

Check out the agenda! Summit: Aug. 6-10 in Chicago

Join us for the **10th Annual Home Health Coding Summit** at the Westin Chicago River North, **Aug. 6-10**. This year's event will feature a briefing on the 2012/2013 code, guideline, case-mix and regulatory updates; disease-specific code training; hands-on exercises and real-life patient scenarios; approaches to consistent and accurate documentation; a comprehensive introduction to ICD-10 codes and guidelines; and much more! For more information, visit www.homehealthcodingsummit.com.

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Assumptions about acute conditions can lead to chronic incorrect coding

You can code acute conditions, such as acute gastrointestinal (GI) bleeds, in home health, but first you must verify the patient still has the condition.

The confusion for coders arises because physicians often will note acute conditions in their documentation because that's what they treated the patient for in the hospital. But the documentation doesn't clearly show whether the condition resolved, says Judy Adams, HCS-D, president, Adams Home Care Consulting, Chapel Hill, N.C.

"You don't want to automatically code it just because that was the reason they were in the hospital," Adams adds.

(see **chronic incorrect coding** on p. 6)

2012 Home Health Coding Professional Salary Survey Coding professionals report salaries on the rise, but so are workloads

Home health coding professionals earned slightly more this year than they did in 2010, but many also report being stretched by an increased workload as agencies try to do more with less.

The average coder's salary for 2011 was \$51,781, up 2.93% from \$50,307 in 2010, according to 327 respondents to *Diagnosis Coding Pro's* 2012 Home Health Coding Professionals' Salary Survey.

(see **salary survey** on p. 8)

Master complicated wound coding to avoid denials

The selection and sequencing of wound codes is contingent on knowing the ins and outs of a patient's wound, as well as the rules and guidelines surrounding each different wound type. When this resource-intensive care is coded accurately, you'll ensure proper reimbursement, but one mistake can cost your agency valuable case-mix points. Join home health coding expert Trish Twombly on **May 15, 1-2 p.m. E.T.**, as she shows you how to accurately code the most common wounds in home health. For more information, visit www.decisionhealth.com/conferences/A2244.

CMS delays ICD-10 implementation by one year, keeps ICD-9 freeze

Your agency has an additional year to prepare for the monumental shift to ICD-10. HHS released a proposed rule April 9 that would delay implementation of the ICD-10 code set until Oct. 1, 2014.

The delay may mean a lifting of the ICD-9 partial code freeze for Oct. 1, 2012, speculates Judy Adams, HCS-D, president, Adams Home Care Consulting, Chapel Hill, N.C.

However, HHS' proposed rule does not indicate any changes to the partial code freeze. But it's the ICD-9 Coordination & Maintenance Committee, not HHS, that has the final say on whether to lift or extend the freeze, Adams points out.

One thing that is certain is the partial freeze for ICD-10 will continue through Oct 1, 2015, said Pat Brooks, RHIA, ICD-9 Coordination & Maintenance Committee member and senior technical advisor for CMS' Hospital and Ambulatory Policy Group, during the April 16 American Health Information Management Assn. (AHIMA) ICD-10 Summit.

Why a one-year delay? HHS states its decision to delay is justified in part by problems during the switchover to 5010, the claims submission standard that is a crucial component of the transition to ICD-10.

Enforcement has been delayed twice, most recently through June 30 (*see brief on page 8*).

"We believe the change in the compliance date for ICD-10, as proposed in this rule, would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition by all industry segments," HHS says in the proposal.

At the same time, HHS indicates it has considered a two-year delay, but worries such a long time period would call into question the federal agency's commitment to implementing the new code set and dramatically slow the momentum of providers' preparations, the proposed rule states.

Editor's note: Comments on the proposal can be submitted at www.regulations.gov until 30 days after the rule's publication in the *Federal Register*, rather than the usual 60 days, HHS states. The proposed rule, published April 17, can be viewed at www.gpo.gov/fdsys/pkg/FR-2012-04-17/pdf/2012-8718.pdf.

HHS decided to shorten the comment period because there is "some urgency" to finalize plans for the ICD-10 transition, a CMS spokesman tells *Diagnosis Coding Pro*. — Steven Brust (sbrust@decisionhealth.com)

OIG finds coding errors in 20.2% of home health claims

Expect stepped-up scrutiny of your claims by payment and fraud contractors following a new report by the HHS Office of Inspector General (OIG) that found one-in-five home health claims are coded inappropriately.

