OASIS Alert

ICD-9 Coding: Avoid These V Code Errors and Keep Your Reimbursement Accurate

Watch your sequencing or pay the price.

The **Centers for Medicare & Medicaid Services** is keeping an eye on your V code use. Make sure you know when you must list a V code versus when listing one in M1020/M1022 gives an inaccurate picture of the care you're providing.

The problem: CMS expects home health agencies to understand the limitations of listing V-codes and to consider reporting them on the OASIS as an "assignment of last resort," according to Appendix D of the OASIS-C Guidance Manual. V codes do not provide the level of detail that numeric diagnosis codes supply, so overusing them has a negative impact on specificity.

Don't List an Aftercare V Code When Caring For an Acute Diagnosis

Because home care agencies so often provide aftercare, coders may have a tendency to overuse the aftercare V codes.

For example: If your patient has a urinary tract infection due to a catheter, you should list an acute diagnosis code such as 599.0 (Urinary Tract Infection, unspecified) rather than V53.6 (Fitting and adjustment of urinary catheter), says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principal of **Selman- Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas.

Get it in writing: The physician must document that the UTI was caused by catheter before you can list the code 996.64 (Infection and inflammatory reaction due to indwelling urinary catheter), Selman-Holman says. Try to get documentation that specifies the cause of the UTI, she recommends. For example, if you have documentation of an acute bladder infection or cystitis, then you can list the code is 595.0 (Acute cystitis), rather than the unspecified UTI code.

Generally, you'll report an aftercare V code when caring for a patient "with a resolving disease or injury, or a chronic, long-term condition requiring continuous care," according to the ICD-9-CM Official Guidelines for Coding and Reporting. If the care you provide is instead focused on a current, acute, diagnosis or symptom, you should list a numeric diagnosis code for that acute condition.

Another example: Your patient has had an elective knee replacement and was admitted to home care with the primary diagnosis of aftercare for a joint replacement. This patient is not "acutely ill" but is in need of care for a specific purpose - rehabilitation and safe healing of the new joint, says **Jan McLain, RN, BS, LNC, HCS-D, COS-C,** with **Adventist Health System Home Care** in Port Charlotte, Fla. So for this patient, you would list two V codes: V54.81 (Aftercare following joint replacement) and V43.65 (Organ or tissue replaced by other means; joint; knee).

Don't Let Sequencing Trip You Up

When it's appropriate to list an aftercare V code, you'll usually list it in M1020 as primary to explain the specific reason for the encounter. But V codes may sometimes be listed in a secondary position in M1022 when you're providing aftercare in addition to the reason for admission and no diagnosis code is applicable.

For example: If you were providing teaching or direct care of a new colostomy in addition to the treatment of another condition, you could list V55.3 (Attention to artificial openings; colostomy) as a secondary code in M1022.

Sequencing tip: If the focus of your care is the result of a condition that has been corrected by surgery or is no longer present for another reason, list the appropriate V code as primary. But if you are simply including V codes for additional

information, you can place them later on in your list of codes. You'll generally list aftercare V codes first, but the sequencing of additional V codes is discretionary, Selman-Holman says. To avoid excessive use in the M1020/M1022 data items, sequence additional V codes last, she suggests.

Looks familiar: Aftercare V codes for surgery and joint replacement are among the most common primary diagnosis V codes you'll use as a home health coder. The V57.xx (Care involving use of rehabilitation procedures) codes are also used frequently, says McLain.

"I may add other V codes at the bottom of the list of diagnoses to provide supplemental information such as new oxygen use, but V codes should be used sparingly," McLain cautions.

Don't List a V Code with Complications

When your patient has experienced a complication of medical or surgical care, such as infection or wound dehiscence, you must report a numerical code specific to the complication rather than a V code. For codes used to report surgical complications, look to Chapter 17, Injury and Poisoning, in your ICD-9-C M Coding Manual.

"Complication codes trump V codes," says **Shirley Kucirek, HCS-D** with **Acorn's End Training & Consulting** in Rice Lake, Wis. Most complication codes already describe the situation so listing a V code in conjunction with a complication code is rare, she says.

Example: When reporting 996.83 (Complications of transplanted heart) there's no need to also list status V code V42.1 (Heart transplant status), Kucirek says. The status code doesn't provide any additional information in this case -- the complication code itself indicates that the patient has had a heart transplant.

Tip: The joint replacement complication codes (996.4x, 996.66, and 996.77) are the only complication codes with an instruction to also code a V code, Selman-Holman says. These codes all ask you to add the V43.6x (Organ or tissue replaced by other means; joint) code to indicate the joint affected.