Some Basics on ICD-10-CM

- Version 5010
- Index and Tabular List
- Some more specific information required
- Many of other conventions and guidelines are the same.
- Case mix and OASIS
- Coding Freeze

Coding and 7th Character Extensions

- 2 - 7 Numeric or Alpha
- Additional Characters
- Alpha (Except U)
- Category
- Etiology, anatomic site, severity
- Added code extensions (7th character) for obstetrics, injuries, and external causes of injury
Regarding all Coding Data Items

- The assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write in the diagnoses and a coding specialist may enter the actual ICD-9 codes once the assessment is completed. P and P should allow for correction or clarification of records to meet professional standards. It is prudent to allow for a p and p that includes correction or completion of a clinical record in the absence of the original clinician due to vacation, sick time or termination.
- This applies to M1010, M1016 and M1020/1022/1024.

M1012 Inpatient Procedures

CMS has determined that the data from M1012 is not currently used for payment, quality measure development, or risk adjustment. Therefore, effective immediately, any response reported for M1012 ("UK", "NA", or the reporting of procedures and codes) is acceptable to report, and the impact of the response is insignificant. **Note that at this time, the item cannot be left blank. 04/20/11**
No resolved conditions

Skilled services are used in judging the relevancy of a diagnosis to the POC and to the OASIS

Primary diagnosis
  ▪ Diagnosis most related to the POC
  ▪ Most acute diagnosis
  ▪ Chief reason for providing home care

Secondary diagnoses
  ▪ All conditions that existed at the time the POC was established, or which developed subsequently, or affect the treatment or care.
  ▪ Not only conditions actively addressed but also any co-morbidity affecting the patient’s responsiveness to treatment and rehab prognosis, even if the condition is not the focus of any home health treatment itself.
  ▪ Avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome.

Each diagnosis should be supported by medical record documentation (POC and comprehensive assessment)

Avoid assigning excessive V codes to the OASIS.

V codes are less specific to the clinical condition of the patient than are numeric diagnoses.

V codes are appropriately assigned when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (i.e., surgical aftercare or aftercare for rehab).
M1020/1022 Diagnoses and Symptom Control

Assessment Strategies

- Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician.
- Review current medications and other treatment approaches. Determine if add’l diagnoses are suggested by current treatment regimen, and verify this info with the patient/caregiver and physician.
- Use the current ICD-9-CM guidelines.

Additional Guidance from Appendix D

Formerly known as Attachment D

Some Selected Info from Appendix D

- Code only the diagnoses supported by the patient’s medical record documentation (i.e., the home health plan of care and clinical comprehensive assessment).
- If the diagnosis under consideration is not supported by the patient’s medical condition and clinical care needs, then the diagnosis must not be reported on the OASIS.
- If the patient has an acute condition relevant to the plan of care, continue to report the code for the acute condition.

Some Selected Info from Appendix D

- If there is a complication of medical or surgical care, such as infection or wound dehiscence, select a code specific to either complication rather than a V-code.
Some Selected Info from Appendix D

- No longer must always code a numeric diagnosis code in the optional case mix diagnosis M1024.
- Grouper will look to M1022 to award appropriate points
- Example:
  - V58.42 AC 174.9
  - 174.9 Breast ca

Some Selected Info from Appendix D

- Assign the underlying diagnosis to M1020 or M1022 only if the surgery did not eliminate the disease or the acute phase of the disease has not ended.
  - V58.73
  - 414.00 CAD after CABG

Some Selected Info from Appendix D

- When it is not appropriate to code a secondary numeric diagnosis code in M1022 (V code used but do not code underlying diagnosis):
  - If the acute diagnosis is no longer applicable (e.g., the surgery eliminated the disease or the acute phase has ended, or the acute code is a fracture code), then no [underlying] numeric code should be coded in M1022.

When To Use M1024 According to Appendix D #1

The V code that is primary replaces a case mix diagnosis that earns more points when primary from one of the following diagnosis groups:
- Diabetes
- Skin 1-Traumatic wounds, burns, and post-operative complications
- Neuro 1-Brain Disorders and Paralysis.
What about M1024?

Neuro 1

- Patient has primary brain cancer and has surgery to remove. Will have continuing treatment.

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare following surgery for neoplasm</td>
<td>V58.42</td>
<td>191.x Primary brain cancer</td>
</tr>
<tr>
<td>Primary brain cancer</td>
<td>191.x</td>
<td></td>
</tr>
</tbody>
</table>

Need in M1024 to avoid losing pts.

What about M1024?

Trauma Wound

Routine care of trauma wound after surgery-no complications

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC surgery injury/trauma</td>
<td>V58.43</td>
<td>891.0</td>
</tr>
<tr>
<td>Trauma wound</td>
<td>891.0</td>
<td></td>
</tr>
</tbody>
</table>

Complicated trauma wound (even if surgery)

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma wound</td>
<td>891.1</td>
<td></td>
</tr>
</tbody>
</table>

Use of M1024 (3) and (4)

- Patient has an amputation of his left leg (BKA) for diabetic peripheral angiopathy. Focus of the care is aftercare.

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>M1024(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020(a) ac surg circulatory</td>
<td>V58.73</td>
<td>250.70 DM with periph circ</td>
</tr>
<tr>
<td>M1022(b) diabetes with periph circ</td>
<td>250.70</td>
<td></td>
</tr>
<tr>
<td>M1022(c) peripheral angiopathy</td>
<td>443.81</td>
<td></td>
</tr>
<tr>
<td>M1022(d) Amputation status BKA</td>
<td>V49.75</td>
<td>250.70 diabetes with periph circ</td>
</tr>
</tbody>
</table>

250.70 peripheral angiopathy
**Lest you think...**

- Patient had a benign brain tumor removed. No further treatment required.

<table>
<thead>
<tr>
<th>M1020/M1022(a)</th>
<th>(b)</th>
<th>M1024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare following surgery for neoplasm</td>
<td>V58.42</td>
<td>225.0</td>
</tr>
<tr>
<td>Do not code benign brain tumor but may code history</td>
<td>V12.41</td>
<td></td>
</tr>
</tbody>
</table>

**When To Use M1024 According to Appendix D**

- Use M1024 if the underlying diagnosis to the V code is a case mix diagnosis and is not coded in M1022 because it is a resolved condition.

**What about M1024? Herniated disc**

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC MS system</td>
<td>V58.78</td>
<td>Herniated disc</td>
</tr>
<tr>
<td>Herniated disc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not coded here</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What about M1024? Gall bladder**

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC surgery digestive</td>
<td>V58.75</td>
<td>575.0 Acute cholecystitis</td>
</tr>
<tr>
<td>Do NOT code cholecystitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What about M1024?
Colon cancer

□ If still present

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC surgery neoplasm</td>
<td>V58.42</td>
<td>No need to use M1024</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>153.9</td>
<td></td>
</tr>
</tbody>
</table>

□ If cancer is resolved

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC surgery neoplasm</td>
<td>V58.42</td>
<td>153.9</td>
</tr>
<tr>
<td>History of colon cancer</td>
<td>V10.x</td>
<td></td>
</tr>
</tbody>
</table>

How To Use M1024
According to Appendix D

□ Use M1024 if the underlying diagnosis to the V code is a fracture and is not coded in M1020/M1022 because coding acute fractures when no “active treatment” is being provided is not allowed.

What about M1024?
Fracture

Receiving aftercare for fracture of hip

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare for healing fracture of the hip</td>
<td>V54.13</td>
<td>820.8</td>
</tr>
</tbody>
</table>

Fracture codes are not allowed in M1020/M1022

When Medicare’s plan doesn’t work...

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare following surgery for neoplasm</td>
<td>V58.42</td>
<td>172</td>
</tr>
<tr>
<td>Melanoma</td>
<td>172</td>
<td></td>
</tr>
</tbody>
</table>
Other Comments

- Medicare is only considering a diagnosis a case mix diagnosis if it meets the criteria in Table 2A.
- Creates additional problems.
- For now, this is a preferred method and not a requirement.
- Look for this being the rule rather than the exception in the future.

Primary and Secondary Diagnoses

- As stated in OASIS C instructions
- The difficult parts:
  - Choosing the correct primary diagnosis
    - Focus of care is not always the first listed diagnosis
  - Choosing what is appropriate as secondary
    - Documentation requirements

Secondary Diagnoses

- Certain co-morbidities always should be coded if part of the patient’s record because they are considered to always impact the care even in the absence of documented active intervention:
  - Diabetes
  - HTN
  - Chronic diseases such as Parkinsons
  - COPD
  - Blindness
  - Status amputation
  - PVD
  - CAD, CHF
  - History of malignant neoplasm when care is directed at a current neoplasm or otherwise impacts

Source: Coding Clinic, published by the AHA
Newest Info On Comorbidities

- All diagnoses must be supported by interventions and goals.
  - A medication on the med list is not enough intervention.
- Lots of misinformation as to the number of diagnoses there should be.
- Version 5010—up to 25 diagnoses

The Rules--Etiology/manifestations

- Buddy codes—have to be sequenced together with etiology preceding the manifestation
- Conventions
  - Alphabetical index two codes with second one within [italicized brackets] called manifestation
  - Tabular List: Code title in italics (a code in italics in the tabular may NEVER be coded without its cause preceding it).
  - Tabular List: Code first underlying condition at manifestation
  - Tabular List: Use additional code to identify manifestation (not always) at etiology

Conventions

- “With”
  - The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetical Index, or an instructional note in the Tabular List.
  - “Not necessarily a cause and effect relationship but could be”

Etiology/manifestations--Examples

- Diabetic polyneuropathy
  - 250.60 diabetes with neurological manifestations
  - 357.2 polyneuropathy in diabetes
**Warning!**

- If there is no documentation that the two conditions are related, then do not code them as etiologies/manifestations.
- Diabetes *and* polyneuropathy
  - 250.00 Diabetes without mention of manifestations
  - 356.9 idiopathic polyneuropathy
  - These can be in any order!!!!