More specifically, 10.4% of home health claims analyzed were upcoded and 9.8% were downcoded. The OIG estimated that upcoding led to \$278 million in improper Medicare payments, with downcoding costing agencies \$184 million in underpayments, according to the March 13 report, which analyzed 2008 home health claims.

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The report highlighted gastroesophageal reflux disease (GERD) as an example of a diagnosis often coded inappropriately or absent from claims when it ought to be included.

The problem: Diagnoses, such as GERD, reported on home health claims are not supported by documentation and not addressed in the patient’s plan of care.

It’s not enough to simply note the patient is taking medication for a condition such as GERD. “Although a beneficiary may be accurately diagnosed with a disease, it is appropriate to list it for payment purposes only when the plan of care addresses the condition,” the report says.

That means your plan of care has to reflect that the clinician is evaluating the patient for exacerbations, monitoring medication compliance or actively treating the patient for that condition, says Judy Adams, HCS-D, president, Adams Home Care Consulting, Chapel Hill, N.C.

Tip: Don’t fall into the trap of simply following a comorbidity list. There are no comorbidities to always code, Adams says. While there are conditions that almost always impact the plan of care, the same rule applies to all secondary diagnoses — you can’t code a diagnosis unless it’s identified and addressed in the plan of care.

Conversely, the report found claims where GERD was not listed as a payment diagnosis although there was “documentation on diet and medication education along with an assessment that specifically addressed the GERD diagnosis.” (*For more on coding GERD, see the March 2012 issue of CPH.*)

The high percentage of downcoded claims might reflect a trend by agencies to code a patient without looking at the plan of care or even before the plan of care has been developed, says Ann Rambusch, a Georgetown, Texas-based senior clinical associate with Fazzi Associates. In these cases, the coder completes the claim using some combination of a diagnosis list from the hospital, the OASIS and maybe a clinical note — documentation that, without the plan of care, may not paint a complete picture.

The plan of care establishes precisely what services and treatments your agency is providing for the patient and thus is essential to accurate coding, Rambusch says.

CMS will share the report’s findings with its contractors “to consider as they determine where to focus resources in the future,” the federal Medicare agency says in its response to the report. The enforcement effort will

employ the “innovative system of predictive analytics and other sophisticated analytic tools.”

To view the report, go to <http://oig.hhs.gov/oei/reports/oei-01-08-00390.pdf>. – Steven Brust (sbrust@decisionhealth.com)

? Ask the Expert

Dementia following CVA, diabetes and CAD, neurogenic pain

Question: *What is the correct code for dementia following CVA? And if the medical documentation makes the connection between the stroke and vascular dementia, what is the correct coding sequence?*

Answer: Let’s address these questions separately. In the first question, the type of dementia is not known. You’ll look up “Late, effect(s) of, cerebrovascular disease, with, cognitive deficits.” in the alphabetical index, as the dementia is a late effect of the CVA. That search will lead you to the correct code, 438.0 (Cognitive deficits as late effect of cerebrovascular disease).

In the second question, the documentation states the type of deficit — vascular dementia — that results from the CVA. Your coding must be completed to the highest level of specificity possible with the documentation available.

In the alphabetical index, a search of “Dementia, vascular” turns up code 290.40 (Vascular dementia, uncomplicated). Instructions in the tabular at subcategory 290.4x tell coders to “use [an] additional code to identify cerebral atherosclerosis (437.0).”

But category 437 (Other and ill-defined cerebrovascular disease) is reserved for inpatient use only, unless the individual has not suffered a CVA. In this case, coders are directed to category 438 (Late effects of cerebrovascular disease), so you’ll code this scenario as:

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a	Vascular dementia, uncomplicated	290.40	
M1022b	Cognitive deficits as late effect of cerebrovascular disease	438.0	

Question: *If the diagnosis statement says diabetes complicated by coronary artery disease (CAD), which diabetes mellitus code do you use?*

Answer: You should code 250.00 (Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled) and the appropriate code from 414.0x (Coronary atherosclerosis).

