ICD-9-CM: INTERMEDIATE CODING FOR HOME CARE PROFESSIONALS WITH ICD-10-CM

Presented by
Selman-Holman & Associates, LLC

Quote for the Day

“DO YOUR BEST, AND BE A LITTLE BETTER THAN YOU ARE.”
—GORDON HINCKLEY

Update
ICD-10 and OASIS-C1

- ICD-10 implementation moved to October 1, 2015
  - Continue your progress
  - Dual code at the latest January 1, 2015

Slow and steady wins the race?
ICD-10 and OASIS-C1

- OASIS-C1/ICD-9 Version effective January 1, 2015 at 12 MN
  - M1011, M1017, M1021, M1023, M1025
  - M1010, M1016, M1020, M1022, M1024
- Stop transmitting OASIS C via the state on December 26
- Start transmitting OASIS C1 (and any left over OASIS C) via ASAP on January 1

Exams

- ICD-9-CM Initial Certification
- ICD-9-CM Reassessment
- ICD-10-CM exam for certified
- ICD-10-CM exam for non-certified

Update on Case Mix

M1024 Today

- V code as primary or secondary replaces a fracture
- V54.1x codes $\rightarrow$ M1024
- V54.2x codes $\rightarrow$ M1024
- But NOT V54.81
- And NOT V54.0x
May continue to place the resolved case mix diagnoses in M1024, however there will be no points.
- Risk adjustment only
- Is that condition already in M1010/M1016??

Change up the V code as primary replaces a case mix diagnosis that gets more points as primary.

Diabetes    Rows 4 and 5
Neuro 1     Rows 12-14
Skin 1      Rows 25-26

These categories of case mix codes earn more points when primary.

<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></td>
</tr>
<tr>
<td>Trauma wound</td>
<td>891.0</td>
<td></td>
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</tbody>
</table>

Still get primary points!

M1020/M1022 (1) | (2) | M1024(3) |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>AC surgery injury/trauma</td>
<td>V58.43</td>
<td></td>
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<tr>
<td>Surg dressing change</td>
<td>V58.31</td>
<td></td>
</tr>
<tr>
<td>Trauma Wound</td>
<td>891.0</td>
<td></td>
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</tbody>
</table>

Secondary points only!
This Also Applies to NRS Scoring

<p>| | | | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Primary diagnosis = Anal fissure, fistula and abscess 15</td>
<td>11</td>
<td>Primary diagnosis = Other infections of skin and subcutaneous tissue 16</td>
</tr>
<tr>
<td>2</td>
<td>Other diagnosis = Anal fissure, fistula and abscess 13</td>
<td>12</td>
<td>Other diagnosis = Other infections of skin and subcutaneous tissue 7</td>
</tr>
<tr>
<td>3</td>
<td>Primary diagnosis = Cellulitis and abscess 14</td>
<td>13</td>
<td>Primary diagnosis = Post-operative Complications 23</td>
</tr>
<tr>
<td>4</td>
<td>Other diagnosis = Cellulitis and abscess 8</td>
<td>14</td>
<td>Other diagnosis = Post-operative Complications 15</td>
</tr>
<tr>
<td>5</td>
<td>Primary diagnosis = Diabetic ulcers 20</td>
<td>15</td>
<td>Primary diagnosis = Traumatic wounds, burns 19</td>
</tr>
<tr>
<td>6</td>
<td>Primary diagnosis = Gangrene 11</td>
<td>16</td>
<td>Other diagnosis = Traumatic wounds, burns 8</td>
</tr>
<tr>
<td>7</td>
<td>Other diagnosis = Gangrene 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Primary diagnosis = Malignant neoplasms of skin 15</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Other diagnosis = Malignant neoplasms of skin 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Possible use of V codes with these.

Changes to Case Mix Effective Jan2014

- Deletion of 170 case mix codes effective January 1, 2014
  - Too acute
    - Diabetes with hyperosmolarity
    - Ulcers with hemorrhage
    - Appendicitis
  - Do not increase utilization
    - GERD
    - Blepharospasm
    - Broken tooth
- Average case-mix weight drop from 1.3517 to 1.3417 if those codes hadn’t been case mix in 2012
Diagnoses on the OASIS

Expectations

- CMS expects that the professionals who complete the OASIS to be able to choose the primary diagnosis and other diagnoses that should be listed on the POC as part of care planning.
- CMS does not expect that those same professionals to be able to actually assign the code.
  - Although agencies may expect the clinicians to assign the codes, coding is a specialty and CMS states that a coder may assign the code.
- If an error is made in coding, there is a professional obligation to correct the error so that coding is in compliance with Official Coding Guidelines and with other professional guidance, i.e., CMS requirements.