**The Rules—Use additional code and Code, if applicable, causal condition first**

- Code as buddy codes together, when information is available as to causal condition. (teenage buddies)
- Conventions
  - Alphabetical index--Appear as etiology and manifestation codes with second code in *italicized brackets*.
  - Tabular List: Code, if applicable, causal condition first (not always)
  - Tabular List: Use additional code to identify manifestation as: (generally only at diabetes)

**Examples**

- **Diabetic ulcer**
  - Appear as manifestation in alphabetical index  250.8 [707.15]
  - At 250.8, states to use additional code…
  - At 707.1 (not in italics), states to code first, if applicable, causal condition first.
  - Has to be coded
    - 250.80
    - 707.1x if diabetic ulcers are documented.

- **Diabetic gangrene**
  - Appear as manifestation in alphabetical index  250.7 [785.4]
  - At 250.7, states to use additional code…
  - At 785.4 (not in italics), states to code first, if applicable, associated condition.
  - Has to be coded
    - 250.70
    - 785.4 if diabetes and gangrene are present and no other cause of the gangrene is documented.
Quiz

Choose the answers that meet the definition of manifestation coding.
- A) 821, 781.2
- B) 250.70, 443.81
- C) 428.0, 514
- D) 250.00, 585.3
- E) 714.0, 357.1
- F) 682.2, 041.11

Bonus: Which of the above are not allowed in home care coding?

Rule--Use additional code and Code first in tabular and guidelines

- Hypertensive chronic kidney disease
  - Assumed relationship between HTN and CKD. Cause is coded preceding the CKD.
  - 403 states to use additional code for CKD.
  - CKD states to code 403 (or 404) first.

- Hypertensive heart disease
  - Relationship between HTN and heart disease must be stated or implied by the physician. If stated or implied, cause is coded preceding the heart failure.
  - 402 states to use additional code for heart failure.
  - 428 states to code 402 (or 404) first.

- Pressure Ulcers
  - Guidelines state to code the location and then the stage
  - 707.0 states to use additional code for stage (707.2).
  - 707.2 states to code first site (707.0).
The Rules—Use additional code

- Use the additional code as a secondary diagnosis if information is available.
- Sequencing of the additional code is somewhat discretionary.
- What makes sense?

Use Additional Code

- CC Clarification: “It is not necessary to report the code identified in a “use additional code” note in the diagnosis field immediately following the primary code. There is no strict hierarchy inherent in the guidelines, nor in the ICD-9-CM classification, regarding the sequencing of secondary diagnosis codes.”

Use additional code--Examples

- Infected colostomy states to use additional code for cellulitis.
- Cellulitis states to use additional code for the causative organism.
- The infected colostomy has to precede the code for cellulitis. It makes sense to use the causative organism after the cellulitis code.
  - 569.61 infected colostomy
  - 682.2 cellulitis abdomen
  - 041.11 Staph aureus

Use additional code--Examples

- V54.81, aftercare following joint replacement, states to use additional code to identify the joint replaced.
- Where you place the V43.6x code is discretionary as long it is coded after the V54.81. It will still make sense.
Use additional code--Examples

- Diabetes at 5th digit ‘0’ and ‘2’ states to use additional code for insulin use (V58.67).
  - Where does that have to go???
- Obesity codes state to use additional code for BMI (V85)
  - Where does that have to go?

Coding Guidelines: Late Effects

- Coding Guidelines effective Oct 1, 2011
- Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.
- Exceptions to the above guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) or the classification instructs otherwise.

Rule—Late Effects

- General rule is to code condition or nature of the late effect (condition produced) followed by the late effect.
  - Patient has spastic hemiplegia of the dominant side as a result of a head injury.
  - 342.02 spastic hemiplegia, dominant side
  - 907.0 late effect of head injury

Rule—Late Effects

- CVAs are also an exception to the general rule (expanded to include the manifestation).
- Combination codes include the cause (late effect) and condition produced in one code.
- Some combination codes require an additional code to provide more information. See 438.5, 438.6, 438.7, 438.82, etc.
- Use additional code means what?
- What makes sense?
Rule—Late Effects

- Classification indicates otherwise.
  - 326 and 310.81
- If the condition produced happens to be coded with a manifestation code, it cannot be coded before the late effect code.
  - Patient has osteopathy as a late effect of polio.
  - 138 late effect of polio
  - 730.7x osteopathy of polio

Classification indicates otherwise

- 310.81 Pseudobulbar affect due to organic brain disease states to code first the late effect of head injury code.
  - 907.0 Late effect intracranial injury
  - 310.81 Pseudobulbar affect

Rule—Sequencing V Codes

- Aftercare codes are generally coded first.
- Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

Sequencing V Codes--Example

- Patient is to receive aftercare following surgery for cancer of the colon. Orders include dressing changes on the surgical wound and teaching colostomy care. Other diagnoses include diabetes and CHF.
**Discretionary Sequencing**

<table>
<thead>
<tr>
<th>V58.42 AC neoplasm</th>
<th>V58.42 AC neoplasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>153.9 cancer of the colon</td>
<td>V55.3 attention to colostomy</td>
</tr>
<tr>
<td>250.00 diabetes</td>
<td>V58.31 dressing changes</td>
</tr>
<tr>
<td>428.0 CHF</td>
<td>153.9 cancer of the colon</td>
</tr>
<tr>
<td>V55.3 attention to colostomy</td>
<td>250.00 diabetes</td>
</tr>
<tr>
<td>V58.31 dressing changes</td>
<td>428.0 CHF</td>
</tr>
</tbody>
</table>

**Rule—V57**

- When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis.
- Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter.
- These codes should not be reported if they do not meet the definition of principal or first-listed diagnosis.

**And then what does CMS say?**

- **Primary**—chief reason for home care (but still have to follow coding guidelines)
- **Example:** Cancer is the focus of care but the cancer is in a transplanted organ.
  - 996.8x Complication of transplanted organ
  - 199.2 Cancer assoc with a transplanted organ
  - Then the cancer code!!

- **Secondary or other diagnoses are those that require active intervention or will affect the patient’s responsiveness to treatment and rehab prognosis, even if the condition is not the focus of any home health treatment itself.**
- **How does that secondary diagnosis impact your care?** Document that in the comprehensive assessment and POC.
And then what does CMS say?

- Other than the specific sequencing rules such as those we’ve covered, sequencing of secondary diagnoses is discretionary.
- Guidance: List the secondary diagnoses to best reflect the seriousness of the patient’s condition and to reflect the disciplines and services provided.
  - No requirement to code in order of degree of symptom control
- Guidance: Avoid excessive use of V codes (especially in M1020 and M1022s).

The Secret to Sequencing

- Shhhhh…don’t tell anyone…
- Read the Official Coding Guidelines for specific coding conventions regarding sequencing and specific guidelines for sequencing certain other diagnoses.
- Read and follow the instructions in the tabular list regarding sequencing.
- When discretionary, use common sense.

Diabetes as a Case Mix Code

- Diabetes has points for primary and points for secondary but you cannot get both on the same episode.
- Diabetes diagnostic category includes all 250, 357.2, 362.01, 362.02 and 366.41
- Secondary diabetes (249) is not case mix.
Diabetes Case Mix

<table>
<thead>
<tr>
<th>Primary Diagnosis = Diabetes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>13</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

| Other Diagnosis = Diabetes | 3 | 5 | 1 | 5 |

Diabetes 5th digit

- Default is ‘0’
- The majority of diabetics are Type 2
- If Type 2 or unspecified type diabetes, use ‘2’ only if the physician says the diabetes is uncontrolled.
- Variation in blood sugars doesn’t make the diabetic uncontrolled.
- Acceptable—out of control
- Not acceptable—poorly controlled, brittle, severe
- ICD-10—Uncontrolled not a concept

Diabetes 5th digit--250

- Type 1 diabetics have no ability to produce insulin. They are dependent on insulin for survival, hence “insulin dependent”
- If referral states IDDM, you need to clarify with the physician what type of diabetes
- Do not use 5th digits 1 or 3 unless the physician designates that the patient has juvenile or Type 1 diabetes.
  - Only 5-10% of diabetics and even rarer in a Medicare population

Diabetes 5th digit--249

- 0—not stated as uncontrolled
- 1—uncontrolled

- Same rules apply when choosing the 5th digit regarding the definition of uncontrolled
V58.67—Long term use insulin

- If Type 2 or unspecified type of diabetes or secondary diabetes and the patient takes insulin, use V58.67 as a secondary diagnosis.
- NO need to use V58.67 with Type 1 diabetic.
- NEVER primary.
- Sequence at the bottom of the list.

Diabetes 4th Digits

- The 4th digit is used to identify the type of complication or manifestation associated with diabetes.
- There may be multiple 250 (or 249) codes if there are multiple types of complications/manifestations.
- Medicare is particular about the correct 4th digit being used.

