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Home Health ICD-9/ICD-10 Alert

Coding How-To: How To Avoid 5 Common ICD-9 Errors

The dollars are in the details.

A surefire way to improve your reimbursement is to avoid giving money away unnecessarily, and foolproof diagnosis coding is the best way to bank the money you deserve.

Diagnosis codes are an important part of the Health Insurance Prospective Payment System (HIPPS) codes home health agencies use to bill Medicare for their services. If you're pressed for time when selecting codes, you may make an innocent mistake that will come back to haunt you.

Experts suggest checking the following common errors as you work toward improving coding accuracy:

Mistake #1. Inaccurate neoplasm coding. Don't code neoplasms only from the index, experts warn. In the alphabetical list, you'll find neoplasms listed by anatomical site, explains home health coding expert **Prinny Rose Abraham** with **HIQM** in Minneapolis.

But there are six possible code numbers for each site. You must code according to whether the neoplasm is malignant (primary or secondary), benign, in situ, of uncertain behavior or of unspecified nature. Also consult specific instructions in the coding guidelines in your book for sequencing neoplasms, she suggests.

Mistake #2. Ignoring "excludes" notes. If you use codes the ICD-9-CM system defines as mutually exclusive, you'll see returned claims and payment delays, says consultant **Lynda Dilts-Benson** with St. Petersburg, FL-based **Reingruber & Co**. For example, if you code both 332.0 (Parkinson's disease) and one of the 331 codes for dementia, your intermediary will return the claim for correction. With the new codes that took effect in October 2003, 332.0 excludes Parkinson's with dementia, which is now assigned 331.82 (Dementia with Lewy bodies).

Mistake #3. Not enough specificity or precision. Prevent future edits by coding to the highest level of specificity. Intermediaries already flag providers in some settings if they code more than 20 percent of claims with unspecified codes, and home care could also attract that kind of attention, experts warn. Using an unspecified code is often a habit, Abraham notes. Asking questions and requesting more information will help you be as accurate as possible - and will show the feds you take coding seriously.

Look carefully at the record to determine the precise diagnosis. Not all pneumonias are the same, Abraham warns. If the patient has pneumonia, you need to ask if it is viral or bacterial, what organism caused it and even if it is related to influenza, because each of these factors will require you to use a different code. And be careful with diagnostic terms that look similar, but have very different meanings, such as arthritis and arteritis.

Mistake #4. Misusing E codes. Never record E codes in M0230, experts warn. You should record them in M0240 if there is a trauma code in M0230. Remember, E codes are companion codes and specify the external cause of an injury, poisoning or adverse effect of a drug.

Mistake #5. Inadequate documentation. Even if your choice of the primary diagnosis code is accurate, your intermediary can downcode the claim - and pay you less - if the record doesn't include information sufficient to support the diagnosis, warns consultant **Pat Sevast** with **American Express Tax & Business Services** in Timonium, MD. If you choose a case mix diagnosis, it's even more important to check for the underlying documentation, experts say.

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