ICD-9 Raises Concerns for Home Health Information Managers

by Prinny Rose Abraham, RHIT, CPHQ

Home health information managers need to keep a keen eye on the prospective payment system (PPS) for home health to avoid coding conflicts and even financial loss. Many agencies did not pay attention to the quality of ICD-9-CM coding data prior to October 2000 when Medicare implemented the PPS for home health, but mistakes resulting from not being vigilant can lead to damaging results.

The home health resource group (HHRG) case mix classification is calculated from data submitted by a nurse or therapist after completing the Outcome and Assessment Information Set (OASIS.) One mistake could result in $80 to $1,856 of lost revenue, which are funds that could help ensure that a specific patient receives the level of services that they deserve without the agency experiencing a financial loss.

Because of such devastating consequences, data consistency and data entry accuracy among all clinicians that complete OASIS is crucial. This article focuses on what home health information managers need to know about the PPS for home health to avoid coding problems and conflicts in the future.

Scrutinizing Coding Accuracy

The data submitted in the OASIS Diagnosis and Severity Index Sections MO230-Primary Diagnosis and MO240-First Secondary Diagnosis serve as sources for case mix report information used by the Department of Health and Human Services (HHS) surveyors when preparing to survey an agency for Medicare certification and state licensure compliance.

In addition, the Office of Inspector General (OIG) announced two studies designed to verify these data integrity issues in its 2002 Work Plan.[1] Following are the plans for those studies:

Home Health Payment System Controls

The OIG announced its plans to evaluate the adequacy of controls in place to ensure that services are provided only to homebound individuals and that those services are sufficiently documented, properly coded, and medically necessary. In addition, it plans to evaluate controls over advance payments to providers.

Coding of HHRGs

The OIG announced that its review will determine whether home health agencies classified their patients in the appropriate case mix category. Under the PPS system, home health agency payments are based on a 60-day episode and are case mix and wage adjusted. The OIG plans to assess whether home health agencies received higher payments than necessary due to miscoding.

The OIG uses certain terms to describe unacceptable, yet unfortunately prevalent, coding practices. These are practices that do not meet the AHIMA standards of ethical coding practices and are highly discouraged. The terms are:

- **upcoding:** coding to increase reimbursement while investigating Medicare claims
- **overcoding:** coding signs and symptoms characteristic of a diagnosis
- **undercoding:** ignoring code also instructions
- **code jamming:** putting a zero in front of the diagnostic category to complete a code missing a fourth or fifth digit

Reducing ICD-9-CM Data Quality Concerns

Minimizing ICD-9-CM data quality concerns requires some study. Sometimes correcting coding data quality problems are simple housekeeping issues. At other times, the coding problem requires designating the errors as either system, process, or user errors.

For example, previously there was only one code for constipation. This year's coding changes included a new fifth-digit expansion, meaning differentiation can be made between constipation, unspecified slow transit constipation, outlet dysfunction constipation, and other specified types of constipation. Nurses and therapists that complete the OASIS data using point-of-care computers must recognize that classifying constipation now requires five digits and that there is a difference between assigning 564.00, Constipation, unspecified and 564.09, Other constipation.

System problems occur when the agency has not updated its coding database. If the agency computer vendor has not updated its coding database, the claim may be returned to the provider because the diagnosis codes are incongruent with the current database at the regional home health intermediary. The agency must update all servers, desktops, and portable computers. Agency-specific pick lists and crib sheets must also be updated, and coding books must be updated or new books ordered.

Avoiding Problems

Overcoding and undercoding may be either process or user errors. The nurse or therapist using a point-of-care system to complete the OASIS is assigning the ICD-9-CM code when he or she enters or selects a diagnostic description from the system database. Many point-of-care systems do not include conventions that alert the user to specific sequencing requirements dictated by coding guidelines or specific conditions requiring two codes. The nurse or therapist using a point-of-care system or paper-based system to complete the OASIS may not consistently use the coding book to confirm the correct code assignment. If these clinicians reference a current coding book, they may not use the classification system correctly.

Upcoding can also be disastrous, but the problem is more likely due to this same lack of understanding about how to use the coding book. For example, clinicians are often surprised to learn that their coding book has three volumes. They may also be surprised to learn that the codes shown in brackets in the index indicate a sequencing requirement. Clinicians often mistake coding instructions to code first (shown in the tabular list in italics) to mean code the diagnosis as primary.

For example, ICD-9-CM coding guidelines instruct the user to code diabetes first when treating a patient with a diabetic leg ulcer. However, if that same patient also has a stage four pressure ulcer that requires the most intensive services, then 707.0, Decubitus ulcer, is the primary diagnosis, not diabetes. The PPS case mix recognizes initial secondary diagnosis in MO240 only for selected ICD-9-CM manifestation codes with additional points.

