OASIS Alert

Widespread Edits: Stay on Top of Widespread Edits to Keep Your Claims Safe

Don't fall into this open wound trap.

Delays or denials resulting from claims caught up in edits can cost your agency dearly. Keep your reimbursement safe, by knowing which diagnoses draw the most scrutiny and how you can safely report them.

When an RHHI or MAC has a hunch that home health agencies might be submitting certain claims incorrectly, a probe edit is launched. During the probe, the payer will examine a sample of claims that fit the parameters they want to study to see what the denial rate is. A high denial rate can cue a widespread edit, said **Beth Noyce, RN, BSJMC, HCS-D, COS-C,** director of professional services with **Applegate HomeCare and Hospice** in Ogden, Utah.

Widespread edits automatically reroute claims at high risk of payment errors for review before payment to verify that care was appropriate, Noyce said during the session "Using Widespread Edits and Edit Probes to Help Your Agency Avoid Denied Claims" at the Oct. 2010 **National Association for Homecare and Hospice** Annual Meeting and Exposition.

Don't Let Edits Empty Your Agency's Pocketbook

The claim denials and down-codes that come as a result of widespread edits can mean lower payment or no payment for services your agency has already provided, Noyce says. That can mean hundreds or thousands in lost revenue.

Remember: Your agency has already paid the clinician for delivering care by the time the claim is denied, Noyce says. Being aware of current widespread edits can help your agency better understand coverage and help clinicians document more accurately.

Know Why Diagnosis Codes Matter

The principal diagnosis code you report must correctly illustrate the focus of care for each patient, Noyce says. And secondary diagnosis codes should show which co-morbidities could impact the patient's response to treatment or affect the plan of care.

Keep current: You should update the diagnosis codes you report for each episode, Noyce says. Make sure the current primary diagnosis is the focus of home care services in each episode.

"Too many coders and agencies choose to keep the codes the same episode after episode, without regard to what is really going on with the patient," 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. "It's one issue when you're deciding between something like hypertension and heart failure as primary, but when the coder continues to go with the higher earning code as primary, such as diabetes, and when services don't support the code, then that decision can lead to downcoding in audits."

The patient record should show that the physician has verified all diagnoses, Noyce says. And the clinical documentation should support the diagnoses reported and the treatments ordered.

Keep Track of These Widespread Edits

Some current widespread edits that pertain to diagnosis codes include the following:

#1. 496 (Chronic airway obstruction, not elsewhere classified) as primary. COPD code 496 is not specific, Noyce says. This code should be used only when the type of COPD is unclear.

In addition, if COPD is primary, the most common service you're providing is observation and assessment, Selman-Holman points out. Observation and assessment require that there be a potentially fluctuating condition. But by using 496, you're essentially saying there has been no change in the condition. That is what attracts the attention of auditors, she says.

If you're considering listing 496 as your principal diagnosis code, stop and contact the physician. Ask what kind of COPD your patient has -- asthmatic, bronchitic, or emphysemic, Noyce says.

Bonus: Listing a more specific code from the 491.x (Chronic bronchitis), 492.2 (Emphysema), or 493.xx (Asthma) can earn you case mix points while reporting 496 won't, Noyce says. Plus these more specific codes don't raise the red flag 496 does.

#2. Codes from the 870.x-879.x (Open wound of head, neck, and trunk) category. Claims listing trauma wound diagnoses are most often denied because the wound being treated isn't actually due to trauma or the patient may actually have a trauma wound, but that wound isn't the focus of care and the code is listed as primary, Noyce says.

To protect your claim, your documentation must show that the trauma injury was caused by an accident or violence, Noyce says.

Tip: If your patient truly has a trauma wound, listing an E code to describe how the patient came to get that wound can lend credibility to your coding.

#3. Codes from the 920-924.x (Contusion with intact skin surface) categories as primary. These diagnoses are most likely being used incorrectly when listed as primary, Noyce says. "Why would you see a patient for a bruise?" she asks.

If you're considering listing a code from these categories as principal, check for a more specific wound care code. Claims listing 920-924.x codes are denied because the medical necessity is unclear.

There are three types of covered wound care services, Noyce says:

- Direct, hands-on treatment;
- Teaching of wound care; and
- Skilled observation and assessment of the wound.

#4. Diabetes as primary with CHF as secondary on non-start of care episodes. These claims are often denied due to lack of medical necessity, Noyce says. After start of care, diabetes is often no longer the focus of care, she says. Instead, your focus of care becomes the patient's congestive heart failure (CHF) as you work more on the patient's edema, teaching on medication, etc. You should change the primary diagnosis once the diabetes is under control.

Red flag: Diabetes adds more case-mix points when listed as primary than it does when listed as a secondary diagnosis. Therefore, it draws greater scrutiny as a principal diagnosis. Only list diabetes in M1020 when it is the focus of care and not just a co-morbidity, Noyce says. The only exception to this rule is when a diabetic manifestation that requires mandatory multiple coding is the focus of care.

#5. V58.61 (Long-term [current] use of anticoagulants) as primary. Codes in the V58.6x series can't be listed as principal diagnoses. These are secondary diagnosis only codes, Noyce says.

Venipuncture has not been a qualified stand-alone skilled service for home health since 1997, Noyce says. Listing V58.61 as an additional code when you are also providing qualified skilled services is fine.

That's not all: Other diagnoses under scrutiny include hypertension (see Home Health ICD-9 Alert v8, n1), 344.61 (Cauda equina syndrome with neurogenic bladder), and 295.xx (Schizophrenic disorders). Check with your RHHI or MAC to see which edits are in effect in your service area, and make certain your documentation supports medical necessity in cases

where any code under scrutiny is the correct code to list.