It's important to note the difference between "complication of" and "complicated by." CAD is not typically a manifestation or "complication of" diabetes mellitus. A subcategory does exist for diabetes with peripheral circulatory disorders (250.7x), but those codes are used for just that — peripheral circulatory disorders. The damage or disease is to the arterial blood vessels, usually in the feet, legs or hands due to the diabetes.

While CAD is not a manifestation or complication of diabetes mellitus, each disease process is a risk factor for the other and may complicate the other disease as a result. Cardiovascular disease is the leading cause of death in individuals with diabetes and so it is essential to control cardiac risk factors such as diabetes mellitus, obesity, smoking, hypertension, sedentary lifestyle and dyslipidemia. Blood sugar control and managing other major risk factors help prevent complications of heart disease.

Coder's note: The only assumption which can be made when coding complications and manifestations of diabetes mellitus is gangrene and osteomyelitis. The physician must state the etiology and manifestation for all other manifestations which may be caused by diabetes mellitus.

Documentation to watch for when coding diabetes mellitus with a manifestation include: "DM neuropathy"; "retinopathy due to DM"; "Chronic renal disease caused by DM"; "Diabetic ulcer." All of these examples clearly link the DM to the manifestation. If the coder is ever in any doubt about etiology/manifestation, the physician should be contacted for verification.

Question: *What is the correct code for neurogenic pain? The patient is a paraplegic due to heterotopic ossification and the pain is severe.*

Answer: Neurogenic refers to pain which originates in the nervous system or is related to functions of the nervous system. But if you look up "neurogenic" in the alphabetical index, there is no reference to pain. And if you look up "pain," you won't find neurogenic. There is, however, a listing at "pain, nerve NEC" that points coders to 729.2 (Neuralgia, neuritis, and radiculitis, unspecified).

It's important to note the "NEC" because a search for neuralgia (pain along the nerve), neuritis (inflamed nerve) or radiculitis (inflamed nerve root) will return many more specific codes.

There are also several excludes notes in the tabular at 729.2, so be sure to use the appropriate code if your documentation reflects those conditions. You also can contact the physician to see if they have a specific location for the neurogenic pain and then check to see if there is a more specific code.

Without mention of a specific site, you'll code this case as follows:

Primary and Secondary Diagnoses			M1024 Case Mix	
			3	4
M1020a	Neuralgia, neuritis, and radiculitis, unspecified	729.2		
M1022b	Paraplegia	344.1		
M1022c	Calcification and ossification, unspecified	728.10		

Editor's note: *The Ask the Expert answers were provided by Jean Bird, RN, HCS-D, COS-C, clinical coordinator at Gentiva in Fall River, Mass., and winner of the 2011 Home Health Coding Summit coding contest. Submit your questions to sbrust@decisionhealth.com.*

CB Coding Basics

Document terminal diagnosis, supporting co-morbidities for proper hospice coding

By Maurice Frear, HCS-D

There are two crucial pieces of information every coder needs to accurately code a hospice referral: a primary diagnosis that reflects the patient's terminal prognosis, and an up-to-date patient history that reflects the co-morbidities impacting the primary diagnosis.

That's true whether you're a coder at a home health agency that also provides hospice care, or you work for a stand-alone hospice agency.

Medicare coverage of hospice depends on the physician's certification that an individual's prognosis is a life expectancy of six months or less, if the terminal illness runs its normal course. Coders should refer to their Medicare administrative contractor's (MAC's) local coverage determination (LCD) to determine if the patient meets the clinical criteria for admission to hospice.

Once the terminal diagnosis has been established, documentation must support it. The MACs have reported insufficient documentation to support the terminal diagnosis as the top reason for hospice claims denials.

Documentation also needs to show the co-morbidities that impact the patient’s condition and support terminal status. The following co-morbidities should be coded, when appropriate, as they help support the patient’s prognosis of a life expectancy of six months or less, notes CGS Medicare, the home health and hospice MAC for Jurisdiction B, in an LCD (<http://tinyurl.com/CGSHospiceLCD>):

- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Ischemic heart disease;
- Diabetes mellitus;
- Neurological disorders — cerebrovascular accident (CVA), amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson’s;
- Renal failure;
- Liver disease;
- AIDS;
- Dementia; and
- Neoplastic disease

The following scenarios will help you navigate through hospice cases and accurately identify the patient’s terminal diagnosis and relevant co-morbidities.

