OASIS Alert

Diagnosis Coding: Dodge these Coding Landmines to Keep your Claims in the Clear

Watch for diagnosis matches between these key medical record components.

If you're making one of these common diagnoses coding errors, you agency's reimbursement could be in danger. Make certain your coding practices are in step with other documentation to help your claims hold up.

Gather Accurate Diagnosis Documentation Up Front

The condition for which the patient was being treated in the Face-to-Face encounter should be related to the reason the patient requires home health services, says **Ann Rambusch, MSN, RN, HCS-D, HCS-O, COS-C,** with **Rambusch3 Consulting** in Georgetown, Texas.

You can save time in the long run by asking the physician to list more than one diagnosis on the F2F, Rambusch suggests. If the physician provides a list of diagnoses that he is seeing and treating at the time of the F2F, any one of those diagnoses could be a potential primary diagnosis, she says. If the physician only gives you one diagnosis, then you don't have much to go on and you'll have to go back and ask for more.

Remember: The focus of care on the plan of care (POC) must match the primary diagnosis listed on the OASIS. If you check nothing else for OASIS and diagnosis coding consistency, be sure to check this, Rambusch says.

Watch for these Primary Diagnosis Errors

When the diagnosis you list in M1020 doesn't match up with the rest of the medical record, you're bound to come under fire. Make certain you consider how the POC, the other related OASIS items, and the F2F documentation back up and relate to the diagnosis you list in M1020.

Some common M1020 red flags include the following examples from Rambusch:

- **The primary diagnosis does not match the focus of care** as identified in the POC or the written documentation on the OASIS in record. For example, suppose you coded diabetes mellitus in M1020 but the other documentation seems to indicate that the focus of care is congestive heart failure. The patient's diabetes appears stable. "Diabetes must be the focus of care if you're going to list it in M1020," Rambusch says. The diagnosis you list in M1020 should be the most serious condition the patient has with the greatest skilled need.
- **The primary diagnosis is inconsistent** with the F2F documentation. For example, a traumatic, infected wound code is listed in M1020. But there is no documentation in the record backing up a trauma wound as the focus of care and there are no wound care orders except for application of dry dressing.
- **The POC appears to be nonspecific** or generalized. For example, the POC does not specify what aspects of the condition in M1020 should be addressed. Instead, it simply states "management of disease processes" or "assessment of disease processes of CHF, HTN, weakness."
- **The physician documentation** of the condition coded in M1020 is not evident in the medical record. For example, a diabetic ulcer is coded in M1020 but the documentation indicates that it is a stasis ulcer in a patient with diabetes. There is no physician validation of the diabetic ulcer diagnosis.
- **The primary diagnosis appears to be pre-coded** before the assessment was completed and/or is based on referral data.

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Correct this Secondary Diagnosis Error

Your primary diagnosis selection isn't the only error that can trip up your claim. You also need to make certain the diagnoses you list in M1022 pass muster.

Be careful not to code secondary diagnoses in M1022 that are not addressed in the POC, Rambusch says.

For example: if you're including a GERD diagnosis, make certain it's a current diagnosis, that it's relevant to this patient's care, and that the documentation outlines what you're doing to address the problem. You can't just list a GERD diagnosis when your patient is taking GERD medication, but you're not doing anything for the diagnosis.

The same goes for listing an anemia or low vision diagnosis. Make certain the documentation explains why the condition is relevant to the POC and what you're doing about it.

Don't Let Dementia Derail Your Accuracy

Not listing dementia as a secondary diagnosis code when there are hints or clues in the medical record that indicate the patient may have dementia is another common mistake, Rambusch says.

For example: M1018 □ Conditions prior to medical or treatment regimen change ... states that the patient has memory loss requiring supervision. Other cognitive items and documentation demonstrate that the patient has poor decision making and forgetfulness.

"Sometimes we don't want to say that we're taking care of a patient with dementia for the fourth episode," Rambusch says. "A lot of times, what we find is that patient is being taught over and over because the patient's memory is poor. She's forgetful, has poor decision-making skills. She is on medication known to be a treatment for dementia. But the diagnosis of dementia is never listed even though there are hints and clues that she has dementia and is being treated for this diagnosis by the physician."

Try this: A comprehensive assessment of this patient should include communication with the physician about the symptoms the patient is experiencing and the diagnosis underlying the mediation the patient is taking, Rambusch explains. A diagnosis of dementia will impact the plan of care and your interventions with the patient/caregiver.

However, sometimes providers believe that using a diagnosis of dementia will flag a record for review □ especially in later episodes. "Repetitive teaching to a patient with dementia is not covered because it misses the 'medically reasonable and necessary test," says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, **HCS-O,** consultant and principal of **Selman-Holman & Associates** and **CoDR □ Coding Done Right** in Denton, Texas. "Alzheimer's and dementia fit the bill as secondary diagnoses but your POC has to be specific regarding your interventions and goals for such a patient."

"When we fail to query the physician about [a dementia] diagnosis and/or address the symptoms or the diagnosis in our plan of care, we send a message to a reviewer that the plan of care is incomplete and is not based on individual patient needs," Rambusch says.

Caution: In a scenario like the one described above, the patient's length of stay (this is the fourth episode) may result in review by the MAC or the RAC, Rambusch points out. According to the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.3: "Teaching is reasonable and necessary when the teaching is appropriate to the patient's functional loss, illness, or injury. If patients or caregivers are not able to be trained, then further teaching would cease to be reasonable."

If you're providing other skilled care such as complex wound management, IV therapy, etc., then the patient episode would be reasonable and necessary, Rambusch says. "The key for all patient episodes is documenting skilled care that is also reasonable and necessary and not whether there is potential for improvement."

For more diagnosis coding education, see Eli's Home Health ICD-9 Alert. Information on subscribing is online at

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