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OASIS Alert

Diagnosis Coding: Beware New Diabetes Coding Edit

Diabetic ulcers require careful coding.

Now's the time to check coding accuracy for your diabetic patients - especially those with congestive heart failure - before the claims are denied.

A probe review turned up "inappropriate use" of the primary diagnosis 250.xx leading to a widespread edit for providers served by **Cahaba GBA**, the RHHI announced.

The edit - topic code 5THBK - will select non-start-of-care claims that have a M0230 primary diagnosis of diabetes and a M0240 secondary diagnosis of CHF, Cahaba tells providers.

Case Mix Equals Medicare Scrutiny

Caution: Because diabetes is a case mix code, agencies are paid more for an episode in which diabetes is the primary diagnosis. If you put 250.xx (Diabetes mellitus) in M0230 when it does not belong there, your claim will be downcoded or denied.

Many conditions are exacerbated by diabetes, but that doesn't make the diabetes primary. First ask yourself if diabetes is the most important reason you are providing home care, the most acute diagnosis and the reason for the most intense services, coding experts say.

If you're in the home to manage CHF in a diabetic patient, it is very likely the CHF belongs in M0230, not the diabetes, warns **Mary I. Falbo**, president of Millennium **Healthcare Consulting Inc.** in Lansdale, PA.

Historically, diabetes is addressed in the first episode, says senior clinical consultant **Judy Adams** with Charlotte, NC-based **LarsonAllen Healthcare Group**. Subsequent episodes are more likely to address the CHF, she tells **Eli.**

Hidden trap: Be sure to re-evaluate the diagnosis sequencing at recertification and not just continue with the same listing as the previous episode, Adams warns.

Manifestations Can't Be Primary

Watch for: Mistakes occur when staff do not understand coding language, said coding expert **Lisa Selman-Holman** with Denton, TX-based **Selman-Holman & Associates,** speaking at a recent Eli-sponsored teleconference.

If your patient has manifestations of diabetes, and you look up the code for that manifestation, the instructions will tell you to "code first" the underlying diabetes.

"Code first" does not mean code the diabetes as primary, Selman-Holman explain-ed. If some other condition is the main focus of the episode's home care, you still code that condition in M0230. Then when you place the diabetes manifestation code in M0240, place the 250.xx diabetes code in M0240 before the manifestation code.

Trap: One error clinicians often make is to code the diabetes as primary when the patient has a diabetic ulcer but the ulcer and diabetes are not the main focus of care. This is upcoding, which may result in claims downcoding and fraud and abuse charges, Selman-Holman warns.

Another common error is automatically coding polyneuropathy when patients are re-ceiving home care for insulin administration or prefilling syringes. Don't automatically assume this is the reason patients need such assistance, although it might be. Instead, the patient could have cognitive problems or late effects of a stroke that interfere with self-care, Selman-Holman notes.

Avoid These Errors Leading To Underpayment

Other diabetes coding errors can mean your agency loses money it is entitled to, Selman-Holman warns. Watch for these common problems, she suggests:

1. Missing or wrong digit. The diabetes code must have five digits. The main diabetes category is 250. The fourth digit indicates what manifestations the patient has and the fifth digit denotes the type of diabetes and whether it is controlled or uncontrolled.

Tip: If you code 250.0x (Diabetes mellitus without mention of complication) but then code a manifestation, your claim may be downcoded for incorrect diagnosis coding.

2. Misunderstanding coding symbols. Slanted brackets in the alphabetic index indicate a manifestation, as do italics in the tabular list. A manifestation code can't be coded by itself. The underlying disease must precede it.

Warning: If you code a number of diabetes manifestations, each manifestation that is in a different category must be preceded by its specific diabetes code.

For example, if the patient has diabetic glomerulosclerosis and diabetic gangrene, you would code both 250.4x (Diabetes mellitus with renal manifestations) followed by 581.81 (Nephrotic syndrome in diseases classified elsewhere) and 250.7x (Diabetes mellitus with peripheral circulatory disorders) followed by 785.4 (Gangrene).

3. Failing to query physicians. You can't code for uncontrolled diabetes unless the physician specifically documents that diagnosis. And if the diabetic patient has an ulcer, you must have confirmation from the physician that it is a diabetic ulcer before coding for that.

Watch for: If a diabetic patient has osteomyelitis, you don't have to ask the physician if this is connected to the diabetes.

In coding, osteomyelitis is assumed to be a manifestation of diabetes, Selman-Holman says. In this situation, you would code 250.8x (Diabetes mellitus with other specific manifestations), then 731.8 (Other bone involvement in diseases classified elsewhere) and then 730.xx for the osteomyelitis. Similarly, if a diabetic has gangrene, it is assumed to be a manifestation of the diabetes, she adds.

4. Coding diabetic ulcers inaccurately. Unlike pressure or stasis ulcers, diabetic ulcers don't get points through the OASIS wound and lesion M0 items.

If your episode focuses on a diabetic ulcer, but you put the 707.xx manifestation code in M0230, you lose 17 points and the dollars that go with them. Instead, put the 250.8x in M0230 and 707.xx as the first secondary diagnosis, Selman-Holman explains.

Note: The Cahaba edits are at www.iamedicare.com/provider/newsroom/whatsnew/ whatsnew.htm. For more diagnosis coding help, order Eli's Home Health ICD-9 Alert at 1-800-874-9180. And you may order the tape of the Aug. 4 teleconference, "Diabetes Coding Tips for Home Health," by coding expert Lisa Selman-Holman at http://codinginstitute.com/conference/conferencecgi?detail=214.