OASIS Alert

Reimbursement: IMPROPER CODING EQUALS TRAUMATIC RECOUPMENT

If your home health agency has been mistakenly using 800- and 900- series trauma codes to describe wounds on M0230, get ready to return a huge chunk of change to the Medicare program.

Agencies are supposed to use injury codes (categories 800 to 995) only to indicate "injuries from accidents or violence," the **Centers for Medicare & Medicaid Services** notes in its prospective payment system diagnosis coding guidance.

That means most wounds (including surgical wounds and those resulting from a disease) won't fit into this category. (For more information on traumatic vs. surgical wounds, see Eli's OASIS Alert, Vol. 3, No. 4, p. 44.) The most common example of when HHAs should use a trauma code is in the event of a hip fracture or wound due to a fall or other accident, CMS offers.

CMS is cracking down on misuse of trauma codes, because they result in an additional 21 points toward the case mix calculation when an agency also answers 'yes' on M0440 ('Does this patient have a skin lesion or an open wound?'), explains consultant **Melinda Gaboury** with **Health-care Provider Solutions** in Nashville, TN. If agencies have used the trauma codes inappropriately, "they're getting reimbursed for money they shouldn't be reimbursed for," she notes. And the difference could be anywhere between $550 and $1,200 a pop, she tells **Eli**.

CMS isn't taking the problem lying down. "Agencies that have erroneously coded disease-related post-surgical cases with a trauma diagnosis should submit an adjusted claim to ensure accurate payment," the guidance states. This mandate hasn't sunk in with most agencies yet, Gaboury laments, and "it's becoming a huge medical review issue."

Agencies that have been making this mistake must go all the way back to Oct. 1, 2000, when PPS began, and resubmit all erroneous claims, Gaboury emphasizes, no matter how painful the process is. To determine which claims they must adjust, agencies should run a report by primary diagnosis, she instructs. How an agency should do so will depend on the system it uses.

"Once you print that report, pull out all the injury and trauma codes and look to see if they were actually injuries and traumas," she counsels. You'll need to base that decision on the clinical write-up, says consultant **Tom Boyd** with **Boyd & Nicholas** in Rohnert Park, CA. If it turns out you used the trauma codes in error, you must submit an adjusted claim.

And HHAs should be careful not to repeat this mistake in the future, experts note. "Agencies should not lose sight of the fact that if they mischaracterize costs on their cost report, they may amount to false claims," warns Burtonsville, MD-based attorney **Elizabeth Hogue**. If you exhibit a pattern of miscoding, then the feds "could claim there was intent to defraud the government by upcoding," Hogue notes. "There is certainly a great deal to worry about if we are using codes improperly," she concludes.