4th Digit Diabetes

- Always code the manifestations under the diabetes code.
- Even though diabetes may be the number one cause of a problem or is a major cause of a problem, the only manifestations that can be assumed are gangrene and osteomyelitis. Others need physician confirmation.

Diabetes 4th Digit 0

- If there are multiple 250 codes, 250.0x cannot be one of them.
- Never code 4th digit ‘0’ when also coding a manifestation of diabetes.
- What’s wrong with these?

<table>
<thead>
<tr>
<th>250.02 DM w/o manif</th>
<th>250.02 DM w/o manif</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.72 DM w circ</td>
<td>357.2 polyneuropathy</td>
</tr>
<tr>
<td>785.4 gangrene</td>
<td>785.4 gangrene</td>
</tr>
</tbody>
</table>

- (Same rule applies to 249)
- ICD-10-CM: Most diabetic manifestations are combination codes.
Diabetes Mellitus in ICD-10-CM

- Inadequately controlled Type 2 diabetic with gangrene. Takes insulin.
- E11.52 Type 2 DM with diabetic peripheral angiopathy with gangrene
- E11.65 Type 2 DM with hyperglycemia
- Z79.4 Long term use insulin

Diabetes with Manifestations

<table>
<thead>
<tr>
<th>Renal</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmic</td>
<td>5</td>
</tr>
<tr>
<td>Neurological</td>
<td>6</td>
</tr>
<tr>
<td>Circulatory</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>

4th Digit (4) Renal Manifestations

- Code Type 1 diabetes causing CKD Stage 4
- Code Type 1 uncontrolled diabetes and CKD Stage 4

Answer

- 250.41 diabetes, type 1, with renal manifestations
- 585.4 CKD Stage 4
- 250.03 diabetes, type 1, uncontrolled, no mention of complications
- 585.4
4th Digit (5) Ophthalmic Manifestations

- Diabetic patient has glaucoma
- Patient has diabetic macular edema
- BTW, if coding glaucoma on or after October 1, you have to add the stage code with a 365.7x code (only applies to certain glaucoma codes).

Answers

- 250.00 Diabetes without mention of complications
- 365.9 Glaucoma, NOS
- 250.50 Diabetes with ophthalmic manifestations
- 362.07 diabetic retinal edema
- 362.01 diabetic retinopathy

4th Digit (6)

- 250.6—diabetes with neurological manifestations
  - Difference between polyneuropathy 357.2 and peripheral autonomic neuropathy 337.1
  - Difference in how points are calculated
  - Code Diabetic polyneuropathy
  - Code Diabetic gastroparesis
  - Now what if they have both?

Answer

If both are present:

- 250.60 Diabetes with neurological manifestations
- 357.2 polyneuropathy
- 536.3 gastroparesis
- 337.1 also may be coded
4th Digit (7)

- 250.7—Diabetes with peripheral circulatory disorders
  - Gangrene is assumed to be a complication of diabetes unless otherwise stated by the physician
  - Patient has diabetes with gangrene toes 250.70, 785.4
  - Gangrenous pressure ulcer (Stage 3) for a patient, who also has diabetes.
    - 707.0x, 707.23, 785.4, 250.00
    - Look up decubital gangrene.
  - Code uncontrolled diabetes with diabetic PVD

Answer

- Uncontrolled diabetic with diabetic PVD
- 250.72 diabetes, type 2 or unspecified, uncontrolled with peripheral circulatory disorder
- 443.81 peripheral angiopathy

4th Digit (8)

- 250.8—Diabetes with other specified manifestations
  - Diabetic hypoglycemia
  - Diabetic ulceration
  - Diabetic bone changes
    - Osteomyelitis is assumed to be a complication of diabetes unless otherwise stated by the physician
    - Takes 3 codes 250.80, 731.8, 730.xx

Diabetes with ulcers (8)

- Arterial, neuropathic and other etiologies including infection, pressure, and muscular atrophy and bone changes
- If the doctor documents diabetic ulcer related to arterial, then MAY code 250.70, 707.1x
- If the doctor documents diabetic ulcer related to neuropathy, then MAY code 250.60, 707.1x
- Otherwise diabetic ulcers are coded with 250.80, 707.1x
- What impact on supplies?
  - Same with 249.80, 707.1x
What if the ulcer is described as?:

- Diabetic atherosclerotic ulcer (on the calf)
  - 250.70
  - 440.23
  - 707.12

Neuropathic Ulcers

- Typical neuropathic ulcer results from DM peripheral neuropathy and is:
  - Painless
  - Surrounded by callus
  - Associated with good foot pulses (as long as there are no arterial complications)
  - At the bottom of the foot and tips of toes
- Ulcers in ICD-10: coded as to severity

Multiple Manifestations of Diabetes

- The patient has multiple diabetic ulcers on the toes, diabetic retinopathy and stage 3 chronic kidney disease due to diabetes. Focus of care is the ulcers.

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020(a) diabetes with other specific</td>
<td>250.80</td>
</tr>
<tr>
<td>M1022(b) ulcer</td>
<td>707.15</td>
</tr>
<tr>
<td>M1022(c) diabetes with ophth manif</td>
<td>250.50</td>
</tr>
<tr>
<td>M1022(d) diabetic retinopathy</td>
<td>362.01</td>
</tr>
<tr>
<td>M1022(e) diabetes with renal manif</td>
<td>250.40</td>
</tr>
<tr>
<td>M1022(f) CKD Stage 3</td>
<td>585.3</td>
</tr>
</tbody>
</table>

Sequencing Example

- What if the patient also has CHF and COPD that require intervention? Which of the diagnoses in the scenario require active intervention and which ones are just co-morbidities that may impact the care?

<table>
<thead>
<tr>
<th>(1)</th>
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</thead>
<tbody>
<tr>
<td>M1020(a) diabetes with other specific</td>
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<tr>
<td>M1022(b) ulcer</td>
<td>707.15</td>
</tr>
<tr>
<td>M1022(c) CHF</td>
<td>428.0</td>
</tr>
<tr>
<td>M1022(d) exacerbation of COPD</td>
<td>491.21</td>
</tr>
<tr>
<td>M1022(e) diabetes with ophth manif</td>
<td>250.50</td>
</tr>
<tr>
<td>M1022(f) diabetic retinopathy</td>
<td>362.01</td>
</tr>
<tr>
<td>OPDx</td>
<td>369.20, 250.40, 585.3</td>
</tr>
</tbody>
</table>
How do you code aftercare of an amputation?

- V54.89
- Diabetic ulcer
- Diabetic peripheral angiopathy
- Diabetic osteomyelitis
- Diabetic gangrene
- Ran over the toes with the lawn mower
- If a V code (as primary) replaces diabetes, then consider placing diabetes in M1024 with its manifestation in M1024(4).
- But what if the amputation is complicated?

Amputation site (BKA) is infected with MRSA after amputation for diabetic angiopathy

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M1020(a) Infected amputation site</td>
<td>997.62</td>
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<tr>
<td>2</td>
<td>M1022(b) MRSA</td>
<td>041.12</td>
</tr>
<tr>
<td>3</td>
<td>M1022(c) Diabetes w/ circ disorder</td>
<td>250.70</td>
</tr>
<tr>
<td>4</td>
<td>M1022(d) Peripheral angiopathy</td>
<td>443.81</td>
</tr>
<tr>
<td>5</td>
<td>M1022(e)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>M1022(f)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>OPDx</td>
<td></td>
</tr>
</tbody>
</table>

Answers

- Aftercare code not used
- Amputation site status not used
- Dressing change code not used
- BTW, if the amputation site is dehisced, then 997.69 is primary
- Dehiscence is coded before infection
- What makes an amputation complicated?
Secondary Diabetes—249

- Neither Type 1 nor Type 2
- Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).
- Diabetes caused by pancreatectomy is coded with 251.3

Pancreatic Transplant

- The patient is receiving aftercare after a pancreas and kidney transplant with dressing changes as well as diabetic ulcers on her toes. She also has “diabetic triopathy.” H and P states that the patient no longer has Type 1 diabetes and insulin is not required.

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020(a)</td>
<td></td>
<td></td>
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<tr>
<td>M1022(b)</td>
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<tr>
<td>M1022(e)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1022(f)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Other pertinent diagnoses: | xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx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xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Coding Circulatory Conditions

Hypertension

- 4th digits
  - 0 Malignant
  - 1 Benign
  - 9 unspecified

- 401 Essential hypertension
  - Code according to the information available!!
  - ICD-10: No malignant, benign specifications.

402—Hypertensive Heart Disease

- Can only code if:
  - Causal relationship is stated (due to HTN) by the PHYSICIAN
  - Causal relationship is implied (hypertensive heart disease) by the PHYSICIAN

- Use additional code for heart failure
- The same heart conditions with HTN when no causal relationship, are coded separately.

403—Hypertensive Chronic Kidney Disease

- When the patient has hypertension and chronic kidney disease, the relationship is assumed.
- 403 for HTN
- Followed by CKD
- any condition classifiable to 585 and 587 with any condition classifiable to 401 (587 is renal sclerosis)
Question Asked A Lot

- What if the patient has diabetic kidney disease and hypertension?
  - 250.4x
  - 403.xx
  - 585.x
  - CC 1st Q 2003

404 Hypertensive heart and chronic kidney disease

- The patient has documented hypertensive heart disease AND they have CKD.
- Note those 5th digits
  - With heart failure or without
    - Use additional code for heart failure
  - With CKD according to stage
    - Use additional code for CKD.

