OASIS Alert

OASIS News: Home Health Coding Training Goes Online

If you're looking for an easy -- and free -- way to introduce ICD-9 coding to more of your staff, a new computer-based course may be just the thing.

In its June Home Health & Hospice Medicare A Newsline, regional home health intermediary **Cahaba GBA** announces a new interactive online course: Basics of ICD-9-CM Coding for Home Health Clinicians.

The course begins with a short pre-test and ends with a post-test. The first chapter discusses basic coding structure and the difference between numeric codes, V codes and E codes. "Knowledge check" questions ap-pear frequently to check the user's understanding of the material.

Other topics the course covers include:

• choosing the primary diagnosis (em-phasizing the clinician's role)

• using the coding manual

• importance of OASIS accuracy

• understanding case mix codes

• avoiding top coding problems

• when to use a trauma code

• how to code diabetes and strokes

Caution: On page 35, the second bullet point is incorrect, says clinical and coding consultant **Judy Adams** with **LarsonAllen** in Char-lotte, NC. "Both Neuro 1 and Skin 2 earn points as primary or "other" diagnoses according to Table 2A in the PPS final rule or Table 5 in the pseudocodes, she says.

Two other pages might be confusing to beginning coders, Adams predicts:

• On page 24, be sure your staff don't fall into the old myth that you count the number of visits to determine which discipline is primary, she warns. Remind them that they are looking for the most acute condition needing home health services, she says.

• On page 30, clarify to your staff that there are some conditions that require additional symptom codes. But generally you do not code symptoms that are an integral part of the medical diagnosis or condition, according to coding guidelines, she says.

Note: The online course is at http://www.cahabagba.com/rhhi/education/online_courses/hh_icd9/index.html.

• **In a recent memo, CMS made clear for the first time** that non-routine medical supplies payments are prorated for a partial episode payment adjusted (PEP) episode. "For episodes beginning on or after January 1, 2008, the non-routine supply payment amount is ... subject to this proration on a basis of days," CMS explains in May 15 Transmittal No. 1505 (CR 6027).

NRS proration adjustments should be minimal, since the claims system has been prorating the payments since just a few weeks after PPS was implemented, a CMS official tells **Eli**. The NRS proration mechanism has been in place since late January or early February. The transmittal is at http://www.cms.hhs.gov/Transmittals/downloads/R1505CP.pdf.

• **Almost 13 percent of the condition level deficiencies state surveyors cited** in 2007 were for failure of the patient assessment to include a review of medications, according to the **National Association for Home Care & Hospice**. This was number four in the top ten deficiencies the **Centers for Medicare & Medicaid Services** reported in the "Average Number of Deficiencies by State and the Conditional Level Deficiency Pattern Report." Medication-related problems are the leading cause of morbidity and mortality in the elderly, experts warn. OASIS medication questions M0780, M0790 and M0800 can remind clinicians to complete a comprehensive medication review, they suggest.

• **There's a new PPS billing snafu to watch out for.** "The clinical domain is inexplicably, and incorrectly, being downcoded on final claims when more therapy services are delivered and billed than projected on the request for anticipated payment (RAP)," NAHC reports.

This alleged error joins other existing problems such as the claims system's inability to count 2007 episodes when determining early or later episode sequence based on M0110.

CMS plans to fix a number of lingering PPS problems in its July system update, then start correcting erroneous payments.

• **The Home Health Pay for Perfor-mance demonstration project that lasts** from Jan. 1, 2008 to Dec. 31, 2009 includes 569 home health agencies, CMS reports. The HHAs are from Connecticut, Massachusetts, Tennessee, Alabama, Georgia, Illinois and California. In the demonstrations project, agencies were randomly assigned to either a study group or a control group. Study group agencies will have their patients' outcomes monitored during the demonstration and will be eligible for incentive payments.