

# ICD-9-CM Basics: Coding for Compliance

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## Why Develop a Coding Compliance Plan?



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## Why Develop a Coding Compliance Plan?

- Provides guidance in the form of formal policies/procedures from point of care to the billing statement on the claim form
- Provides documentation of the agency's intent to correctly report services
- **KEY to preventing coding errors and resultant reimbursement issues**

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### Why Develop a Coding Compliance Plan?

- Develop an database of consistent, accurate and reliable data
- Assure sound ethical coding practices
- Provide a reference in the event that coding practices are questioned
  - CONSISTENCY
  - CONSISTENCY
  - CONSISTENCY

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### Why Develop a Coding Compliance Plan?

- OIG sees coding & billing as biggest compliance risks for every health care provider
- OIG Compliance Guidance & settlements reflect:
  - General compliance education is required for all provider employees BUT... "additional focused training is recommended for those individuals in high risk areas, like coding and billing"

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## Why Develop a Coding Compliance Plan?

- Use as a basis for ongoing education and training of coding staff
  - Maintain records of education
  - Document attendance
  - Mandatory competency for coders on coding compliance plan
    - Serve as evidence coding staff is familiar with coding compliance plan

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## What Policies Should Be Included in a Coding Compliance Plan?

- Facility-specific documentation requirements
- Payer regulations and policies
- Contractual agreements for coding consultants and/or outsourcing services
  - There is no such thing as a 'cookie-cutter' compliance plan/manual!!

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## Components of a Coding Compliance Plan

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## General Policy Statement

- Commitment of the agency to code and report correctly
  - AHIMA's Standards of Ethical Coding

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## Source of Official Coding Guidelines

- Official ICD-9-CM Coding Guidelines
  - Developed by the "Cooperating Parties" for the ICD-9-CM
    - AHIMA
    - AHA
    - CMS
    - NCHS
- Coding Clinic for ICD-9-CM (AHA)
- Other "quasi-official" sources
  - OIG Compliance Program Guidance
  - CMS Coding Guidance
    - Local and National Coverage Determinations

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## NCD's and LCD's

- There are two coverage policies:
  - • National Coverage Determinations (NCD)
  - • Local Coverage Determinations (LCD)
- National Coverage Determinations Manuals describes whether specific medical items, services, treatment procedures, or technologies can be paid for under Medicare in accordance with title XVIII of the Social Security Act, and in Medicare regulations and rulings. The NCD is organized by categories, e.g., medical procedures, supplies, and diagnostic services.
- Local Coverage Determinations are developed to specify under what clinical circumstances a service is reasonable and necessary. They serve as an administrative and educational tool to assist providers in submitting claims correctly for payment

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## LCD's

- Available at FI's website
  - Include medical necessity information
    - ICD-9 codes that support medical necessity
      - Denials?
      - Palmetto
        - Physical Therapy
        - Occupational Therapy
        - Speech Therapy
        - Alzheimer's Disease

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## NCD's

- Manual is available at CMS' website
  - <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS014961>

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## Who is Responsible for Assigning Codes?

- NOTE: The ultimate responsibility for code assignment rests with the attending physician
  - Reimbursement for Certification, Recertification and Care Plan Oversight

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## What do You do When Clinical Information is Not Clear?

- How do you assign a code in these situations?
- How do you query the physician?
- Do you maintain documentation of this communication?

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What do You do When Clinical Information is Not Clear?

- CMS Issued a policy clarification regarding the use of physician query forms (TOPS 2001-06 issued 10/11/01)
  - Discusses CMS' position to allow the use of the physician query form to the extent that it provides clarification and is consistent with other medical record documentation. The document also clarifies that in conducting medical review for DRG validations, the PRO reviewer shall use his/her professional judgment and discretion in considering the information contained in a physician query form ALONG WITH the rest of the medical record.
    - -AHA Central Office

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How do You Handle Specific Coding Requirements?

- Which companies require CPT codes?
- Are there any payer-specific requirements?

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Which Coding Guidelines do You Use?

