Codify
BY AAPC

Home Health ICD-9/ICD-10 Alert

Conquering Case Mix: You Could Be Losing Thousands in Coding Confusion

Conquering case mix is key to agency profitability

If only you could just worry about what the right code is for a specific disease - like coders in other settings - it wouldn't be so hard. But home health coding has the added headache of case mix, which provides additional reimbursement for some diagnoses but not others.

Home health coders must know and follow the rules under the prospective payment system and the Centers for Medicare & Medicaid Services' National Correct Coding Initiative, says certified coder **Joan Usher**, president of JLU Health Record Systems in Pembroke, Mass.

Home Health Coding's Role: Case mix drives the home health episode reimbursement as well as outcomes risk adjustment. It is a calculation derived from the answers to the OASIS questions, only a few of which involve ICD-9 coding. But diagnosis coding plays an important part in case mix accuracy, experts agree. And inaccurate case mix coding can be a significant drain on agency profitability.

When OASIS items M0230 (primary home care diagnosis), M0240 (initial secondary diagnosis) and M0245 (payment diagnosis) contain orthopedic, diabetic or neurological diagnostic group codes designated for extra payment, they can add points to the Home Health Resource Group.

Agencies receive more money for episodes in which the patient has one of the primary diagnoses listed on pp. 41195-41198 of the home health PPS final rule or one of the secondary diagnoses listed on pp. 41198-41201 of the July 3, 2000, Federal Register.

Example: If the agency is in the home to provide teaching and therapy for a recent exacerbation of multiple sclerosis, a primary diagnosis of 340 (Multiple sclerosis) may be appropriate, and it will add 20 points to the clinical severity score in the HHRG payment calculation. These 20 points can add about $600 to the episode payment.

But if you're in the home mainly to provide catheter care to a patient with multiple sclerosis, more than likely you are not primarily providing treatment for the MS, says consultant **Pat Sevast** with American Express Tax & Business Services in Timonium, Md. Even though MS gives you 20 points, "the purpose of home care in this episode may just be for V53.6 (Fitting and adjustment of urinary devices)," she says.

V Codes: One factor complicating home health coding has been the use of V codes beginning in October 2003. Before that date, V codes weren't allowed, and case mix calculations were developed without taking V codes into consideration, says **Prinny Rose Abraham**, a coding expert with Minneapolis-based HIQM Consulting.

Once the Health Insurance Portability and Accountability Act required providers to use ICD-9 coding correctly - including V codes - CMS had to figure out another way to capture case mix diagnosis information. It came up with M0245.

"Think of M0245 as the payment diagnosis," Abraham says. "It's really no more than a skip pattern." If you use a V code as the primary diagnosis in M0230 and the case mix diagnosis would have gone in M0230, you now put the case mix diagnosis in M0245 to make sure you get paid accurately.

Caution: Codes and medical records must agree. If you select a case mix diagnosis that is not supported by the record,

you lose when the regional home health intermediary downcodes your claim and denies payment or asks for its money back.

During the second half of 2003, regional home health intermediaries denied agencies more than $690,000 in reimbursement for "reduced HIPPS code due to incorrect diagnosis used," **Cahaba GBA** reports in its May 2004 state information denial summary.

But if you don't report a case mix diagnosis when you should - or forget to put it in M0245 - you lose, because the RHHI won't tell you it's wrong and you won't get paid.

Tips: Agencies should expect intermediaries to focus review efforts on the diagnoses that add points - and therefore reimbursement - to the case mix, Sevast says.
Some problems have already attracted CMS' attention, resulting in warnings to providers to pay special attention to these areas:

1. **Ignoring fourth or fifth digits.** "We see many fewer problems with this lately," says consultant **Melinda Gaboury** with Nashville, Tenn.-based Healthcare Provider Solutions, "so agencies are improving their coding."

2. **Coding diabetes unnecessarily.** One of the most common coding errors is coding diabetes as primary when the focus of care is actually other services. "Clinicians often see diabetes as the underlying reason for many other problems the patient has - everything from heart disease to pressure ulcers. Even if that's true, it doesn't make diabetes primary," Sevast says.

3. **Disregarding the underlying disease.** It is incorrect to use 344.61 (Cauda equina syndrome; with neurogenic bladder) instead of 596.54 (Neurogenic bladder NOS), unless the patient has a spinal cord injury, Cahaba GBA reminds coders.

4. **Misunderstanding muscle weakness.** Code 728.2 (Muscle disuse atrophy) is not appropriate for temporary weakness following a short hospitalization. Use it only when there is measurable muscle atrophy and a specific cause reflected in the documentation, Cahaba says. Instead use 728.87 (Muscle weakness).

5. Overusing 436 (Cerebrovascular accident). Most home care episodes do not deal with the initial course of the CVA and should be coded with the 438 series of codes describing late effects of the CVA, experts say. And if providers are only treating one aspect of the disease, that should be coded as primary instead, Cahaba says.

6. Using inaccurate trauma codes. Many clinicians mistakenly use 800- and 900-series trauma codes for surgical wounds and ulcers. This is becoming less common, experts say. To check on the accuracy of using a trauma code, determine whether there is an E code describing the accident or injury causing the wound. If the trauma code is accurate, there will be an E code explaining how it happened, Abraham says.