Codify
BY AAPC

MDS Alert

Coding: Resist Temptation to Refill Coffers Through Queries

Hint: Querying should not be used to massage a diagnosis code.

Portraying a resident's condition accurately on the minimum data set (MDS) is crucial for several reasons (See Reader Question, page 8, for more information).

Judy Wilhide Brandt, RN, BA, CPC, QCP, RAC-MTA, DNS-CT, principal for Wilhide Consulting Inc., in Virginia Beach, Virginia, warns nurse assessment coordinators (NACs) to avoid temptation for fraud.

Check out this scenario and understand why a small adjustment could have big, penalizing implications.

Be Wary in Your Queries

Querying providers is a crucial tool for nailing down accurate assessments, especially concerning diagnoses and other quantifiable aspects of a resident's condition. But Wilhide Brandt is concerned that some NACs may be tempted to query providers to massage a diagnosis into a condition that would be worth more reimbursement. Do not use a telephone order (TO) to make this happen.

She explains a question she recently received: "Isn't a fungal infection called mycosis which is B48.8, other specified mycosis (1 NTA). **We queried the provider and he said 'OK' (signed the TO)**. Our consultant said we could not use this diagnosis code because the hospital provider documented Candidal intertrigo, B37.2 (no NTA). Why can't we use mycosis?"

Wilhilde Brandt condemns this practice, noting that this can be considered fraud. She explains that the original diagnosis was noted by the hospital provider. "Do not go fishing in the NTA lists and try to fit something into some points. This is fraud. You are taking money that does not belong to you. It's a federal crime. Do not try to get your doctor, **who will sign anything you write**, to sign this," she warns.

Respect ICD-10 Coding Rules

Understanding some of the nuts and bolts of ICD-10-CM coding is important, especially now that ICD-10 diagnosis codes can constitute so much of a resident's care - and how much a facility is reimbursed for providing that care.

ICD-10 coding is incredibly specific, but some codes are available for situations where there isn't a dedicated code for a diagnosis or situation. In these cases, the code descriptor may include a phrase like "other specified ...."

"Other specified mycosis (B48.8), is only used if the provider specified the type of fungal infection but you don't have a code for it. We cannot do this if the infection is specified," she explains.

Don't Lean on Pandemic as a Reason for Fraud

"I think that now some places are not overrun with COVID, we are desperate for money and trying to come up with some. This is not the way," she says.

Massaging a diagnosis code may seem like a minor transgression, especially if you get a provider to sign off on the diagnosis you include, but the implications are enormous. The diagnosis justifies the diagnosis code and serves as the compass for the individual resident's care plan, etc. If you change the diagnosis code, you effectively change the diagnosis, even though that is not within anyone but the clinician's power, nor a privilege of any role beyond that of the clinician.

"This is very serious. If your software scrubber tells you to try it, do not listen. And for heaven's sake, do not just write a TO that you know your doc will sign to get "covered." This is laying a paper trail of fraud that **you** committed. Your doctor will fold like a cheap suit when deposed and you will be the fraudster, not them. They'll take a minor hit for mindlessly signing stuff but that won't be a fraud charge. Yours will," she warns.

Remember, this is just one example featuring one diagnosis. Don't worry about the specific code or situation here, just keep in mind the major takeaway: Adjusting a diagnosis code to garner more reimbursement is fraud, she emphasizes.

"Whatever the diagnosis, do not just try to make it into PDPM money by writing a TO, just because you can," Brandt Wilhide says.