HTN Sequencing

- The patient has hypertensive heart disease and CHF.
  - A. Sequencing is based on the focus of care.
  - B. The CHF is sequenced first if focus of care and the HTN is coded with a 402 code.
  - C. The correct sequencing is the 402 code followed immediately by the 428.0.

HTN Sequencing

- The patient has hypertension and CKD Stage V.
  - A. The diagnoses are sequenced according to the focus of care.
  - B. The codes are 401.9 and 585.5.
  - C. The presence of CKD automatically means that the patient has hypertensive chronic kidney disease and there is a specific sequencing rule.
**HTN—Which category?**

- Patient has HTN, CHF, and ESRD.
- Patient has HTN and CHF.
- Patient has CHF due to HTN.
- Patient has systolic heart failure due to HTN and renal sclerosis.

**Heart Disease**

- For what period of time is a myocardial infarction considered acute?
- How do we know that?
- What 5th digit is used for home health since it is always a subsequent episode of care?
- What code is used if it has been longer than 8 weeks since the myocardial infarction and the patient still has symptoms?
  - 414.8 (chronic ischemia of the heart)
- ICD-10: Acute for only 4 weeks!

**Heart Failure**

- Not all heart failure is congestive
- Let's look at the definitions
  - Acute on chronic
    - an exacerbation of a chronic failure OR
    - acute failure along with a different chronic failure, e.g. patient has an acute heart failure along with CHF
- CHF is considered chronic.
- Look for hints in sequencing.
- ICD-10: No longer an issue!
Circulatory Exercises

- Systolic heart failure
- Your patient with CHF is discharged from the hospital with the diagnosis of acute combined systolic and diastolic failure.
- Your patient has chronic diastolic heart failure due to hypertension.
- Your patient has hypertension and CHF.

Heart Failure Answers

- Systolic heart failure 428.20
- Your patient with CHF is discharged from the hospital with a diagnosis of acute combined systolic and diastolic failure. 428.43, 428.0
- Your patient has chronic diastolic heart failure due to hypertension. 402.91, 428.32
- Your patient has hypertension and CHF. 401.9 and 428.0 in either order depending on focus of care.

Circulatory Exercises

- The patient had a heart attack at the inferolateral wall 9 weeks ago and is being admitted to home care for his continuing symptoms.
- The patient had a heart attack 3 weeks ago and is in acute diastolic heart failure. He also has HTN.
- The patient has systolic and congestive heart failure. The physician says “due to HTN” in the H and P that came with the referral.
**Atherosclerosis**

- 440.2 subcategory for atherosclerosis of extremities
  - Notice the includes notes
- 440.23 atherosclerosis with ulcer
- 440.24 atherosclerosis of the extremities with gangrene

- Code atherosclerotic gangrene with ulceration on the lateral side of the midfoot

---

**Arterial Ulcers**

- Round “punch out” with pale wound bed
- Thin shiny skin; no hair

---

**Venous Stasis Ulcers**

- Ulcer
  - Stasis (leg) (venous) 454.0
    - With varicose veins 454.0
    - Without varicose veins 459.81
    - Inflamed or infected 454.2

- If a 454 code is used, no need for the ulcer code.
  - Excluded under 707.
- If no documentation of the varicose veins, use 459.81, 707.1x

---

**Stasis Ulcers**

**General Definition**

Venous Insufficiency (Stasis) Ulcers are caused by problems in the veins of the lower leg. Leaky valves, obstructions, or regurgitation disturbs the flow of blood from the lower extremities back to the heart. The blood collects in the lower leg, damaging the tissues and causing wounds.
### Pulmonary Embolism

- **415.19 Pulmonary embolism, other**
  - Acute PE treated with anticoagulants for 3-6 months
- **416.2 Chronic pulmonary embolism**
  - PHYSICIAN has to say chronic PE
- **V12.55 History of pulmonary embolism**
  - Prophylactic after acute phase is done

### Circulatory Exercises

- The patient has venous stasis and resulting venous thrombosis in the deep veins of the distal lower extremity. He is on anticoagulant therapy. He also has a history of CAD with a CABG 3 years ago. The focus of the care is the venous thrombosis and chronic venous insufficiency and monitoring the effectiveness of the anticoagulant therapy.
- What is the code for the venous thrombosis?

### Coding Late Effects

#### Including CVAs

### How to Code Late Effects

- Found under ‘Late’ in alpha index
- A late effect is a residual deficit left after the acute phase of an injury or illness is over.
  - Late effects of strokes
  - Late effects of head injuries or fractures
- The trick is in their sequencing
4.5 Ways to Sequence Late Effects

1) Late effect, generally
   Hemiplegia as a result of a head injury
   Residual deficit 342.xx
   Late effect head injury 907.0
   1a. Unless the book instructs otherwise

2) Manifestation as a late effect
   Late effect code 138
   Osteopathy 730.7x

3) Late Effect CVAs combination code
   Late effect code that includes the residual deficit 438.21

4) Late effect CVA combo that requires a second code
   438.7
   Residual deficit 368.8

Guideline Change Affects M1010 and M1016

- Guideline change regarding the neurologic deficits related to acute CVAs. Code even when they’re resolved by discharge from the facility.
- Codes in category 438 are only for use for late effects of cerebrovascular disease, not for neurologic deficits associated with an acute CVA.
- Do not code 434.91 with 438.21 to show hemiplegia.

Sequencing Late Effects

- Late Effect CVAs
  - Combination code (438.21)
  - Late effect code followed by the residual deficit (438.7 and 368.8)

- Other Late Effects
  - Residual deficit (342.11) followed by the late effects code (907.0)
  - Unless the tabular instructs otherwise

CVAs

- ALL STROKES, except if there are no deficits
- The patient had a stroke two weeks ago resulting in hemiplegia of the dominant side and dysphagia.
  - A. 438.21, 438.82, 787.20
  - B. 434.91, 342.21, 787.20
  - C. 436, 342.21, 787.21

If there are no deficits after a CVA or TIA—V12.54
**Stroke Exercise**

- The patient is being admitted for speech and physical therapies for dysphagia, dysarthria, muscle weakness and mild memory disturbance after a stroke.

**Stroke Answer**

<table>
<thead>
<tr>
<th>M1020/1022 (1)</th>
<th>(2)</th>
<th>M1024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple therapies</td>
<td>V57.89</td>
<td></td>
</tr>
<tr>
<td>Dysarthria as LE CVA</td>
<td>438.13</td>
<td></td>
</tr>
<tr>
<td>Dysphagia as LE CVA</td>
<td>438.82</td>
<td></td>
</tr>
<tr>
<td>Dysphagia</td>
<td>787.20</td>
<td></td>
</tr>
<tr>
<td>Other late effects of CVA</td>
<td>438.89</td>
<td></td>
</tr>
<tr>
<td>Mild memory disturbance</td>
<td>310.89</td>
<td></td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>728.87</td>
<td></td>
</tr>
</tbody>
</table>

**Another Late Effects Example**

- A seventy four-year old female fell off the toilet and suffered a head injury. When the patient had sufficiently recovered from the acute injuries, she was transferred to home health for further physical therapy, speech therapy and nursing. As a result of her intracranial injury, the patient had significant problems with dysarthria, oral dysphagia for which a gastrostomy was placed and generalized muscle weakness. How should this be coded?

**Late Effects Answer**

<table>
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<tr>
<th>M1020/1022(1)</th>
<th>(2)</th>
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</thead>
<tbody>
<tr>
<td>Dysarthria</td>
<td>784.51</td>
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<tr>
<td>Oral dysphagia</td>
<td>787.21</td>
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<td>Muscle weakness</td>
<td>728.87</td>
<td></td>
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<tr>
<td>Late Effect Intracranial injury</td>
<td>907.0</td>
<td></td>
</tr>
<tr>
<td>Attention to Gastrostomy</td>
<td>V55.1</td>
<td></td>
</tr>
</tbody>
</table>
Potential Health Hazards related to Personal History

- Explain a patient’s past medical condition that has the potential for recurrence and, therefore, may require continued monitoring.
- Home care – only personal history

Examples to Code

- The patient was discharged from the hospital after being admitted with pneumonia. The patient is receiving no further treatment of the pneumonia, but has some SOB and fatigue.
- The patient had rapid onset of stroke but the facial weakness has resolved. Teaching on s/s of stroke.
- Patient has a catheter and has frequent UTIs that require more frequent catheter changes.
- The patient has lymphedema of the left arm after a mastectomy for breast cancer. The cancer has been eradicated.

History Codes

- V10 History of malignant neoplasm
- V12.55 History of Pulmonary Embolism
- V12.42 Personal history of infection CNS
- V12.61 Personal history of pneumonia
- V13.02 Personal history UTI
- V15.88 History of falls (P or S)
- V15.51 History of traumatic fracture
- V15.52 History of traumatic head injury
- V12.53 history of sudden cardiac death
- V12.54 history of CVA/TIA without residuals
Shhhh….I’m reviewing.