Policy Requirement

- HHAs should have a policy and procedure for correcting errors that involves the assessing clinician.
- The policy should follow established clinical record professional practice standards and guidance found in relevant CMS regulations and guidance.
- Normally, if an error is identified through audit or review, the individual who made the original entry into the patient’s record would, whenever possible, make the necessary correction by following agency policy.

Policy Requirement

- A correction policy may allow the auditor who found the error to contact the clinician, discuss the discrepancy in the medical record and make the correction following your policy including information such as who discovered the error, and the date and time of communication with the assessing clinician who agrees that it was an error. Correction of an error will not impact the M0090, Date Assessment Completed.
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.
- This applies to M1010, M1016 and M1020/1022/1024.

Who Does What?

- Assessing clinician writes in diagnoses (e.g., CHF, aftercare following surgery)
- Assessing clinician marks degree of symptom control (0-4)
- Coder may assign the codes.
- All must be compliant with professional guidance (CMS and Official Coding Guidelines)
- So if there are changes or corrections?

What about technical corrections?

- For example, the clinician placed a manifestation code without its required etiology preceding it or the clinician entered a diagnosis that is not supported by documentation.
- The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M1020, and ICD-9-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for manifestation coding requirements, the assessing clinician must be contacted and agree.

Approval By the Clinician

- If after discussion of the manifestation coding situation between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor and that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC using current ICD-9-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made.
- Category 4, Q44.1
What about technical corrections?

- If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a “technical” error and the coding specialist may not automatically make the correction without consulting with the assessing clinician.
- Category 4, Q44.1

Diagnoses Not Supported

- A diagnosis not supported by documentation may mean that the clinician has decided on a diagnosis not confirmed by the physician, or
- The clinician has omitted necessary information in the documentation to support why that particular diagnosis is pertinent to the Plan of Care.
- The assessing clinician should be asked for supporting documentation to substantiate the diagnosis chosen.
- It may mean that the physician must be queried to confirm the questionable diagnosis and be asked for orders to address the diagnosis when confirmed. Remember, CMS expects that all diagnoses listed have interventions and goals.

Chasing the Clinician Around

Potential Policies/Procedures

- Clinician completes OASIS
- Corrections are made on separate document and discussed with assessing clinician
- If approved, corrections are entered and locked
- Clinician completes OASIS, except for coding
- Diagnoses and coding are discussed with clinician and clinician enters into OASIS
- Clinician completes OASIS
- Coder enters system and enters codes, makes corrections
- Clinician enters approval
Policy Requirements

- In a case where the original documenter is not available, the clinical supervisor or quality staff may make the correction to the documentation following the correction policy. The supervisor must document why the original assessing clinician is not available to make the correction and how the error was identified and validated as a true error.
- What is Not Available?

Impact of Corrections

- When corrections are made to assessments submitted to state, you must determine the impact of the correction on the POC, HHRG, the Plan of Treatment, RAP and make corrections to those documents and billing, as applicable.

Impact of Corrections

- When the comprehensive assessment is corrected, the HHA must maintain the original as well as subsequent corrected assessments in the patient’s clinical record per requirements at 42 CFR 484.48. CMS urges HHAs to make corrections and/or submit inactivations as quickly as possible after errors are identified so the state system will be as current and accurate as possible, as the data is used to generate OBQM, OBQI, PBQI, Patient-Related Characteristics Report and HHRG.

What About M0090?

- If the clinician makes a change or agrees to a change in the assessment within the time period for the assessment, e.g., within 5 days after the SOC, then the M0090 date should change. If changes are made after the time period for the assessment, do not necessarily change M0090.
What About M0090?

- If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made.
- If an error is identified at any time, it should be corrected following the agency’s correction policy and M0090 would not necessarily be changed.
  
  Category 4, Q19.3

What About M0090?

- Only one clinician can complete the comprehensive assessment including the OASIS. If the clinician responsible for completing the OASIS assessment gathers new information during the 5 day assessment time period, s/he may change the response to that item and change the M0090 date to reflect the date the latest new information was gathered. This would apply to M2200.
  