- Specifically, which sections of the coding guidelines apply to your setting?
  - **Home Care**
    - Section I
    - Section II
    - Section III
  
  - MO245 ONLY – CMS Guidance PRIOR to 10-1-03

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Principal/Primary Diagnosis –UHDDS

- “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”
  - Since the development of these data elements included in the UHDDS, the definition has been expanded to include...all ‘**non-outpatient**’ settings (acute care, short-term, long-term care, and psychiatric hospitals; **home health agencies**; rehab facilities; nursing homes, etc.)

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Primary/Principal Diagnosis – Home Care Specifics (MO230)

- **Principal/Primary Diagnosis**
  - Primary Diagnosis: may or may not be related to the patient’s most recent hospitalization BUT must relate to the services provided by the HHA.
  - If more than one diagnosis is being treated concurrently, select the one that represents the most acute condition and requires the most intense services.

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V-Code General Rules

- The use of V-codes is governed by ICD-9-CM Guidelines for Coding & Reporting
- If the patient has an acute condition relevant to the POC, continue to report the acute condition.
- V-codes may be used as the principal or secondary diagnoses.

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## V-Code General Rules

- Major use of V-codes in home care results when a person with a current or resolving disease or chronic long-term condition encounters the health system for specific aftercare of that disease or injury.
- If there is a complication such as an infection, that code would be the principal diagnosis – **not** the V-code.

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## V-Codes: Aftercare

- If a patient is admitted for surgical aftercare and the medical diagnosis is no longer applicable:
  - E.g., surgery eliminated the disease or the acute phase has ended, then a V-code for 'surgical aftercare' is generally appropriate

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## Case Mix MO Items – Clinical Severity

### Domain

- MO230/MO240/MO245 Primary diagnosis and secondary diagnosis (manifestation only)
- MO250 (IV infusion/Parenteral/Enteral Therapies)
- MO390 Vision
- MO420 Pain
- MO440 Wound/Lesion
- MO460 Most Problematic Pressure Ulcer (Stage)
- MO476 Stasis Ulcer
- MO488 Surgical Wound Status
- MO490 Dyspnea
- MO530 Urinary Incontinence
- MO550 Bowel Incontinence
- MO550 Ostomy
- MO610 Behavioral Problems

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Case Mix MO Items – Functional Status  
Domain

- MO650/660 Dressing
- MO670 Bathing
- MO680 Toileting
- MO690 Transferring
- MO700 Locomotion

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Case Mix MO Items – Service Utilization  
Domain

- MO175 Discharged from hospital/SNF/rehab facility within past 14 days
- MO825 Therapy threshold (10 or more rehab visits)

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Manifestation Codes

- Sometimes with ICD-9-CM, it takes more than one code to report a condition
  - The “Birth” of MO245b
  - These instances are clearly shown in the ICD-9-CM Manual
    - ALPHA INDEX – lists condition with manifestation code in brackets
      - Diabetic neuropathy
        - 250.6x AND [357.2]
      - TABULAR INDEX – lists manifestation in *italics*
        - “code first underlying disease”

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## Case Mix Diagnoses

- A primary/principal diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurologic or burns/trauma group for Medicare PPS case mix assignment.
  - May involve manifestation coding
  - V-codes CANNOT be used in case mix as there is no assignment of points to these codes
    - No change in this designation since 2000
      - (...to be continued)

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## Case Mix Diagnosis – MO245

- Inconsistent data
  - Crosswalk results
  - AHIMA, NAHC, CMS input
- HIPAA Requirements
- Revised OASIS (coding changes effective 10-1-03)

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## Case Mix Diagnosis – MO245

- EFFECTIVE 10-1-03, V-codes may be utilized in OASIS as follows:
  - V-code may be reported in M0230 or in M0240 (b) through (f);
  - If a V-code replaces a 'case mix' diagnosis in M0230, it indicates optional reporting of M0245
  - V-codes may not be entered in M0245(a) or (b) as the case mix does not assign any points to V-codes

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Official ICD-9-CM Rules for Assigning  
Principal/Primary Diagnosis

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Principal/Primary Diagnosis

■ **Codes for symptoms, signs and ill-defined conditions**

- Use only when a related definitive diagnosis has not yet been established

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Principal/Primary Diagnosis

■ **Two or more interrelated conditions – each potentially meeting the definition for principal diagnosis**