Osteoarthrosis

- DJD is a Ortho 2 case mix diagnosis
- Generalized means that multiple sites are affected
- Localized means one site but can be bilateral
- Note which codes cannot be used with 5\textsuperscript{th} digits 5 and 6
- OA in knees and hips
  - 715.35
  - 715.36

Joint Replacements

- Patient underwent joint replacement to the hip and is receiving PT and nursing for aftercare, including PT/INRs. Other conditions include HTN and a gastric ulcer.
- M1020/1022
- V54.81 AC jt replacement
- 781.2 abn of gait
- 401.9 HTN
- 531.90 gastric ulcer
- V43.64 hip
- OPD: V58.83, V58.61
### Joint Replacements
- Patient underwent joint replacement to the hip and is receiving PT for aftercare. Other conditions include HTN and a gastric ulcer.
  - M1020/1022
  - V57.1
  - 781.2 abn of gait
  - V54.81 AC joint replacement DJD or fracture
  - 401.9 HTN
  - 531.90 gastric ulcer
  - V43.64 hip DJD or fracture

### Abnormality of Gait
- Q: The coders at our home health agency are debating as to whether symptoms codes should be assigned along with the aftercare codes. For example, is it appropriate to assign a code for gait abnormality when a patient is receiving home health aftercare following joint replacement?
- A: Yes, symptom codes may be assigned in conjunction with V codes when they provide additional information about the specific problem being addressed. So, in the given example, code 781.2, abnormality of gait, may be assigned in conjunction with code V54.81, Aftercare following joint replacement.

### Revision of Joint Replacement
- Patient has a peri-prosthetic fracture at her hip prosthesis. It has been revised and she is admitted for home care for aftercare.
  - 996.44 or V54.81 or V58.43 or V54.82???
    - V54.82 Aftercare following explantation, Encounter for a revision
  - V88.21 Acquired absence of hip joint
  - Acquired absence of hip joint following explantation of joint prosthesis, with or without presence of antibiotic-impregnated cement spacer
  - V88.22 Acquired absence of knee joint
  - Acquired absence of knee joint following explantation of joint prosthesis, with or without presence of antibiotic-impregnated cement spacer

### Explantation
- Patient had revision of hip joint replacement after peri-prosthetic fx
  - V54.82 Aftercare
  - V43.64 hip
- Patient had joint prosthesis removed because of infection and comes home with a cement spacer impregnated with antibiotics.
  - 996.66 Infection due to presence of prosthesis
  - V88.21 Acquired absence of hip joint prosthesis
Aftercare For Healing Fractures

- There are three options for pathologic and trauma fx in homecare.
  - V54.10-V54.19
  - V54.20-V54.29
  - V54.81 if repair of fx by joint replacement!
- Stress fractures are a different story!
- ICD-10: No ‘V’ codes for fractures
  - Code the fx with 7th character extension

ICD-10-CM Example 7th Character Fractures

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

Fractures

- The 800 and 733.1 fracture codes are not appropriate for home health claims which means they cannot be placed in M1020 or M1022s.
- The fracture codes can only be used during “active treatment.”
  - The aftercare for healing fracture codes are used instead.
- You may place the fracture codes in M1024, M1010 and M1016.
- Doesn’t matter what kind of treatment they had for the fracture

Typical Fracture Scenario

Patient has a fracture of the femur and is in a non-weight bearing cast. He will need nursing and therapy. Nursing will do observation and assessment, cast care and teaching. Therapy will have the most intensive care plan with transfers, etc.

M1020/1022 M1024
V54.13 fracture
781.2

What about that pressure ulcer at the ankle as a result of the cast?
Also has history of CABG, a gastric ulcer and anemia after the surgery.
Patient has a trauma fx of femur repaired by an ORIF

What is the correct aftercare code?
- A. V58.43 Aftercare following surgery for trauma
- B. V54.09 Aftercare involving the internal fixation device
- C. V54.15 Aftercare healing trauma fracture
- D. V58.78 Aftercare following surgery for musculoskeletal condition

Respiratory Conditions

COPD
- When acute bronchitis is documented with COPD, code 491.22
- COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned
- You may only code 491.20 if the patient has chronic bronchitis.
The physician has documented COPD and chronic asthma. The patient is being seen mainly for the wound care of a trauma wound on his hand where he got bit by a dog. The physician repaired it but it dehisced and there is greenish drainage. He is on antibiotics. He is on oxygen therapy and had a pacemaker 3 years ago for persistent sinus bradycardia.

Guidelines/Tips

- Complicated trauma wound? Special code for this wound?
  - Use V code?
- COPD guidelines and inclusion/exclusion notes
- Status codes
- Bradycardia still there?

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
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<tr>
<td>M1020(a)</td>
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<td>M1022(b)</td>
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<td>M1022(c)</td>
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<td>M1022(d)</td>
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<td>M1022(e)</td>
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<tr>
<td>M1022(f)</td>
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</tr>
</tbody>
</table>

Other pertinent diagnoses:

- Dehisced trauma wound 998.33
- Infected trauma wound 882.1
- Chronic asthma 493.20
- Bradycardia 427.81
- Oxygen therapy V46.2
- Status pacemaker V45.01
- Other pertinent diagnoses: E906.0
Coding Neoplasms

- History of Neoplasms
  - V10 history malignant neoplasm
    - By body system
    - Also leukemia and lymphoma
  - Only if cancer has been eradicated and receiving no further treatment
  - Assume the cancer is still there if no evidence that it is eradicated.
  - Same rule in ICD-10-CM
  - V12.41 for history of benign neoplasm of the brain

Use of Certain Drugs

- Active treatment of malignancy or prophylaxis
- V07.51 Use of selective estrogen receptor modulators (SERMs) (Tamoxifen)
- V07.52 Use of aromatase inhibitors (Arimidex®)
- V07.59 Use of other agents affecting estrogen receptors and estrogen levels (fulvestrant (Faslodex®)
- V07.5 codes are considered eligible V codes

Eradicated/Prophylactic vs Treatment

- How do you code a patient with past breast cancer, says she is “cancer free” but is taking Tamoxifen???
- 174.9 breast ca and V07.51?
- OR
- V07.51 and V10.3?
Aftercare following Surgery for Neoplasm

Code with other aftercare codes to fully identify reason for aftercare
If reason for surgery was numeric codes 140-239, use V58.42
Then use:
- Numeric code for type of neoplasm if undergoing continued treatment OR
- V10.xx Personal history of neoplasm as a secondary code if neoplasm is eradicated
- Does not have to be directly underneath aftercare code

Use of Neoplasm Table

- Must know anatomical site affected
- Six possible code numbers for each site
  - Malignant = Primary, Secondary and Ca In situ
  - Benign
  - Uncertain behavior
  - Unspecified—AVOID!!
- Look for terms such as: primary site, 'mets to' 'mets from'
- When coding a metastatic site, it is also important to code the primary site.
- But what if you don’t know?

Next Step—Histology

- Adenocarcinoma of head of pancreas
- Dermatofibroma on the leg
- Look for basal cell carcinoma on the chin

Step 1—look up term in alpha index
Step 2—note morphology code and instructions
Step 3—go to Appendix A if necessary
Determine whether malignant, benign etc and primary, secondary
Step 4—go back to neoplasm table in alpha index

Sequencing Primary and Mets Sites

- The primary site is coded before the mets site EXCEPT IF:
  - The mets site is the focus of care
    - Usually when primary site has been resolved/resected
  - Colon ca with mets to liver
  - Metastatic site esophagus with primary site of larynx resected/resolved
Neoplasms—Palliative Care

M1020 191.7 Ca
M1022 338.3 Neoplasm related pain
M1022 V66.7 palliative care
M1022 V49.86 DNR

OR
M1020 338.3
M1022 191.7
M1022 V66.7
M1022 V49.86 DNR

Patient is referred to home health for SN for teaching, pain management and the care of an ulcer where the cancer has eaten through the skin. The patient has breast cancer (upper-inner quadrant) and bone mets to the sternum and vertebrae with severe pain due to bone mets. The patient also has Hx of Diabetes and HTN. The focus of care is pain management and the fulminating ulcer.

Guidelines/Tips

- What goes first? Depends on focus of care—pain? Bone mets? Ulcer?
- Is the bone mets sequenced before or after the breast cancer?

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<tbody>
<tr>
<td>M1020(a) Ulcer breast</td>
<td>707.8</td>
<td></td>
</tr>
<tr>
<td>M1022(b) Neoplasm related pain</td>
<td>338.3</td>
<td></td>
</tr>
<tr>
<td>M1022(c) Breast Ca (upper-inner quadrant)</td>
<td>174.2</td>
<td></td>
</tr>
<tr>
<td>M1022(d) bone mets</td>
<td>198.5</td>
<td></td>
</tr>
<tr>
<td>M1022(e) DM2</td>
<td>250.00</td>
<td></td>
</tr>
<tr>
<td>M1022(f) HTN</td>
<td>401.9</td>
<td></td>
</tr>
<tr>
<td>Other pertinent diagnoses:</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx</td>
<td></td>
</tr>
</tbody>
</table>
More on Cancer Coding

- Generally cancer is coded as primary when treatment is for cancer. There are a number of exceptions.
  - If aftercare is the focus of care, code the aftercare code as primary, not the cancer code.
  - If the surgical complication is the focus of care...
  - If neoplasm related pain is the focus of care...
  - If the patient is receiving treatment, code the cancer, not the V10 code for history.
  - If the primary focus of care is administering chemotherapy for cancer, then use V58.11 as primary, followed by the cancer.