  Category 4, Q19.4

What About M0090?

- If the OASIS is completed by the assessing clinician and then, through an internal review process in the office, it is discovered that the OASIS data contains one or more errors, the identified data item(s) could be corrected by the qualified clinician responsible for performing the review following your agency's correction policy and in such cases of error correction, M0090 would not be changed. Category 4, Q19.4

OASIS Not Completed

- What if the assessing clinician did not complete the OASIS, e.g., left some items blank, and now is unavailable to finish?
What You Can and Can’t Do

- Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
  - 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
  - 1 - With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
  - 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on level surfaces. Also requires improved vision or assistance to negotiate stairs, steps or uneven surfaces.
  - 3 - Able to walk only with the supervision or assistance of another person at all times.
  - 4 - Chairfast, unable to ambulate but is able to wheel self independently.
  - 5 - Chairfast, unable to ambulate and is unable to wheel self.
  - 6 - Bedfast, unable to ambulate or be up in a chair.

Another qualified clinician would have to visit the patient and complete a new comprehensive assessment including OASIS. The other OASIS answers cannot be answered based on a guess or even by another clinician who has seen the patient.

…it is not a collaborative effort between field staff or field staff and supervisors.

One Clinician ‘Rule’

- If the comprehensive assessment for a patient requiring OASIS data collection was completed in a non-compliant manner and the OASIS data items were not completed, the agency should send another qualified clinician out during the allowed timeframe for completing the assessment, within 5 days after the Start of Care (SOC) date, to start and complete an entire comprehensive assessment, not just the OASIS items.

Who Adds Documentation?

- When a clinician signs the assessment, it is an attestation that everything contained in the assessment is truthful and accurate, based on that clinician’s assessment. Information in the medical record cannot be "made up" or "created" in an effort to be compliant with the Comprehensive Assessment of Patient Condition of Participation’s (484.55) required timeframes. Careful documentation should be included in the medical record to explain the circumstances that led to the non-compliance. Category 4, Q37.4
Recommendations

1. Ensure that all qualified clinicians are trained in OASIS data collection to minimize errors.
2. Ensure that all qualified clinicians are able to use care planning skills in order to select the primary and other diagnoses that are appropriate for the Plan of Care of the individual patient.
3. Ensure that coders are qualified and competent to assign the correct codes to the diagnoses selected utilizing official guidance at a minimum and/or be able to review all available information, query the physician when appropriate, request additional documentation from the clinician as needed, and recommend diagnoses and sequencing to the assessing clinician at the optimum.

4. Always request that the assessing clinician approve any changes to the assessment.
   A. The best corrections are made by the clinician himself or herself within the time frame allowed for that assessment. Follow the standards outlined by Medicare for amendments, corrections and delayed entries.

OASIS Correction Worksheet

- Document the original answer, the changed answer and the rationale for making the change (you will not remember why the change was made next year when that chart is called for medical review).
- Last, but certainly not least, the assessing clinician must approve the changes before they are entered into the system.
- If your agency uses an EHR, ensure that the system meets Medicare criteria.
Recommendations

5. If the assessing clinician is no longer available, (employment has been terminated, vacation, leave, etc) then have a clear process for how necessary changes are made and by whom they may be made.

The error must be a true error and not just a difference in opinion. The supervisor or designated person must document why the original assessing clinician is not available to make the correction and how the error was identified and validated as a true error. Always maintain the original answer, as well as any changes, along with rationale for the change.

6. Implement a data quality audit program to find errors prior to ‘locking’ and transmitting the OASIS.

7. To be compliant with Medicare Conditions of Participation, the OASIS must be transmitted within 30 days of M0090 (Date Assessment Completed). According to claims processing requirements, the OASIS must be ready for transmission prior to the RAP being submitted. A lot of extra work may be avoided, if an agency holds to these principles.

Errors Found After Transmission, Dropping, Sending

- If errors are found after the OASIS was transmitted or after the RAP has been submitted, then there must be a process to determine the impact of the error on the OASIS and the RAP.

Errors

A. Any error in OASIS will have impact on outcomes as every item is used in the outcome process, either directly or for risk adjustment.

B. Only errors in case mix items will impact the RAP. Any change to diagnoses will impact claims processing, therefore the RAP will need to be canceled. (Remember the diagnoses on the claim must match that on OASIS.)