Scenario: Lung cancer with multiple co-morbidities

A 78-year-old male, diagnosed by his physician as terminal, is admitted to hospice with the primary diagnosis of lung cancer. He also has metastatic disease to the liver, COPD, hypertension, stage 3 chronic kidney disease and CHF. The physician has noted that the patient has requested not to be resuscitated.

Primary terminal diagnosis: 162.9 (Malignant neoplasm of bronchus and lung, unspecified)

Other diagnoses:

- 197.7 Malignant neoplasm of liver, specified as secondary
- 496 Chronic airway obstruction, not elsewhere classified
- 403.90 Hypertensive chronic kidney disease, unspecified, with chronic kidney disease, stage III
- 585.3 Chronic kidney disease, stage III (moderate)

- 428.0 Congestive heart failure, unspecified
- V66.7 Encounter for palliative care
- V49.86 Do not resuscitate status

Rationale:

- The documentation and focus of care is related to the lung cancer. All other diagnoses listed are pertinent and help support the terminal prognosis of the patient.
- Use V66.7 to indicate the patient requires palliative care only.
- V49.86 “may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay,” the official coding guidelines say (Section I.C.18.d.3).

Scenario: Metastatic breast cancer to the liver

The patient is a 68-year-old female with a history of breast cancer that was treated with bilateral mastectomies, chemotherapy and radiation therapy. Recent hospitalization revealed a large liver mass. Biopsy shows adenocarcinoma with cells consistent with breast cancer. The patient, diagnosed by her physician as terminal, also has cognitive deficits from multiple CVAs and requires maximum assistance for ADLs. The physician has noted that the patient has requested not to be resuscitated.

Primary terminal diagnosis: 197.7 (Malignant neoplasm of liver, specified as secondary)

Other diagnoses:

- 438.0 Cognitive deficits as late effect of cerebrovascular disease
- V66.7 Encounter for palliative care
- V49.86 Do not resuscitate status
- V10.3 Personal history of malignant neoplasm of breast

Rationale:

- The liver metastases are the focus of care, as the patient was effectively treated for breast cancer in the past.
- Use V66.7 to indicate the patient requires palliative care only.
- V49.86 “may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay,” the official coding guidelines say (Section I.C.18.d.3).
- The adenocarcinoma cells are consistent with breast cancer, but that primary cancer is no longer receiving

treatment, so a personal history code (V10.3) is used.

Scenario: Alzheimer’s dementia

An 89-year-old female, diagnosed by her physician as terminal, is admitted with end stage Alzheimer’s dementia. She is non-communicative, has dysphagia, is bed-bound and has a stage IV sacral decubitus. The physician has noted that the patient has requested not to be resuscitated.

Primary terminal diagnosis: 331.0 (Alzheimer’s disease)

Other diagnoses:

- 294.11 Dementia in conditions classified elsewhere with behavioral disturbance
- 787.20 Dysphagia, unspecified
- 707.03 Decubitus ulcer lower back
- 707.24 Pressure ulcer stage IV
- V49.84 Bed confinement status
- V66.7 Encounter for palliative care
- V49.86 Do not resuscitate status

Rationale:

- Although the patient was admitted with end-stage

dementia of the Alzheimer’s type, instructions at subcategory 294.1 tell you to code the Alzheimer’s first, followed by the appropriate dementia code.

- Stage 3, 4 or unstageable pressure ulcers follow the same rules in hospice as they do in other home health settings. Because these ulcers may close but never heal, they should continue to be coded. Proper coding requires you to list both the site and stage.
 - Use V49.84 to indicate the patient is bed bound.
 - Use V66.7 to indicate the patient requires palliative care only.
 - V49.86 “may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay,” the official coding guidelines say (Section I.C.18.d.3).

About the Author: *Maurice Frear, HCS-D, has worked for Bon Secours of Virginia Home Health and Hospice since 2005. Prior to that, he served in the United States Navy for 30 years as an Independent Duty Hospital Corpsman.*

chronic incorrect coding

(continued from p. 1)

Acute conditions like GI bleeds typically are resolved by the time the patient reaches home health, notes Jamie Seghers, HCS-D, COS-C, medical coding manager, Amedisys, Baton Rouge, La. But coders can’t assume the condition is resolved either.