- EITHER may be sequenced first (unless circumstances of the admission, therapy provided, Tabular or Alpha index dictate otherwise)
  - “Maximization”

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## Principal/Primary Diagnosis

- **Two or more diagnoses that EQUALLY meet the definition for principal diagnosis**

- May use EITHER

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## Principal/Primary Diagnosis

- **Two or more comparative or contrasting conditions**

- "Either/or"
  - Code as if the diagnoses were confirmed
  - Sequence according to circumstances of the admission
    - If no further determination can be made as to which diagnosis should be principal, EITHER may be sequenced first

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## Principal/Primary Diagnosis

- **Symptom followed by a contrasting/comparative diagnosis**

- Sequence the SYMPTOM first
- All other comparative diagnoses should be listed as additional diagnoses

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## Principal/Primary Diagnosis

### ■ Original treatment plan not carried out

- Principal diagnosis is the condition which, after study, occasioned the admission - even if no treatment was provided

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## Principal/Primary Diagnosis

### ■ Complications of surgery or other medical care

- Complication is sequenced FIRST
- If code is from 996-999 category and the code is not specific enough to describe the situation, an additional code for the specific complication should be assigned

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## Principal/Primary Diagnosis

### ■ Uncertain diagnosis

- In home care, you cannot code uncertain diagnoses.
- Code only to the highest degree of certainty
  - NOTE: This guideline is applicable ONLY to short-term, acute, long-term care, and psychiatric hospitals

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Official ICD-9-CM Rules for Assigning  
Secondary/Additional Diagnoses

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Secondary Diagnoses

■ UHDDS Definition (which includes home care)

- "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay"

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Secondary Diagnoses

■ Previous conditions

- "If the provider has included a diagnosis in the final diagnostic statement such as the discharge summary or the face sheet, it should ordinarily be coded."
  - If resolved conditions or diagnoses or status post procedures are included that have no bearing on the current stay, such conditions are NOT to be reported and are coded ONLY IF required by hospital policy
  - History codes may be used as secondary diagnoses if the historical condition or family history has an impact on current care or consequences

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## Secondary Diagnoses

### ■ Abnormal findings

- Abnormal x-ray, lab, path reports, etc. are not coded and reported unless the provider indicates their clinical significance
  - QUERY the provider if he/she wants abnormal finds added
    - NOTE: This differs from outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider

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## Secondary Diagnoses

### ■ Uncertain diagnoses

- If the diagnosis documented at the time of discharge is qualified as 'probable', 'suspected', 'questionable', 'possible', or 'still to be ruled out', **DO NOT** code the condition as if it existed or was established
  - EXCLUSION NOTE: Only code these when in short-term, acute, long-term care, or psychiatric hospital setting

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## Secondary Diagnoses – Home Care Specifics

### ■ Secondary Diagnoses (home care specific): (MO240)

- Include NOT ONLY conditions actively addressed in the POC 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.
  - CC's
  - MedPar Data

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■ **From:** OASIS QandA [mailto:OASIS.QandA@UCHSC.EDU]  
**Sent:** Friday, August 22, 2003 10:58 AM  
**To:** Blevins, Ida  
**Subject:** RE: M0245

■ On 08/14/03, you asked again how to add the answer to M0245 on the HCFA 485. You stated you asked your FI and they were unable to answer you. CMS no longer requires agencies to use a specific form to document the Plan of Treatment. **The diagnosis listed at M0245 on the OASIS assessment form would be considered a pertinent diagnosis and should be identified on the Plan of Treatment.** As we explained before, we can only answer OASIS-related questions at this site. We cannot answer billing procedure questions. If your contact at the RHHI does not know the answer, they must use their internal resources to answer your questions.