C. The HHA must cancel a RAP sent in error. RAPs cannot be adjusted. They may be rebilled with appropriate information after cancellation. Type of bill (TOB) 328 is used for a cancel transaction, for both claims and RAPs.

10.1.11 -Payment, Claim Adjustments and Cancellations (Rev. 1, 10-01-03) HH-467.20, A3-3639.20
**Errors**

D. OASIS corrections information, once the OASIS has already been submitted can be found on the CMS website. (See Resources below.)

E. Beginning January 1, 2010, home health agencies (HHAs) are required to submit an OASIS as a condition for payment. Contractors may deny the claim as a result of not meeting this regulatory requirement. The assessment must be patient specific, accurate, and reflect the current health status of the patient. This status includes certain OASIS elements used for calculation of payment including documentation of clinical needs, functional status, and service utilization.

**Last Word from Medicare**

- Correction of clinical documentation errors is more time consuming because the documentation must be returned to the clinician with an explanation of the error. The clinician must correct the error promptly and return the record to the data entry staff person. The correction is then entered and the record checked again for errors.

**Errors**

- With promulgation of §484.250 as a condition of payment, entire home health claims are now subject to denial if agencies do not submit start-of-care and recertification assessments for every Medicare episode to the state.

- The HIPPS code on the final claim must match that received on the OASIS validation report AND OASIS data has to have been submitted prior to the final claim. (Please note that all OASIS assessments have to be transmitted if the payor is Medicare, Medicare HMO, Medicaid or Medicaid HMO as required by the CoPs. Only those involved in payment (SOC, Recertification and ROC when acting as a Recertification) are involved in this last requirement.)

- If copies of documentation are submitted for data entry, the procedure will need to include steps to ensure the correction is made in the official agency clinical record as well as in the data submitted to the State agency.
As with other process changes, once the process is finalized, it must be rigorously enforced. The agency can monitor its own compliance with the 30-day submission requirement by including this component in the tracking system.

Category 4, Q37.3 [Q&A EDITED 01/11; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #2]

A complete assessment
- At the time services are rendered
- Will result in more complete documentation with fewer errors
- Thorough training in OASIS with emphasis on the “tricky” parts can decrease your OASIS errors
- Trained people auditing the OASIS
- Complete policy for any corrections

**Avoid Panic**

**Additional Resources**

- All OASIS official documentation including the Q and A can be found at: https://www.qtso.com/hhadownload.html
- Specific information on developing OASIS Data Accuracy programs and correcting OASIS data already submitted may be found in Appendix B to the OASIS manual found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html Click on link under Downloads for 2012 OASIS-C Guidance Manual.
List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-9-CM Code</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
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<tr>
<td>b.</td>
<td></td>
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<tr>
<td>c.</td>
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<tr>
<td>d.</td>
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<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
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</tbody>
</table>

List each Inpatient Procedure and the associated ICD-9-CM procedure code relevant to the plan of care.

<table>
<thead>
<tr>
<th>Inpatient Procedure</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
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<tr>
<td>b.</td>
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<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
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</tbody>
</table>

- NA - Not applicable
- UK - Unknown

Diagnoses Requiring Medical or Treatment Regimen Change

List the patient’s Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Changed Medical Regimen Diagnosis</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
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<td>f.</td>
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</tr>
</tbody>
</table>

- NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

- Conditions requiring active treatment
  - Resolved conditions will be included here

- Do not include conditions that have improved over the past 14 days
  - Diabetic taking insulin is put on oral antiglycemics instead.
  - Patient has finished his antibiotics for pneumonia.
  - Resolved conditions will not be included here.
Medicare’s rules for coverage and payment
- CMS expects HHAs to understand each patient’s specific clinical status before selecting and assigning each diagnosis.
- Each patient’s overall medical condition and care needs must be comprehensively assessed BEFORE the HHA identifies and assigns each diagnosis for which the patient is receiving home care.

### M1020/1022 Diagnoses and Symptom Control

- 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.
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.

Sequencing Home Health Diagnoses

Presented by Selman-Holman & Associates, LLC
Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D

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### 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 Parkinson’s
  - 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*
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

Sequencing Rules

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 on toes
  - 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.
Examples

- 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) 438.82, 787.20
- D) 250.00, 585.3
- E) 714.0, 357.1
- F) 682.2, 041.11

Bonus: Which of the above is 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.

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

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

- 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.

Z47.1 Aftercare following joint replacement
Use additional code to identify joint Z96.6-

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
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?