The only solution is that coders need to verify the status of the acute condition with the physician, adds Kathy Domenz, RN, BSN, HCS-D, Perfection Coding LLC, Arlington Heights, Ill.

If the physician confirms the patient’s acute condition is still present when the patient is sent home, you can code it as acute but make sure you have interventions in the plan of care for the acute diagnosis, says Cindy Watson, RN, case manager, Excelsa Health Home Care and Hospice, Greensburg, Pa.

Look for specific orders from the patient’s provider that support a plan of care for an acute condition. For example, the agency will be asked to perform hemocult blood tests (to determine the presence of blood in the patient’s stool) or hemoglobin and hematocrit tests (to see if the levels indicate the patient has anemia) if a patient is sent



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home with an acute GI bleed diagnosis, Adams says.

These diagnostic tests are “the only definitive way to know how active this bleed is,” she explains.

You would code acute GI bleed in home health as 578.9 (Hemorrhage of gastrointestinal tract, unspecified) in M1020/M1022.

However, if the GI bleed was resolved in the hospital, list the 578.9 diagnosis in M1010 (Inpatient diagnosis), then document it in the orders and goals, Seghers suggests.

Coder’s note: Not all acute conditions can be coded in home health. Coding guidelines dictate that acute CVA and acute fracture codes are used in acute settings only. Home health coders instead should use the appropriate late effect or aftercare code in these cases.

Don’t forget to code anemia with GI bleeds

A patient with an acute GI bleed may develop anemia, so remember to code the anemia as well if it is addressed in the plan of care.

The presence of tests to determine the patient’s hemoglobin and hematocrit levels in the plan of care indicates the patient has anemia. Probably 90% of patients who have suffered an acute GI bleed will suffer subsequently from anemia, Watson estimates.

Report code 285.1 (Acute posthemorrhagic anemia) if the physician has established that the anemia is a direct result of the patient’s acute GI bleed, Adams says.

Scenario: Acute GI bleed with anemia

A 64-year-old woman is discharged from the hospital and is admitted to home health following a hospital stay for an acute gastrointestinal bleed, the cause of which is not clear. The physician cauterized the site of the bleed but has confirmed the condition still hasn’t completely resolved. He has requested home health monitor for signs and symptoms of ongoing bleeding, including hemocult blood tests. The physician also has diagnosed anemia related to the GI bleed and ordered hemoglobin and hematocrit tests for monitoring.

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a	Hemorrhage of gastrointestinal tract, unspecified	578.9	
M1022b	Acute posthemorrhagic anemia	285.1	

Rationale:

- The GI bleed has not resolved according to the physician, therefore it is the primary reason for home health and should be coded in M1020.
- The physician has linked the anemia to the GI bleed, and the clinician will be monitoring the anemia through hemoglobin and hematocrit tests, so 285.1 should be reported as a secondary diagnosis

Scenario: Diverticulitis with blood in stool

A 73-year-old man is admitted to home health following a hospital stay for an acute gastrointestinal bleed caused by diverticulitis of the small intestine. The physician has confirmed the GI bleed still is not completely resolved. The clinician noted blood in the patient’s most recent bowel movement and the physician has ordered continued hemocult blood tests to monitor the GI bleed.

Warning: M1020 and physician’s F2F diagnoses should relate

Confirm your primary diagnosis with the physician in cases in which the physician’s acute hospital diagnosis doesn’t match the home health reason for care.

Home health agencies are responsible for ensuring that the primary diagnosis in M1020 reflects the reason for home care addressed in the physician’s face-to-face (F2F) documentation, and the nature of GI bleeds complicates that task.

Physicians often will document GI bleed in the face-to-face paperwork because that was the focus of care when they saw the patient in the hospital, says Ann Rambusch, a Georgetown, Texas-based senior clinical associate with Fazzi Associates.

If the GI bleed still is active when the patient comes to home health and there are interventions in the plan of care for treating it, then the primary diagnosis would be the acute GI bleed (see story, p. 1).

However, GI bleeds typically are symptoms of an underlying condition diagnosed by the time the patient reaches home health, Rambusch says.

In these cases, the focus of care in home health shifts to the underlying condition and that is what home health coders should list as primary, says Judy Adams, HCS-D, president, Adams Home Care Consulting, Chapel Hill, N.C. “So, if the reason for the GI bleed is diverticulitis or a neoplasm, then that may be more the focus because [the agency is] going to be teaching about that overall condition, teaching signs and symptoms of bleeding and what to do about it.”