Cancer and Anemia

- If anemia is the focus of care, code anemia then cancer.
  - 285.22 is the code for anemia associated with cancer
  - 285.3 is the code for chemo induced anemia (doesn't need E code)
  - 284.89 is the code for aplastic anemia due to treatment for cancer (needs E code)
  - Chronic and needs documentation from physician
  - Different in ICD-10-CM!

Guidelines—Complications of Cancer

- If treatment is directed at dehydration:
  - 276.51 dehydration focus of care
    - Code dehydration then cancer
  - 276.51 dehydration from the therapy for cancer
    - Code dehydration, E code for therapeutic use then cancer.
    - Example:
      - 276.51 dehydration
      - E933.1 adverse effect of anti neopastics given therapeutically
      - Cancer
  - If treatment is directed towards the cancer, use the dehydration code as a secondary.

Neoplasms Associated with Transplants

- 199.2 Malignant neoplasm associated with transplant organ
- The patient has cancer of the kidney after transplantation of the kidney.

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<tbody>
<tr>
<td>M1020(a) Comp of transplanted organ, Kidney</td>
<td></td>
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</tr>
<tr>
<td>M1020(b) Cancer of a transplanted organ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1022(c) Kidney cancer, primary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

996.81
199.2
189.0
Remission

- Certain codes require 5th digits to indicate remission.
- Cannot code remission if the physician doesn’t confirm.

Trauma Wounds

Open wound = trauma wound = wound caused by accident or violence
- Open wound ≠ a wound that is open
- Medically caused wounds should NEVER be included in this category.
- Includes: animal bites, avulsions, cuts, lacerations, puncture wounds, traumatic amputations

Trauma Wounds

- Complicated (definition)
  - Delayed healing
  - Foreign body
  - Delayed treatment
  - Infection
- If complicated, no V codes will be used for the wound (no V58.43) even if there was surgery.
Is the wound complicated? Delayed treatment or healing, infected, foreign body or dehisced? 

Yes

Code the complicated wound and do not code the V code for aftercare or dsg change.

No

Was there surgery?

Yes

Then code V58.43, the uncomplicated wound and the dsg change as applicable

No

Code the uncomplicated trauma wound

Don't forget to place the wound in M1024 if the V code is primary.

Example Trauma Wound—Patient was mowing lawn and ran over wire hanger which penetrated his calf above the achilles tendon. He pulled it out and kept mowing. Three days later he has an infected necrosed wound. He undergoes surgery to clean it up and close the laceration.

<table>
<thead>
<tr>
<th>If Clean</th>
<th>If complicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020 AC inj or trauma</td>
<td>V58.43</td>
</tr>
<tr>
<td>M1022 open wound calf, no mention of complication</td>
<td>891.0</td>
</tr>
</tbody>
</table>

Skin Tears

- Most skin tears or partial thickness wounds are coded as superficial injuries (910-919)
  - Require only simple wound care
  - Not covered under Medicare
  - Since most are caused by some type of injury (e.g., bumped on wheelchair), may be tempting to code as a trauma wound.
  - May code as trauma wound if:
    - If skin tear is extensive – i.e., extends into dermis – or no longer has a flap
    - Wound is complicated – i.e., delayed healing, foreign body, primary infection
    - There is an underlying condition, such as diabetes or atherosclerosis, that could complicate healing
    - Documentation must support the need for skilled care!
- Payne Martin classification

Payne-Martin Category 1 Skin Tear - No Tissue Loss

1. **Linear type** - the epidermis and dermis have been pulled apart, as if an incision has been made.
2. **Flap type** - the epidermal flap completely covers the dermis to within 1mm of the wound margin.

Illustration: Jan Rice, Wound Foundation of Australia
**Payne-Martin Category 2 Skin Tear – Partial Tissue Loss**

- **Scant tissue loss** = partial thickness wound in which 25% or less of the epidermal flap is lost and in which at least 75% or more of the dermis is covered by the flap.

- **Moderate to large tissue loss** = partial thickness wound in which >25% of the epidermal flap is lost and in which >25% of the dermis is exposed.

**Category 3 Skin Tear – Full Tissue Loss**

- Epidermal flap is missing.

**Burns--Guidelines**

- V code (V58.43) only if patient had surgery (not debridement) and burn is not complicated

- Code location of burn with severity of burn
  - Code worst burn first
  - Classify burns of the same local site but of different degrees to the subcategory identifying the highest degree recorded

- Do NOT use 946 or 949!!
Burns Guidelines

- Then code total body of area burned with a code from 948 category, especially if the burn is 3rd degree and covers more than 20% of the body
- If burn is infected, follow with 958.3
- Patient has necrosed infected burn that is debrided.
  - Burn
  - 958.3 Post traumatic wound infection, NEC

Non-Healing Burn

- Code a non-healing burn as an acute burn
- Your patient has an ulcer on his lower leg where he left a heating pad and burned his leg. Because of his atherosclerosis (with claudication) the second degree burn never healed. The focus of the care is the care of the ulcer/burn.
  - 945.24 Burn of lower leg
  - 440.21 arteriosclerosis with claudication
  - E924.8 Burn by an electrical appliance (optional)

Complication of a burn—infection

- The patient has a burn to the hand after the pan of grease she was heating caught on fire and in her panic she picked it up and then dropped it on her left hand causing 3rd and 2nd degree burns to her hand and wrist. The burn has become infected.
  - M1020(a) 944.36 3rd degree burn back of hand
  - M1022(b) 944.37 3rd degree burn wrist
  - M1022(c) 958.3 Post traumatic wound infection

Late Effect of a Burn

- Same patient 3 years later—the patient has contractures in her wrist from the burn. PT and OT are treating.
  - M1020(a) V57.89 Multiple therapies
  - M1022(b) 709.2 Scar conditions and fibrosis of skin
  - M1022(c) 906.6 Late effect burn to wrist
Late Effect and Complication

- Same patient but some areas of the burn on the back of hand haven’t healed and have turned into a seeping ulcer and there are contractures in her wrist. She has nursing and OT.
- M1020(a) 944.36 burn on back of hand
- M1022(b) 709.2 contractures
- M1022(c) 906.6 late effect, burn wrist
- M1022(d)

Three ways to code surgical wounds

1. Aftercare when condition is resolving OR
2. Surgical wound complications
3. If the patient had surgery but the condition that required surgery or some other condition is the focus of care the aftercare code may be sequenced secondary.

Aftercare V codes should only be used when the condition treated by surgery has resolved or is resolving. Are you treating the condition or are you providing aftercare following surgery?

Examples—code the condition

The patient had surgery for removal of a cancerous tumor to the neck. The tumor was wrapped around the carotid and the trachea and so the surgeon was not able to remove the entire tumor. The patient continues to have difficulty breathing, speaking and swallowing as well as problems with his blood pressure all related to the tumor.

Are you going to code the cancer first or aftercare?
Examples—code the complication

- 998.83 non-healing surgical wound **
- 998.3x dehiscence **
- 998.59 other post-op infection **

Other more specific complications of surgical wounds
- 996.66 infection due to joint prosthesis
- 997.62 amputation stump infection
- 996.52 non-healing skin graft

If you are coding any of the above codes, do NOT use the aftercare code for that condition, including dressing change code V58.31

Examples—some other condition focus of care

- The patient had to have her gall bladder out. While in the hospital she caught an acute bronchitis which has exacerbated her chronic bronchitis and her HTN. She has some small incisions from her gall bladder surgery but the focus of your care will be the acute infection and HTN.

M1020/M1022 491.22 401.9 V58.75 575.0

Aftercare Guidelines

- Initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of disease.
- The aftercare V code should not be used if treatment is directed at a current, acute disease or injury.
- Generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable.

Ostomies—Assuming No Complications

<table>
<thead>
<tr>
<th>Status</th>
<th>Attention to</th>
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<tbody>
<tr>
<td>V44.0 trach</td>
<td>*V55.0 trach</td>
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<tr>
<td>V44.1 gastrostomy</td>
<td>V55.1</td>
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<tr>
<td>V44.2 ileostomy</td>
<td>V55.2</td>
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<tr>
<td>V44.3 colostomy</td>
<td>V55.3</td>
</tr>
<tr>
<td>V44.4 Other GI</td>
<td>V55.4</td>
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<tr>
<td>V44.5x cystostomy</td>
<td>*V55.5 cystostomy</td>
</tr>
<tr>
<td>V44.6 Other urinary</td>
<td>*V55.6 other urinary</td>
</tr>
<tr>
<td>V44.7 artificial vagina</td>
<td>V55.7</td>
</tr>
<tr>
<td>V44.8 other artificial opening</td>
<td>V55.8</td>
</tr>
</tbody>
</table>
Complications of Ostomies

- 519.0x Complication of tracheostomy
- 536.4x Complications of gastrostomies
- 569.6x Complications of colostomies and enterostomies
- 596.81 Infection of cystostomy
  - Use additional code to specify type of infection, such as:
    - abscess or cellulitis of abdomen (682.2)
    - septicemia (038.0-038.9)
  - Use additional code to identify organism (041.00-041.9)
- 596.82 Mechanical complication of cystostomy
- 596.83 Other complication of cystostomy
  - Fistula
  - Hernia
  - Prolapse