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Secondary Diagnoses and Case Mix

■ **CMS Active Projects Report -Studies in Home Health Case Mix**

- Performance of the existing adjuster for long-stay patients
- Feasibility of an adjuster for supply costs
- Prediction of therapy costs and other approaches to accounting for high-cost therapy users
- Performance of additional diagnosis groups and comorbidities
- Miscellaneous refinements of existing diagnosis groups
- Time trends in OASIS item coding

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Secondary Diagnoses and Case Mix

■ **Potential Change in OASIS Regulations**

- Case mix points for certain diagnosis combinations (comorbidities)
- Include primary AND secondary diagnoses
  - Cancer
  - Blood disease
  - Cardiac disease
  - Pulmonary disease
  - GI
  - Psych
  - Wounds and/or skin lesions (other than trauma)

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### How do You Make Corrections?

- What is your policy/procedure for correction of inaccurate code assignments?
- How do you notify agencies to which the codes have been reported?
  - HAVEN/OASIS changes
  - Fiscal Intermediary requirements

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### How do You Audit Your Coding?

- What is your policy/procedure for auditing coding for accurate reporting?
  - Benchmarking
  - Number and type of records to be audited
  - Target proficiency rate
  - Severity of error
    - Inaccurate HHRG vs. data quality issue
  - Frequency of audits
  - Follow-up

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## What are the Qualifications Required of Coders/Auditors?

- Do you use credentialed staff only as coders and/or auditors?
- How many hours of CE are required annually?
- What type of corrective action plan do you have in place for inaccurate coding?

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- **From:** OASIS QandA [mailto:OASIS.QandA@UCHSC.EDU]  
**Sent:** Tuesday, July 01, 2003 11:40 AM  
**To:** Blevins, Ida  
**Subject:** RE: M0245 and HCFA 485
- On 06/18/03, you asked questions about using V-codes and the use of M0245. These are primarily billing questions which you should ask of your Regional Home Health Intermediary (RHHI).
- In answer to your first question, if a non-case mix diagnosis is inadvertently entered at M0245, it will be ignored. **Because coding issues can dramatically affect an agency's financial status, we encourage agencies to consult coding professionals (preferably with home health experience) for coding questions. Many agencies have recognized the importance of having someone available to them with adequate training and experience in coding to assist with such determinations. Leaving such decisions up to individual clinicians who are not trained coders may produce inconsistent decisions. Coding educational resources can be found on the web site for the American Health Information Management Association at <http://www.ahima.org>, and your Regional Home Health Intermediary (RHHI) may be able to provide some guidance.**

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## Do You Use Outside Coding Services?

- Require all outside services to sign agreement to following your coding compliance plan
- Indicate what happens if plan is not followed
- Who audits these people??

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## What are the Essential Resources Available to Coders?

- Have you identified which resources that you will have available for your coders?
  - ICD-9-CM – Official ICD-9-CM Coding Guidelines (book may be updated twice a year)
    - If you use an encoder, do you have code books, as well
      - Logic loops
  - Diagnosis Coding for Medicare Home Health Under PPS (MO245)
  - Case Mix Diagnosis Code List (7-3-2000 Federal Register)
  - AHA's Coding Clinic
  - CPT
  - HCPCS
  - FI's Training Manual
  - Local Coverage Determinations
  - WOCN Guidance
  - Dictionary/Anatomy References/Drug References

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## What's the Process for Coding New Procedures or Unusual Diagnoses?

- What do you do when you come across unusual situations?
  - Tracking responses to physician query
  - Incorporate into manual
  - Email responses from AHA, CMS, AHIMA, etc.
- Coding changes TWICE a year (effective 2005)
  - April/October
    - Guideline changes??

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## How Do You Identify Which Codes You Use for Statistical Purposes?

- Long-term current drug use?
- Nutritional counseling?
- Wound VAC?
- History of falls?
- Immunization status?
  - Data in / Data out

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What Do You Do When the Physician (or Nurse) Disagrees?

- Do you run these situations past your medical director?
- Who 'trumps' whom?

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Maximize Reimbursement?

- Do you have a statement indicating that you assign codes without purposefully maximizing reimbursement or assuring coverage?
  - HEADLINE NEWS
    - Corporate Integrity Agreements

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Do You Have Physician Documentation to Support Your Code Choices?

- Do any parts of the medical record 'stand alone'?
- Lab reports?
- Path reports?
- X-ray reports?
- OASIS?

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AHIMA Standards of Ethical Coding

- All coding compliance plans should include reference to AHIMA's standards of ethical coding
- [www.AHIMA.org](http://www.AHIMA.org)

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Do You Use Coding "Guidance Documents"?