Check the documentation for the underlying condition and, when necessary, contact the physician if you feel the physician’s face-to-face diagnosis doesn’t reflect the diagnosis in M1020 closely enough, she says (CPH, 9/11). – Steven Brust (sbrust@decisionhealth.com)

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a	Diverticulitis of small intestine with hemorrhage	562.03	

Rationale:

• When the cause of the GI bleed is identified, such as diverticulitis in this case, coders should use the most specific code (562.03) rather than a nonspecific code like 578.9, Adams says.

• Diverticulitis is listed under the Excludes note for category 578 (Gastrointestinal hemorrhage), so the blood in stool (578.1) is not coded separately.

Scenario: Resolved GI bleed caused by diverticulitis

A 70-year-old man is admitted to home health following a hospital stay for a now-resolved acute gastrointestinal bleed caused by diverticulitis of the colon. The physician has ordered hemoglobin and hematocrit tests for monitoring of anemia the physician has confirmed is related to the GI bleed.

The plan of care includes educating the patient on his diverticulitis, including what signs and symptoms to look for and what to do when those appear.

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a	Acute posthemorrhagic anemia	285.1	
M1022b	Diverticulitis of colon (without mention of hemorrhage)	562.11	
M1022c	Personal history of other diseases of digestive system	V12.79	

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Rationale:

• The gastrointestinal bleed has resolved so the focus of care is the anemia caused by the bleed. Therefore, 285.1 is listed as the primary diagnosis.

• Diverticulitis, the underlying cause of the GI bleed, is still an active condition, so 562.11 is listed as a secondary diagnosis.

• There is no specific code for personal history of gastrointestinal bleed, so code that instead to V12.7x (Personal history of diseases of digestive system), Adams says. A resolved GI bleed caused by peptic ulcer disease or colonic polyps can be reported using codes V12.71 (Personal history of peptic ulcer disease) or V12.72 (Personal history of colonic polyps), respectively, she adds. In this case, the underlying cause is diverticulitis, so use code V12.79.

– Steven Brust (sbrust@decisionhealth.com)

News brief

5010 enforcement delayed again: Providers have until June 30 before enforcement of the new 5010 claim submission standard begins, CMS announced March 15. As a result, providers who submit claims in the old 4010 format through June 30 will not be penalized.

While the 5010 standard's official compliance date was Jan. 1, CMS announced late last year that it would delay enforcement of the standard through March 31 (*CPH 1/12*). Now, the federal Medicare agency has decided to delay enforcement again, noting that "there is still a number of outstanding issues and challenges impeding full implementation."

salary survey

(continued from p. 1)

And the number of coding professionals who received a raise increased as well. More than 64% of home health coding professionals reported a salary increase from 2010 to 2011, with an average raise of 4.8%. That's up from the 49% of respondents who reported a year-to-year raise in our last survey (*CPH 2/10*).

The rebound in the number of raises "could reflect more agencies recognizing the value of coders to their organization and to getting accurate reimbursement,"

says Judy Adams, HCS-D, president, Adams Home Care Consulting, Chapel Hill, N.C.

But it could be coders are seeing these increases based solely on their years at the agency, she says. “Having been in the position for a while, the coders are more established and deserve to have a raise after being loyal to the company.”

More than 58% of survey respondents identified themselves as coders, coding coordinators or coding supervisors, while another 17% reported spending more than half their day performing ICD-9 coding-related responsibilities. These other home health coding professionals reported titles such as clinical supervisor/case manager, director of nursing/patient services and QA/QI director or coordinator, among others. *(For average salaries by title, see chart to the right.)*

Doing more, often with less

While salaries have risen slightly, coding professionals are being asked to increase their output as well.