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.

- 326 and 310.81

General Rule: Code what you see first and the sequela code (original injury with an S or original illness, e.g. polio) comes later.

- G81.11 Spastic hemiplegia affecting right dominant side

- S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela

Code the sequela code first when what you 'see' cannot go first (manifestation code).

- E64.3 Sequela of rickets

- M49.82 Spondylopathy in diseases classified elsewhere

Sequela of cerebrovascular accidents

- I69.351

Classification indicates otherwise (pseudobulbar effect)
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.

Example

- Patient is to receive aftercare following surgery for cancer of the brain. Orders include dressing changes on the surgical wound. Other diagnoses include diabetes, emphysema, diverticulitis with a colostomy and CHF.

Discretionary Sequencing

- V58.42 AC neoplasm
- V58.31 dressing changes
- V55.3 attention to colostomy
- V58.31 dressing changes

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.
- No equivalent code in ICD-10
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!!

And then what does CMS say?

- Active intervention, or
- 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? Why is that diagnosis important enough to list (especially in the first 6)? 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.
Coding Diabetes

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.

<table>
<thead>
<tr>
<th>250.60</th>
<th>249.60</th>
</tr>
</thead>
<tbody>
<tr>
<td>357.2</td>
<td>357.2</td>
</tr>
</tbody>
</table>

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
- Uncontrolled not a concept

| E11.- |

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

| E10.- |
Diabetes 5th digit--249

- 0—not stated as uncontrolled
- 1—uncontrolled
- Same rules apply when choosing the 5th digit regarding the definition of uncontrolled
- E08.-, E09.-, E13.-

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
- Z79.4

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 4\textsuperscript{th} Digit 0

- If there are multiple 250 codes, 250.0x cannot be one of them.
- Never code 4\textsuperscript{th} 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 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>

Diabetes 4\textsuperscript{th} Characters

- 2 as 4\textsuperscript{th} character
  - R- Renal/Kidney complications

- 3 as 4\textsuperscript{th} character
  - O- Ophthalmic

- 4 as 4\textsuperscript{th} character
  - N- Neurological

- 5 as 4\textsuperscript{th} character
  - C- Circulatory

- 6 as 4\textsuperscript{th} character
  - O- Other—arthropathy, skin complications, oral complications, hypoglycemia, hyperglycemia and other

4\textsuperscript{th} Digit (4) Renal Manifestations 4\textsuperscript{th} Digit (2) in ICD-10

- Code Type 1 diabetes causing CKD Stage 5 with dialysis
- Code Type 1 uncontrolled diabetes and CKD Stage 5 with dialysis
- Hospice pt with Type 1 uncontrolled diabetes and stage 5 refusing dialysis
Answers

- 250.41 diabetes, type 1, with renal manifestations
- 585.6 CKD ESRD
- V45.11 dialysis status

- 250.03 diabetes, type 1, uncontrolled, no mention of complications
- 585.6
- V45.11

- 585.6 CKD
- V66.7 palliative care

4th Digit (5 or 3) Ophthalmic Manifestations

- Diabetic patient has glaucoma and low vision
- Patient has diabetic macular edema and low vision
- Requirement to support low vision in your POC

Answers

- E10.22 Type 1 diabetes with CKD
- N18.6 CKD ESRD
- Z99.2 dialysis status

- E10.65 Type 1 diabetes with hyperglycemia
- N18.6 ESRD
- Z99.2 dialysis status

- N18.6 CKD
- Z51.5 palliative care
  no relationship between ESRD and diabetes

- 250.00 Diabetes without mention of complications
- 365.9 Glaucoma, NOS
- 369.20 Low vision

- 250.50 Diabetes with ophthalmic manifestations
- 362.07 diabetic retinal edema
- 362.01 diabetic retinopathy
- 369.20 Low vision
**Answers**

- E11.9 Diabetes without complications
- H40.9 Unspecified glaucoma
- H54.2 loss of vision

- E11.311 Type 2 DM with unspecified diabetic retinopathy and macular edema
- H54.2 loss of vision

(Code first any associated underlying cause of blindness)

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**4th Digit (6 or 4)**

- 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

---

**Answers**

- E11.42 Diabetes with polyneuropathy
- E11.43 Diabetes with peripheral autonomic neuropathy
- K31.84 Gastroparesis (optional according to CC)
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
- Code uncontrolled diabetes with diabetic PVD