Cellulitis and Abscesses

- If associated with a wound or ostomy, code wound or ostomy first.
- If no wound, code cellulitis
- If an I&D and infection is present, code the cellulitis/abscess and not an aftercare code.
- If clean, and had an I&D of abscess, you may code aftercare.
- Significance of M1024

Scenario

- Patient has a post-surgical abscess with cellulitis caused by MRSA on the abdomen. The focus of the care is the care of the abscess/wound. The patient is also getting IV antibiotics.
- How do you code it?
  - M1020/M1022
  - M1024

Scenario Answers

- Patient has a post-surgical abscess with cellulitis caused by MRSA on the abdomen. The focus of the care is the care of the abscess/wound. The patient is also getting IV antibiotics. How do you code it?
  - 998.59 post surgical abscess
  - 682.2 cellulitis on abdomen
  - 041.12 Methicillin Resistant Staph aureus
  - V58.81 fitting and adjustment of vascular device
  - V58.62 long term use antibiotics
Decubitus/Pressure Ulcers

- 707.00 Pressure ulcer, unspecified site
- 707.01 Pressure ulcer, elbow
- 707.02 Pressure ulcer, upper back
- 707.03 Pressure ulcer, lower back (and coccyx!!)
- 707.04 Pressure ulcer, hip
- 707.05 Pressure ulcer, buttock
- 707.06 Pressure ulcer, ankle
- 707.07 Pressure ulcer, heel
- 707.09 Pressure ulcer, other site

Case mix points are from M1308 and M1324, not the diagnosis code.
No code to indicate bilateral.

Pressure Ulcer Staging

- 707.20 (Pressure ulcer, unspecified stage)
- 707.21 (Pressure ulcer stage I)
- 707.22 (Pressure ulcer stage II)
- 707.23 (Pressure ulcer stage III)
- 707.24 (Pressure ulcer stage IV)
- 707.25 unstageable

Pressure Ulcer Guidelines

- Two codes are needed to completely describe a pressure ulcer—the location (707.0x) and the stage (707.2x)
- 707.0x codes:
  - Use additional code to identify pressure ulcer stage (707.20 - 707.25)
- 707.2x Code first site (707.0x)
  - Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis.
  - One code for each pressure ulcer in ICD-10

Guidelines—Unstageable

- Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.
- If pressure ulcers are documented as healed when admitting, do not code.
  See Pressure Ulcer table.
**Pressure Ulcer Guidelines**

- Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

**Bilateral pressure ulcers with same stage**

- When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

  Bilateral stage three ulcers on hips.
  - 707.04, pressure ulcer hip
  - 707.23, stage 3

**Bilateral pressure ulcers with different stages**

- When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.

  - Patient has a Stage 2 on the R hip and a Stage 3 on the L hip
  - 707.04 PU, hip
  - 707.23 stage 3
  - 707.22 stage 2

**Mult pressure ulcers of different sites and stages**

- When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

  - Patient has a pressure ulcer on the hip covered with eschar and a pressure ulcer on the shoulder that is stage 3.
  - 707.04, PU hip
  - 707.25, Unstageable
  - 707.02, PU shoulder
  - 707.23 Stage 3
Multiple Pressure Ulcer Sites all the same stage

- No specific guideline...
- Patient has pressure ulcers on the shoulder, coccyx and heel and they are all stage 3.
- 707.03 coccyx
- 707.02 upper back
- 707.07 heel
- 707.23 Stage 3

Examples

1. Stage 3 pressure ulcer on the buttoc and stage 4 pressure ulcer on the sacrum
   - 707.05, 707.23, 707.03, 707.24
2. Bilateral ankle pressure ulcers – stage 2 on the right and stage 3 on the left
   - 707.06, 707.23, 707.22
3. Suspected DTI on coccyx
   - 707.03, 707.25

Pressure Ulcers with Skin Grafts

- Pressure ulcer with skin graft
  - Edges not healed yet = d1 (unstageable due to the presence of a non-removable device or dressing
  - Edges epithelialized = closed pressure ulcer
    - Code it and mark it on OASIS according to the stage it was prior to the graft
Pressure Ulcers

- The patient has a closed Stage 4 on the right hip, a stage 3 on the buttock, a new skin graft (full thickness) (edges not healed) on what was previously a stage 4 on the shoulder blade. The other shoulder has a Stage 2 that recently epithelialized. Wound care is being provided as well as observation and assessment of the grafted PU and the clean Stage 3.
- A closed stage 3 or 4 is never fully healed.
- What about a stage 1 or 2?

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<tr>
<td>Other pertinent diagnoses:</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxx</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxx</td>
</tr>
</tbody>
</table>

Other pertinent diagnoses:

- M1020(a) PU, shoulder blade 707.02
- M1022(b) PU, unstageable 707.25
- M1022(c) PU, buttock 707.05
- M1022(d) PU, stage III 707.23
- M1022(e) PU, hip 707.04
- M1022(f) PU, Stage IV 707.24

Other pertinent diagnoses:

- V58.30 (1)
Symptoms, Signs and Ill-Defined Conditions

- Generally do not code a SSI if the definitive diagnosis is known.
  - CHF with SOB and edema
- If the SSI is not always part of the condition then add the code for the SSI along with the condition
- Sometimes the coding manual states to also code the symptoms
  - BPH

Proximate Diagnosis vs Underlying Condition

Multiple aspects of care vs. one symptom
MS patient with urinary retention and need for Foley catheter change.
- M1020 V53.6 Fitting and adj of urinary catheter
- M1022 788.20 urinary retention
- M1022 340 MS
- Anything across from V53.6 in M1024?

Proximate Diagnosis vs Underlying

Pt is having an acute exacerbation of MS with increased gait problems as well as ADL deficits. She has changed meds and home care is ordered for neuro assessment, assessment of med regimen, catheter change for neurogenic bladder and PT, OT.
M1020 340 MS
M1022 596.54 neurogenic bladder
M1022 V53.6 catheter change
M1022
Abnormality of Gait

- Neuro issues (staggering, ataxic gait) *when diagnosis hasn’t been made or definitive diagnosis is resolved*
- Orthopedic after corrective treatment ((EEK!!))
- Amputation
- Falling without cause

**NOT**
- Anthalgic gait from injury
- Arthritis related
- Late effects CVA with hemiplegia, monoplegia, etc

Some symptoms are in other chapters

- Difficulty walking
  - Difficulty with gait related to chronic condition of the bone or joint
- Pain in leg
- Muscle weakness

Abnormality of Gait vs Difficulty Walking vs Something Else?

- Patient tripped over a cord and sprained his ankle.
- Patient had a joint replacement.
- Patient’s rheumatoid arthritis is acting up and making it difficult to walk.
- Patient has monoplegia of the left leg.
- Patient has abnormal gait from MS.
- Patient has Parkinsons gait.

E Codes
**E Codes**

- M1022 only (have to be secondary)
  - NOT in M1010, M1016 or M1020 or M1024
- E codes indicate external causes of injury or poisoning
- E codes show how an injury happened and should not be used if there was no injury
- Most E codes are not mandatory in home care. NOT required to show how a trauma fracture occurred. (But the intermediaries like them)

---

**E Codes—Table of Drugs and Chemicals**

- E codes should be used to show a poisoning caused by a drug or chemical or an adverse effect of a drug taken correctly.
- Poisoning—something went wrong—wrong drug (or something you shouldn’t take), wrong dosage, wrong patient, etc
- Adverse Effect—everything was right but something bad happened anyway, i.e. an allergic reaction.

---

**E Codes—Table of Drugs and Chemicals**

<table>
<thead>
<tr>
<th>Poisoning—PEE</th>
<th>Adverse Effect—EE</th>
</tr>
</thead>
<tbody>
<tr>
<td>P—Poisoning code</td>
<td>E—Effect—rash, vomiting, confusion, slow heart rate</td>
</tr>
<tr>
<td>E—Effect—rash, vomiting, confusion, slow heart rate</td>
<td>E—E code to explain whether accident, assault or suicide</td>
</tr>
<tr>
<td>E—E code to explain whether accident, assault or suicide</td>
<td>E—E code to explain adverse effect of that particular class of drugs when used therapeutically</td>
</tr>
</tbody>
</table>

- ICD-10 same concepts

---

**Digoxin**

- The patient is taking digoxin as ordered but has bradycardia.
- Therapeutic use or poisoning?

- The patient took the correct dose from the bottle labeled Digoxin and also the correct dose from the bottle labeled Lanoxin and has bradycardia.
- Therapeutic use or poisoning?
Scenario

- The patient has taken aspirin daily for years to ward off heart disease and now has a gastric ulcer.
- Poisoning or adverse effect?
- What is coded first? Which E code?

Scenario

- The patient ate some candy while in a third world country. Unbeknownst to him, the candy was sweetened with lead acetate. He now has toxic myelitis as a result of the lead.
- Poisoning or adverse effect?
- What is coded first? Which E code?

Infections

- 041 vs 038
- Resistant infections
  - Do not use V09 for MRSA
- Combination codes for infections
  - Staph aureus pneumonia
- Infections as complications
The patient has a post-op wound infection cultured MRSA and VRSA. He will receive nursing for wound care, including dressing changes, and IV antibiotics.