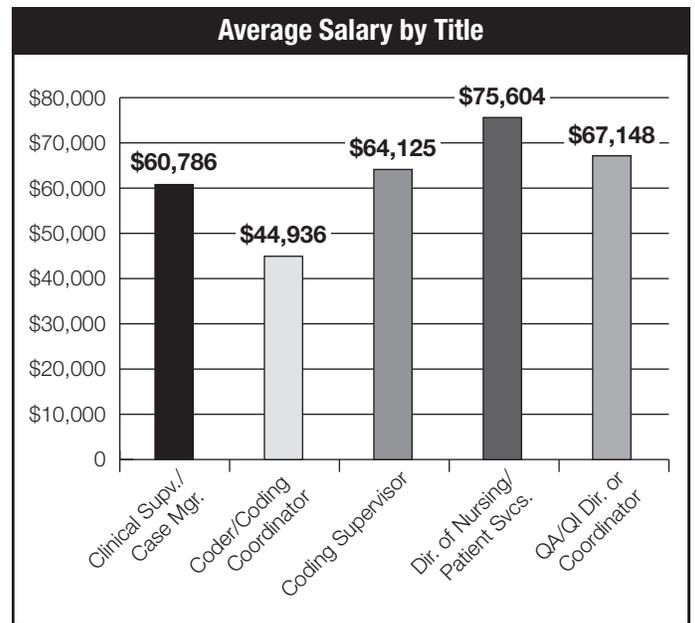
One mid-Atlantic agency pushed for all staff to increase productivity in the face of a growing daily census, a member of its in-house coding team reports. “They were trying to make do with the same number of coding staff,” explains the field clinician turned coder/OASIS reviewer. The coder, who also has a bachelor of science in nursing, requested anonymity so she could speak freely about her salary and workload.

But when that increase proved hard to come by, the agency allowed coding staff to work overtime, she says. The agency’s current productivity standard is 10 charts per coder each day, though the agency allows for some leeway based on meetings and other daily tasks, she adds.

At the end of the year, the coder received a merit raise that was consistent with raises throughout the agency. The raise brought her salary up to \$78,000, much higher than both the national average and the average in the mid-Atlantic region, which ranks first in average home health coding professional salary *(see map, page 10)*.

Doing more with less is a common theme, with more than 10% of respondents reporting staff reductions in the past year.

Pathways Home Health and Hospice decided not to replace a departing coder in 2011, leaving the two remaining coders to pick up the extra work, says Kaylin Chenault, HCS-D, clinical coding manager at the Sunnyvale, Calif. agency. Non-coding responsibilities such as auditing and filing were assigned elsewhere and now the coders simply code, she explains.



Each day, Pathways’ coders “enter diagnoses for upcoming admissions and resumptions based on the history and physical and what the physician has ordered,” says Chenault, who earns an above-average salary. They then “try to sequence it based on the orders and what it seems will be the focus for home health.” The clinicians then review the coding and approve it or note any changes that need to be made, she adds.

The rest of the day “is spent reviewing admissions, resumptions and recertifications that have already occurred,” Chenault says. The coding staff looks at the clinical notes, OASIS and plan of care to make sure everything is in sync with what was “pre-coded.” If there are discrepancies, the clinician or physician is contacted to verify the diagnosis or sequence, she explains.

Most coding professionals though juggle coding and non-coding responsibilities — nearly three in four report having job responsibilities aside from coding, with 58% reporting they have multiple other tasks to perform daily. These tasks range from payroll to auditing (41%) and completing the OASIS (29%).

Colleagues with benefits

Employment compensation doesn’t end with salary. Coding professionals report receiving a benefits package that includes:

- Health insurance (76%);
- Dental insurance (73%);
- 401K (67%);

- Vision insurance (62%);
- Life/Disability insurance (60%); and
- Certification/CEU cost assistance (59%).

Almost all — 95% — of survey respondents say they have at least one certification, and more than half (53%) say that earning or maintaining a coding certification is a condition of their employment. Coding professionals with an HCS-D certification earn \$53,083 on average, about 6% more than those who do not.

Coding professionals report that 62% of agencies paid part or all of their certification expenses, and another 9% were reimbursed after they passed.

Olathe (Kan.) Medical Center Hospice and Home Health created a new position based on her newly acquired HCS-D certification, says Rebecca Hayes, HCS-D, a coder at the agency. The job description and the increased salary — 20% higher than what she was previously making — recognize her as a certified coder, she explains.

