possible code numbers for each site.

You must code according to whether the neoplasm is malignant, benign, in situ, of uncertain behavior or of unspecified nature. And there are specific instructions in a whole section of your coding book for sequencing neoplasms, she added.

TIP: Avoid the "Eureka!" syndrome. If you code from the index, you may find a code that seems to fit and not look further - but that's often a mistake.

3. Prothrombin time confusion. If you're seeing a patient primarily for anticoagulant management - such as drawing a pro time - use V 58.83 rather than the older code, V 58.61, which just indicates the status of the person on anticoagulants.

4. Mistaken trauma codes. Double check trauma codes, Abraham counseled. For example, a patient with a fractured mandible may appear to qualify for a trauma code, when in fact this could be a pathological fracture secondary to a malignancy, she explained.

5. Diagnosing depression. Unless the medical record includes physician documentation of the specific mental disorders, use 311 (depression not otherwise specified). With more information, you may need to use 309.1 (prolonged depressive reaction) or 296.20 (major depressive disorders where there is a single episode and the severity is unspecified).

TIP: If a diagnosis code requires additional information, cover yourself by charting the fact that you contacted the physician and confirmed the specific diagnosis.

6. Imprecision. Read carefully to determine what actually was done. You would code an arterioplasty as 39.59, but an angioplasty as 36.01, she explained.

7. Inappropriate procedure codes. For example, 57.17 is the code for a cystosomy (incision through the abdomen to

drain the bladder with a tube), while a cystoscopy (a procedure done to look at the inside of the bladder) is coded 57.32, and a therapeutic distention of the bladder is coded 96.25, Abraham instructed.

8. Pneumonia ambiguity. Not all pneumonias are the same, Abraham reminded listeners. Pneumonia 482.9 is for bacterial pneumonia while 486 describes pneumonia where the organism is unspecified. v

Editor's Note: To order 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.