Coding and HIM in Home Care: Up to the Challenge

by Ida Blevins, RHIA

Home care coding has always been a challenge given the fact that codes are assigned upon admission or on the "front end" of care provision. The luxury of having a complete medical record filled with physician documentation to support diagnoses (e.g., in acute-care facilities) is a luxury home care coders often times do not enjoy. Home care agency staff, along with the physician, determine a plan of care for the patient based upon a condition or conditions that will be the focus of the agency's care. From that information and any available medical history, home care coders—who are often the primary care nurses—or other clinicians who have not been trained in the use of ICD-9-CM assign the appropriate codes.

Based on home care coding regulations from the Centers for Medicare and Medicaid (CMS), prior to October 1, 2003, home care coders were faced with a dilemma of often being forced to report diagnoses or conditions that no longer existed. That is, prior to October 1, 2003, home care OASIS coding rules prohibited coders from using V-codes as primary or some secondary diagnoses.[1] Given that restriction and the CMS direction to code the condition that precipitated surgery as the primary diagnosis when clinicians were providing aftercare for that procedure, the coded data that has been collected and reported to date in home care may not reflect the actual care provided.

The prospective payment system (PPS) is a relatively new concept to home care. With the implementation of the Balanced Budget Act, a prospective payment system was mandated for home care effective October 1, 2000. Prior to that time, many home care agencies did not credit the impact proper coding might have on their compliance and reimbursement. As reimbursement for home care services dwindled, the expense of hiring a certified coder to identify the appropriate codes was a cost many agencies chose to forego. Rather, they placed the responsibility for coding into the hands of the primary care nurse or other clinicians who may not have received formal coding training.

After it became evident that accurate ICD-9-CM coding could have reimbursement and compliance ramifications, agencies stepped up to the plate and either hired trained coders or provided coding training to their clinical staff. One of the problems in that regard, however, has been the lack of available qualified coding trainers who are familiar with the home care industry.

CMS has released the post–October 1, 2003, coding regulations for home care agencies through various mediums. At a CMS seminar on November 22, 2002, CMS reiterated the need to follow official ICD-9-CM coding guidelines in order to maintain HIPAA compliance.[2] In addition, CMS posted case examples on its Web site and offered further direction in Chapter 8, Attachment D, of the *OASIS Implementation Manual*.[3,4]

Assignment of Primary and Secondary Diagnoses

According to CMS, the primary diagnosis is the diagnosis most related to the current plan of care.[5,6] The diagnosis may or may not be related to the patient's most recent hospital stay but must relate to skilled services being provided by the home health agency.

Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established or which developed subsequently." Coders are instructed to exclude diagnoses that relate to an earlier episode that have no bearing on this plan of care. CMS's coding regulations further clarified this determination by instructing coders to include not only conditions actively addressed in the plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

Given that home care agencies were precluded from using V-codes in the past, CMS had to determine a means to ensure that with the October 2003 change to official ICD-9-CM coding guidelines—which include the use of V-codes—agencies' reimbursement would not be negatively affected. To that end, OASIS item M0245 was created.

Know Your History: M0245

In order to comply with HIPAA regulations, effective October 1, 2003, V-codes may be utilized on the OASIS document in M0230 or in M0240b through M0240f. If a V-code is reported as the primary diagnosis *and* that V-code replaces a "case mix" diagnosis that would have been used as the primary diagnosis prior to October 1, 2003, that case mix code is reported in M0245.

If it sounds a little complicated, it is. In order to complete the OASIS document correctly, home care coders need to know the rules for coding *before* October 1, 2003 (in order to complete M0245) as well as the official ICD-9-CM coding guidelines and home care coding reporting rules applicable *after* October 1, 2003 (in order to complete M0230 and M0240).

Table 8a and 8b of the *Federal Register*, published July 3, 2000, lists the case mix diagnoses.[7] These codes represent diagnoses that have been determined to be more costly to treat in the home care setting and are generally from the diabetic, orthopedic, neurologic, burns, and trauma codes. Again, home care is a little off center as it relates to these groups of codes, as prior to implementation of the home care PPS, many home care agencies were using 800 codes for open wounds to designate what should have been a V-code for aftercare following surgery or, given CMS's direction prior to October 1, 2003, the condition that precipitated the surgery.

As such, not unlike other PPS venues, the original database for development of this prospective payment system was flawed by this miscoding. These trauma codes carry a higher weight in HHRG calculation. As a result, with proper coding, it appears as though case mix is dropping in some agencies when, in fact, they are seeing the identical patient type but with proper coding. It is a reflection of the fact that they are not seeing a trauma patient but rather a postoperative wound care patient. Therefore, resource consumption does not reciprocally change to reflect this change in case mix in this situation.

CMS 485 or Plan of Treatment

To further complicate matters, CMS has determined that the ICD-9-CM code listed on M0245 is considered "pertinent" and, as such, should also be listed somewhere on the CMS 485 or plan of treatment. Given that the listed code in M0245 may represent a condition that no longer exists, agencies have to determine a means to comply with this mandate without violating the HIPAA-mandated official ICD-9-CM coding and reporting guidelines.

Although it has been around for many years, the home care industry is in its coding and health information management infancy. Many agencies are unaware of the existence of AHIMA or that there is training and certification available for coding professionals. Many agencies are unaware that ICD-9-CM codebooks are updated annually (biannually with 2005). Many agencies have not heard of *Coding Clinic for ICD-9-CM*, so consequently do not realize its value as a coding tool.

If ever there was a time to recruit home care agencies into the AHIMA membership population, the time is now. I'm proud to be involved as a HIM professional in the home care industry and am looking forward to what lies ahead. Part of the beauty of home care is that home care professionals have embraced the challenge with vigor and typical professionalism. The potential is great. And training and implementation on ICD-9-CM in home care are only the tip of the iceberg.

Notes

1. OASIS. "Outcome and Assessment Information Set." Available online at www.cms.hhs.gov/oasis/all.pdf.
2. OASIS. "Diagnosis Reporting Segment, OASIS Burden Reduction Web Cast and Satellite Broadcast Handout Package." November 2002. Available online at www.cms.hhs.gov/oasis/1122diagnostic.pdf.
3. CMS. "OASIS Diagnosis Reporting Case Examples." Available online at www.cms.hhs.gov/providers/hhapps/diagnosis.pdf.
4. CMS. *OASIS Implementation Manual*. Chapter 8, attachment D, pp. 145–52. Available online at www.cms.hhs.gov/oasis/rev8.pdf.
5. "Diagnosis Coding for Medicare Home Health under PPS." September 2001. Available online at http://cms.hhs.gov/providers/hhapps/hhdiag.pdf.
6. CMS. "Medicare Home Health Agency Manual, HIM-11." Available online at www.cms.hhs.gov/manuals/11_hha/HH00.asp.

7. “Medicare Program: Prospective Payment System for Home Health Agencies: Final Rule.” *Federal Register* 65, no. 128 (2000): 41128–41214.

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