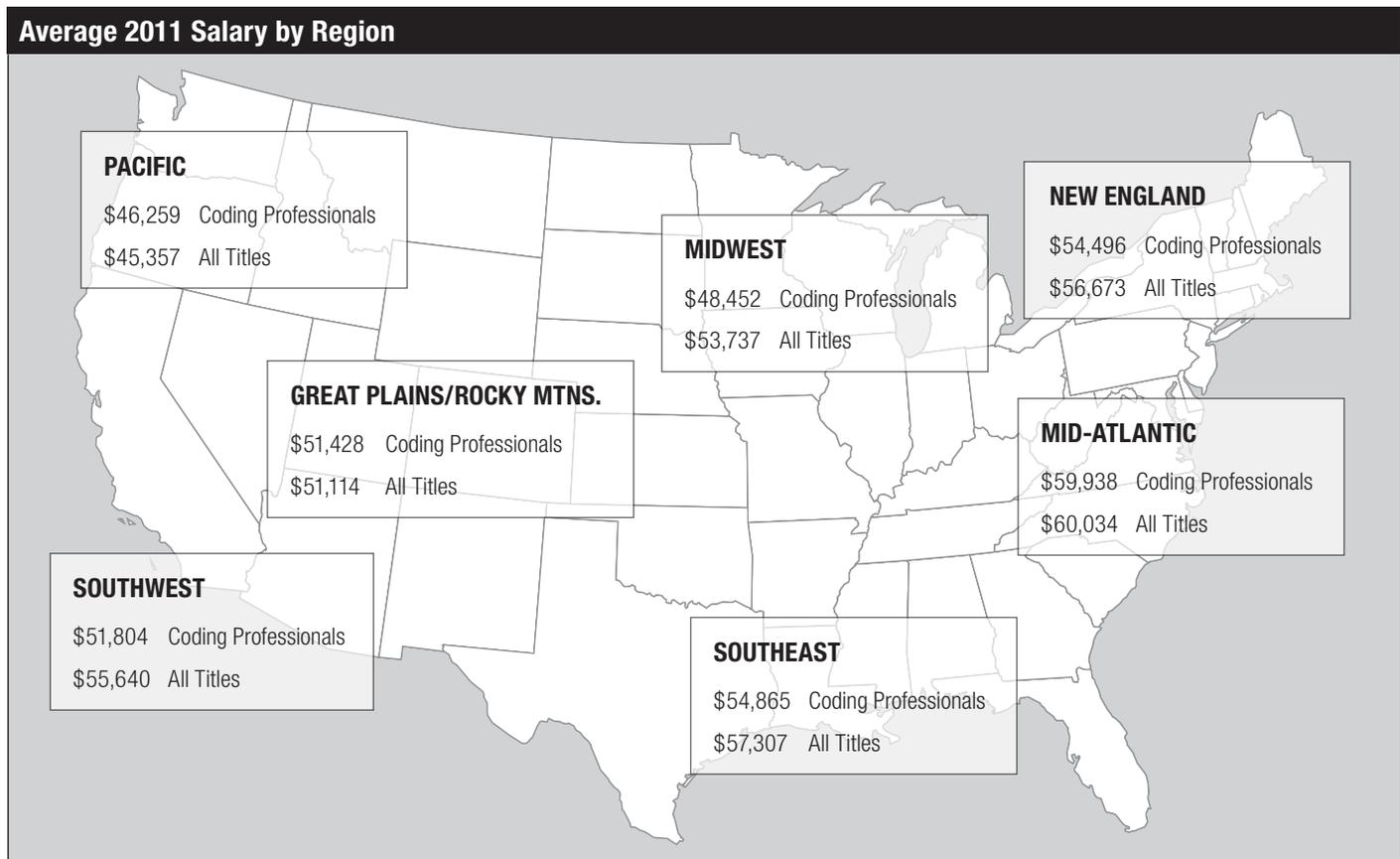
Editor’s note: Look for part 2 of our salary survey report, including more on job responsibilities and challenges, in an upcoming issue of *Diagnosis Coding Pro*. — Steven Brust (sbrust@decisionhealth.com)

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- **Be deemed as useful** to a home health clinician, coder or biller.
- **Fit appropriately with DecisionHealth’s mission** to help our customers operate efficiently to maximize their revenue.
- **Be suitable for electronic format.** Your idea can be a desktop application (runs stand alone in a desktop or laptop) or a mobile application (runs in smart phones and tablets).
- **Be unique.** Please search the Internet and more specifically, if submitting an idea for a mobile application, also search app stores like Apple® App Store or the Android™ Market.
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