- If so, include in compliance plan

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## Fiscal Intermediaries

- What are the fiscal intermediaries doing to assist the OIG in making sure we are all 'playing by the rules'?

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## Documentation Monitoring

- According to Palmetto GBA representatives at a recent annual home health update:
  - The key to Medicare coverage is adherence to the home health benefit through DOCUMENTATION
    - Provider must 'paint a picture' for the nurses, therapists, physicians who are reviewing our claims

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## FI Data Collection Process

- Additional Development Requests (ADRs)
- Focus Audits
  - Diabetic ulcers
  - Therapy threshold
  - Etc.
- Probe Audits

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## FI Documentation

- Coverage determinations are made based upon review of the plan of care, the OASIS and the clinical documentation submitted for review
- The beneficiary's health status and medical needs should be reflected in the plan of care, OASIS and clinical documentation

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## FI Denial Reasons

- Medical Review Downcode
- Non-receipt of medical records
- Documentation does not support the medical necessity of services
- Dependent services are denied based upon qualifying service denial
- Plan of care not signed/dated timely

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## Medical Review Downcodes

- Common problem areas identified in the past:
  - Primary diagnosis
  - Secondary diagnosis
  - Skin lesion/open wound
  - Pressure ulcer
  - Stasis ulcer
  - Surgical wound

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## How to Avoid MR Downcodes

- Be certain that clinical documentation does not contradict OASIS information
- Per PGBA: “Always consult with the physician to ensure the wound type is properly identified and coded accordingly”
  - Physician query

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## How to Avoid MR Downcodes

- Wound Care Flow Sheet
  - PGBA has developed a wound care flow sheet
    - Assists in identification and classification of wounds
    - Assists in differentiating between types of wounds
    - [http://www.palmettogba.com/palmetto/providers.nsf/AttachmentFrameAMA?OpenFrameSet&Frame=AttachmentBottom&src=/palmetto/providers.nsf/AttachmentsAMA/A992678E37BB947B85256E630075BC31/\\$FILE/Wound+Care+Flowsheet.pdf](http://www.palmettogba.com/palmetto/providers.nsf/AttachmentFrameAMA?OpenFrameSet&Frame=AttachmentBottom&src=/palmetto/providers.nsf/AttachmentsAMA/A992678E37BB947B85256E630075BC31/$FILE/Wound+Care+Flowsheet.pdf)
  - ICD-9-CM should reflect the appropriately identified type of wound

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## How to Avoid MR Downcodes

- Refer to CMS direction as to identification of
  - Principal/Primary diagnosis
  - Secondary diagnoses
  - Do not code a pressure ulcer as a burn/trauma or a diabetic wound as both diabetic and stasis
  - Ensure manifestation and etiology codes are used properly
  - Avoid use of ‘open wound’ code – unless the open wound is secondary to trauma

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## BE CONSISTENT!

- Whatever you choose to do, be consistent.
  - If you are audited, be prepared to stand behind your coding decisions
  - An up-to-date coding compliance plan/manual is KEY!

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## Thank You!



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## Website References

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  - <http://www.cahabagba.com/>
- Palmetto GBA
  - <http://www.palmettogba.com/index.html>
- OIG Work plan
  - <http://oig.hhs.gov/publications/workplan.html#1>
- OIG Compliance Program Guidance for Home Health Agencies
  - <http://oig.hhs.gov/authorities/docs/cpghome.pdf>

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- JustCoding.com
  - Coding Guideline Corner
- OIG Work plan 2004-6
- The Physician's Role in Medicare Home Health 2001, OEI-02-00-00620
- Corporate Compliance in Home Health – Establishing a Plan, Managing the Risks (by Far Rozovsky)
- CMS Active Project Report – 2006 edition @<http://www.cms.hhs.gov/ActiveProjectsReports>
- AHA Central Office <http://www.ahacentraloffice.org.news.asp>
- Basic ICD-9CM Coding 2006 (by Lou Ann Schraffenberger, MBA, RHIA, CCS, CCS-P)

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The only consistent thing...is change.

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