One major mistake agencies make is selecting the wrong primary diagnosis, which is the primary problem for which the patient is receiving services. The primary diagnosis in OASIS should match the diagnosis on the plan of care and the claim. Clinicians have to look at the overall picture and pick the appropriate diagnosis as the primary one. Clinicians may have to contact the patient's physician or referral source for additional information to assign and sequence ICD-9-CM codes correctly. This extra step to retrieve supporting documentation adds to service cost and can decrease clinician productivity but may be necessary if it leads to providing the services a patient needs with correctly assigned reimbursement.

Resolving Coding Conflicts

Discrepancies between official coding guidelines, historical home health coding practices, and the PPS reimbursement rules create other coding conflicts. The Centers for Medicare and Medicaid Services (CMS) released "Diagnosis Coding for Medicare Home Health under PPS" in September 2001. The purpose of this document is to assist home health agencies in understanding correct diagnosis coding practices for Medicare home health. The document is divided into three sections: information on general coding principles, with discussion on coding issues pertinent to home health; case scenarios; and frequently asked questions on diagnosis coding.

This document deserves a thorough reading and frequent study. Agencies should refer to it whenever they need to resolve coding conflicts. The online CMS Medicare news source, Medicare A Newsline, recently published a series of articles reviewing the direction from CMS plus additional claim examples.[2] Everyone involved in selecting the diagnosis or coding it should watch remittance advices for evidence of downcoding by their Medicare intermediary. According to a transmittal from

March 2001, remittance advices changed by medical reviewers are coded N72: "PPS code changed by medical reviewers. Not supported by medical records."[3]

Prohibiting V Codes

CMS has clearly stated that OASIS takes precedent when resolving coding conflicts. V codes are not allowed in any part of the OASIS assessment—they are allowed on the plan of care and the claim. Electronic claims transactions will be required to adhere to official ICD-9-CM coding guidelines under HIPAA. The National Association for Home Care, CMS, and AHIMA are participating in a work group assembled to create a coding crosswalk that will be needed when HIPAA transaction standards take effect.

The crosswalk will prevent home health providers from having to apply multiple sets of coding rules and report different ICD-9-CM codes on the claim and the OASIS assessment. The group will create a crosswalk from the codes for the acute condition currently being reported on OASIS to the appropriate V codes that should be reported for the encounter according to official coding guidelines.

This crosswalk is needed because it is difficult to measure clinical outcomes for outcome-based quality improvement based on V codes. For example, V55.3, Attention to colostomy, may describe the reason for home care but does not describe the reason for the colostomy. An agency might expect a different outcome from a patient with a colostomy after years of Crohn's disease and the patient with a colostomy due to a recent trauma.

Knowing the Basics

Whether a home health agency enlists professional coders, clinicians, or clerical staff to code patient diagnosis, nurses and therapists must know the basics about the ICD-9-CM classification system. Clinicians need to know how coding is done and what is important so that they provide the right information. Clinicians responsible for collecting OASIS data have to know the consequences of upcoding or downcoding. Use case scenarios from agency records or the 26 scenarios CMS provided in the Correct Diagnosis Coding Practices guidance.[4]

Be specific when considering training on the basics of ICD-9-CM. Break in-service training into palatable bites by focusing the lesson on specific data quality concerns. Agencies can't afford to let staff repeat coding mistakes. Further, all staff members should be able to consult an in-house coding expert on gray areas.

Notes

1. Health and Human Service Office of Inspector General Fiscal Year 2002 Work Plan—Center for Medicare and Medicaid Services, pp. 7-8. Available at the OIG Web site, http://oig.hhs.gov/publications/workplan.html.

2. CMS Medicare A Newsline 9, no. 6 (March 1, 2002). Available at www.iamedicare.com/provider/newsroom/newslines/2002/030102.pdf

3. "Remittance Advice and Medicare Summary Notice Messages for the Home Health Prospective Payment System." Transmittal AB-01-48, Department of Health and Human Services, Health Care Financing Administration, March 27, 2001. Available at www.hcfa.gov/pubforms/ transmit/ab0148.pdf.

4. Centers for Medicare and Medicaid Services. "Diagnosis Coding for Medicare Home Health Under PPS." September 26, 2001. Available on the CMS Web site at www.hcfa.gov/ medicare/hhdiag.rtf.

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Article citation:
Abraham, Prinny Rose. "ICD-9 Raises Concerns for Home Health Information Managers." *Journal of AHIMA* 73, no.5 (2002): 62-64.