4th Digit 5

- No assumption between diabetes and gangrene
- Gangrene and peripheral angiopathy with diabetes is combination code
- Uncontrolled diabetes with diabetic PVD
- E11.65 Diabetes with hyperglycemia
- E11.51 Diabetes with peripheral angiopathy without gangrene

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

Diabetes with 4th Digit 6

Diabetic ulcer to the bone on the right great toe
- E11.621 DM with foot ulcer
- L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of the bone

Diabetes with chronic osteomyelitis of the right midfoot
- E11.69 DM with other complications
- M86.671 Other chronic osteomyelitis, right ankle and foot
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>
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<tbody>
<tr>
<td>M1020(a) diabetes with other specif</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?

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<td>707.15</td>
</tr>
<tr>
<td>M1022(c) CHF</td>
<td>428.0 (I50.9)</td>
</tr>
<tr>
<td>M1022(d) exacerbation of COPD</td>
<td>491.21 (J44.1)</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>
</tbody>
</table>

How do you code aftercare of an amputation?

- V54.89
- Diabetic ulcer V58.77
- Diabetic peripheral angiopathy V58.73
- Diabetic osteomyelitis V58.78
- Diabetic gangrene V58.49/V58.73
- Ran over the toes with the lawn mower V58.43
- All of these require a V49.6x or V49.7x for the level amputated
- See absence
- But what if the amputation is complicated?
**Amputation site (BKA) is infected with MRSA after amputation for diabetic angiopathy**

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<td>M1022(d)</td>
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<tr>
<td>M1022(e)</td>
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<tr>
<td>M1022(f)</td>
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<tr>
<td>OPDx</td>
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**Answers**

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

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**‘Planned’ vs Traumatic**

- 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?

- Amputations are coded with aftercare codes when routine care is being provided for a planned amputation
  - Z47.81 Aftercare following amputation
- Use additional code to specify the level of amputation and laterality.
- If traumatic amputation…
### Amputations

<table>
<thead>
<tr>
<th>Planned</th>
<th>Traumatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Patient’s right great toe is amputated because of a diabetic ulcer that won’t heal. He also has diabetic PVD.</td>
<td></td>
</tr>
<tr>
<td>□ Z47.81 Aftercare following amputation</td>
<td></td>
</tr>
<tr>
<td>□ E11.51 Diabetes with peripheral angiopathy</td>
<td></td>
</tr>
<tr>
<td>□ Z89.411 Acquired absence of right great toe</td>
<td></td>
</tr>
</tbody>
</table>

| □ Patient’s right great toe was cut off when mowing the lawn (powered lawnmower). |
| □ S98.111D Traumatic amputation of right great toe |
| □ W28.xxxD Contact with powered lawn mower |
| □ (Status code for absence is not used because the traumatic amputation code provides the information) |

### 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

### Diabetes Categories

- □ E08 DM due to underlying condition
  - □ Code first underlying condition
  - □ Use additional code to identify insulin use
- □ E09 Drug or chemical induced DM
  - □ Code first and Use additional code notes. Notice difference between adverse effect and poisoning.
  - □ Use additional code to identify insulin use
- □ E13 Other specified DM
  - □ Use additional code to identify insulin use
  - □ postpancreatectomy

### E08 DM due to underlying condition

- □ Any condition that impacts the pancreas function
- □ Cystic fibrosis- Cystic fibrosis produces abnormally thick mucus, which blocks the pancreas.
- □ Pancreatic cancer, Pancreatitis, and trauma can all harm the pancreatic beta cells or impair insulin production, thus causing diabetes.
- □ Malnutrition
- □ Cushing’s syndrome--induces insulin resistance. Cushing’s syndrome is marked by excessive production of cortisol—sometimes called the “stress hormone.”
### E09 Drug or chemical induced DM

- Some medications, such as nicotinic acid and certain types of diuretics, anti-seizure drugs, psychiatric drugs, and drugs to treat HIV, can impair beta cells or disrupt insulin action. Pentamidine, a drug prescribed to treat a type of pneumonia, can increase the risk of pancreatitis, beta cell damage, and diabetes. Also, glucocorticoids—steroid hormones that are chemically similar to naturally produced cortisol—may impair insulin action. Glucocorticoids are used to treat inflammatory illnesses such as rheumatoid arthritis, asthma, lupus, and ulcerative colitis.