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>M1020/M1022 (2)</th>
<th>M1024 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post op infection</td>
<td>998.59</td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>041.12</td>
<td></td>
</tr>
<tr>
<td>With mention of multiple resistance (VRSA)</td>
<td>V09.81</td>
<td></td>
</tr>
<tr>
<td>Fitting and adj vascular device</td>
<td>V58.81</td>
<td></td>
</tr>
</tbody>
</table>

The Pain Codes (338)

- Are a pain!!!
- Basics:
  - May code primary or secondary based on focus of care
  - Before coding chronic pain, must have that from the physician
  - Post surgical pain is UNUSUAL post-surgical pain.
  - Don’t use the code if it doesn’t contribute useful information

- The patient is being seen for management of acute neck pain received when falling off the porch.
  - 723.1 Cervicalgia
  - 338.11(acute pain due to trauma) 723.1
  - 338.11

- DJD and chronic pain???
The Pain Codes (338)
- 338.0 Central pain syndrome (doc only)
- 338.3 Neoplasm related pain
  - Acute or chronic
  - Benign or malignant
- 338.4 Chronic pain syndrome
  - No coding unless the doc says so

369 Blindness and Low Vision
- 369.4, NOT 369.00 for blindness
- What caused the low vision?
- Not for everyone who needs glasses.
  - Look at the excludes note!
- Not for everyone who scored partial or severe impairment on M1200.
- Watch out!!

Mental Disorders
- Do not code patients with psychiatric disorders unless have been diagnosed.
- Are psychiatric dx pertinent to the POC?
- If primary, do you have psychiatrically trained nurses?
- Alzheimers does not require a psychiatric nurse.
  - with dementia 331.0, 294.1x
**Scenario**

- The patient with schizophrenia is receiving Haldol IM injections.
- What is your primary diagnosis?
- Is a psychiatrically trained nurse required?

**Dementias**

- 294.11 Dementia in conditions classified elsewhere with behavioral disturbance
  - Wandering-off
  - Use additional code, where applicable, to identify:
    - Wandering in conditions classified elsewhere (V40.31)

**294.2 Dementia, unspecified**

- 294.20 Dementia, unspecified, without behavioral disturbance
  - Dementia NOS
- 294.21 Dementia, unspecified, with behavioral disturbance
  - Aggressive behavior
  - Combative behavior
  - Violent behavior
  - Use additional code, where applicable, to identify:
    - Wandering in conditions classified elsewhere (V40.31)
  - Dementia NOS deleted from 294.8

**Example**

- Alzheimers 331.0
- Dementia with behaviors 294.11
- Wandering off V40.31
Presented by Selman-Holman & Associates, LLC
Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C

Selecting Diagnoses—Appendix D

- Avoid assigning excessive numbers of V-codes to OASIS M1020/1022.
- CMS expects HHAs to limit the reporting of V-Codes on the OASIS.
- V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes.
- V codes are an assignment of last resort

Status Codes—Persons with a Condition Influencing Health Status

- V40-49 (V80s) Status Codes—Sequelae or residual of past disease or condition
- Secondary only with a few exceptions
- Should you use the status code?
  - Is there an instruction to use it, e.g. V54.81?
  - If not, is it useful information? Is the information pertinent to the POC?
Use of Status Codes

- Categories V42-46 and subcategories V49.6, V49.7 are for use ONLY if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.
- Unless the book instructs you otherwise don’t use a status code when there is a complication
  - See 996.66, 996.77 and 996.4x

Status Code Categories

- V42—Organs replaced by transplant
  - M1020 V58.44 Aftercare surgery transplant
  - M1022 V42.7 Liver
- V43—Organs replaced by other means
- V45--Other Postprocedural States

Other Postprocedural States—V45

- V45.01 Pacemaker status
- V45.02 Implanted defibrillator
- V45.11 Dialysis status
- V45.12 Non-compliance with dialysis
- V45.3 intestinal bypass or anastomosis
- V45.81—Aortocoronary bypass status
- V45.82—Angioplasty status

They will usually be listed following the AC codes, e.g. V58.73, V45.01.

V48-V49

- Most V48-49s can be redundant
- Exceptions are:
  - V49.6x upper extremity amputation status (P or S)
  - V49.7x lower extremity amputation status (P or S)
    - Can be a new amputation or a longstanding amputation AS LONG AS NOT COMPLICATED
    - One of those co-morbidities that needs to be coded
  - V49.83 awaiting transplant status
  - V49.84 Bed confinement status (P or S)
More Status Codes

- V49.86 Do Not Resuscitate status
- V49.87 Physical restraints status
- V88.11 Acquired total absence of pancreas
  - Acquired absence of pancreas NOS
- V88.12 Acquired partial absence of pancreas

Some Other V Codes You Should Know About...

- But not go crazy about!!
  - Remember, Medicare says to avoid overuse!!

V53—Fitting and Adjustment of Other Device

- V53.6 urinary device
  - Excludes ostomies (V55.5 cystostomy)
  - If a patient has a suprapubic catheter, code V55.5, attention to cystostomy, NOT V53.6 for the fitting and adjustment of an urinary catheter

Routine Care vs Condition vs Complication

- Patient requires foley catheter change for urinary retention
  - V53.6 and urinary retention
- Patient requires teaching of new med, assessment of effectiveness and foley catheter maintenance for BPH
  - BPH and V53.6 as a reason for encounter code at the bottom
- Patient has catheter and UTI (documented as caused by the catheter)
  - 996.64, UTI and NOT V53.6
Attention to Dressings and Sutures
(includes wound packing)

- V58.30 Encounter for change or removal of nonsurgical wound dressing
  - Encounter for change or removal of wound dressing NOS
- V58.31 Encounter for change or removal of surgical wound dressing
- V58.32 Encounter for removal of sutures
  - Encounter for removal of staples

Do NOT use as primary!!
- Only acceptable as primary if the sole purpose of care is a dressing change
  - That shouldn’t be the sole purpose of your care in home care
  - Don’t reduce your practice to tasks.

Code it at the bottom.
Absolutely do NOT use them if the wound is complicated!!!!!!

Long-term (current) Drug Use

Secondary only
- V58.61 Anticoagulants
- V58.62 Antibiotics (not short bout of antibiotics)
- V58.63 Antithrombotics/Antiplatelets
- V58.64 Steroids
- V58.65 Non-steroidal anti-inflammatories
- V58.66 Aspirin
- V58.67 Insulin
- V58.68 Bisphosphonates
- V58.69 Other medications
  - Methadone for pain control

Long term not defined
- Appropriate for use if:
  - you expect that the patient will be on the medication for a time OR
  - the patient on the drug for prophylactic purposes
  - AND it is clinically logical to do so.
- Don’t use for filling med boxes or “medication management” or for every med the patient is on
Aftercare Specific Procedures

- V58.81 Fitting and adjustment vascular catheter
- V58.82 Fitting and adjustment non-vascular catheter
- V58.83 Encounter for therapeutic drug monitoring
  - *Use with additional code for any assoc long term (current) drug use V58.61-V58.69*
  - *Assessment of the effectiveness of meds through lab data*

V Code Application--V58.81

- Patient with urinary catheter is getting IV antibiotics for an acute bladder infection caused by E coli (documented as caused by catheter).
  - M1020 996.64 Infection due to indwelling urinary catheter
  - M1022 595.0 Acute cystitis
  - M1022 041.49 E coli
  - M1022 V58.81 fitting and adj vasc cath
  - M1022 V58.62 use of antibiotics

V Code Application--V58.81

- Patient has a local staph aureus infection of the central line site that will be treated with IV antibiotics
  - M1020 999.33 Local Infection due to central line
  - M1022 041.11 Staph aureus
  - M1022 V58.62 Use of antibiotics
- Patient needs central line flushed TKO for periodic chemo
  - M1020 V58.81

A patient accidentally doubles his dose of Lasix for CHF and the result is dehydration. Home health is referred to administer IV fluids and to perform wound care on an infected picc line on the left arm. Patient has a new picc line on the right arm for IV administration. Patient also has cardiac dysrhythmia and had a defib/pacemaker implanted last year. He had a heart attack 7 weeks ago and has NTG for chest pain.
**Guidelines/Tips**

- Poisoning—PEE
- PICC line—coding vs OASIS
- Complication vs V code (both?)
- New change on implanted defibrillator with pacer
- MI acute or chronic?

<table>
<thead>
<tr>
<th>M1020/M1022 (1)</th>
<th>(2)</th>
<th>M1024(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020(a) POISONING BY OTHER DIURETICS</td>
<td>974.4</td>
<td></td>
</tr>
<tr>
<td>M1022(b) DEHYDRATION</td>
<td>276.51</td>
<td></td>
</tr>
<tr>
<td>M1022(c) ACCIDENTAL OVERDOSE LASIX</td>
<td>E858.5</td>
<td></td>
</tr>
<tr>
<td>M1022(d) INFECTION CENTRAL CATH</td>
<td>999.31</td>
<td></td>
</tr>
<tr>
<td>M1022(e) ACUTE MI</td>
<td>410.92</td>
<td></td>
</tr>
<tr>
<td>M1022(f) CHF</td>
<td>428.0</td>
<td></td>
</tr>
<tr>
<td>Other pertinent diagnoses:</td>
<td>427.9</td>
<td>V58.81,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V58.69,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V45.02</td>
</tr>
</tbody>
</table>

**Finally...**

**Questions??**

Selman-Holman & Associates, LLC  
*CoDR—Coding Done Right*  
214.550.1477  
[www.selmanholman.com](http://www.selmanholman.com)  
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