### E09 Drug or chemical induced DM

- Many chemical toxins can damage or destroy beta cells in animals, but only a few have been linked to diabetes in humans. For example, dioxin—a contaminant of the herbicide Agent Orange, used during the Vietnam War—may be linked to the development of type 2 diabetes. In 2000, based on a report from the Institute of Medicine, the U.S. Department of Veterans Affairs (VA) added diabetes to the list of conditions for which Vietnam veterans are eligible for disability compensation. Also, a chemical in a rat poison no longer in use has been shown to cause diabetes if ingested. Some studies suggest a high intake of nitrogen-containing chemicals such as nitrates and nitrites might increase the risk of diabetes. Arsenic has also been studied for possible links to diabetes.

### Examples

- The patient has steroid induced diabetes from taking corticosteroids for an upper respiratory infection last year.
  - E09.9 Drug or chemical induced diabetes
  - T38.0x5S Adverse effect of glucocorticoids, sequela

- The patient has diabetes from exposure to Agent Orange during the Vietnam conflict.
  - T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela
  - E09.9 Drug or chemical induced diabetes

### E13 Other Specified Diabetes

- Genetic defects of beta cell function or insulin action
- Postpancreatectomy/post procedural DM
- Secondary DM, NEC
- E89.1 Postprocedural hypoinsulinemia
- E13 code(s)
- Z90.41- Acquired absence of pancreas
Code post pancreatectomy diabetes in ICD9

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 state or implied, are coded separately.
General Guidelines
Hypertensive Heart Disease

- Heart conditions classified to I50.- or I51.4-I51.9 are assigned to a code from I11 when a causal relationship is STATED or IMPLIED
  - Physician MUST state or imply relationship
  - I51.4-I51.9 are included however use an additional code for heart failure.
  - Specific sequencing required
- For patients who do NOT have a stated or implied relationship between the same heart conditions (I50-, I51.4-I51.9) and hypertension, the conditions are coded separately (no specific sequencing required with hypertension and the heart disease)
  - I10 Essential Hypertension OR
  - I12.- Hypertensive Chronic Kidney Disease (if CKD present)

General Guidelines
Hypertensive Chronic Kidney Disease

- May assume a relationship between hypertension and chronic kidney disease
- Code to I12.-
  - Stage 5 or ESRD with hypertension I12.0
  - Stage 1-4 or unspecified CKD with hypertension I12.9
  - Specific sequencing required with CKD

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)

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.
General Guidelines
Hypertensive Heart and CKD

- I13—combination code when hypertensive heart disease is verified (I11) and the patient also has CKD (I12).
  - Use additional code for heart failure when present.
  - Use additional code for CKD.

Question Asked A Lot

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

Chapter Specific Guidelines

Patients with CKD may also suffer from other conditions, most commonly diabetes and hypertension. The sequencing of the CKD in relationship to codes for other contributing conditions is based on the coding conventions.

- Relationship between CKD and HTN may be assumed
- Relationship between CKD and Diabetes must be stated by physician

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.
  □ 403.91, 585.6, 428.0
- Patient has HTN and CHF.
  □ 401.9, 428.0
- Patient has CHF due to HTN.
  □ 402.91, 428.0
- Patient has systolic heart failure due to HTN and renal sclerosis.
  □ 404.91, 428.20, 587

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.

Name that category

- Hypertension and ESRD
  □ I10
- Hypertension and CHF
  □ I11
- Systolic heart failure due to hypertension
  □ I12
- Malignant hypertension
  □ I13
- Patient has CKD and hypertensive cardiomegaly
  □ I13
Name that category

- Hypertension and ESRD
- Hypertension and CHF
- Systolic heart failure due to hypertension
- Malignant hypertension
- Patient has CKD and hypertensive cardiomegaly

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
- Lets 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.

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.
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.

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.

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.

Arterial Ulcers

- Mr. Lee is admitted to the home health agency for wound care due to atherosclerosis of the legs with multiple resulting ulcers of the bilateral ankles. The referral from the wound center reports exposure of adipose tissue in both ulcers. Nursing assessment confirms this.
**Answers**

- I70.233 Atherosclerosis of the native arteries of the right ankle with ulceration
- L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed
- I70.243 Atherosclerosis of the native arteries of the left ankle with ulceration
- L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed

**Venous stasis**

- Patient has venous stasis disease.
  - I87.2 Venous insufficiency (chronic) (peripheral)
- Patient has chronic venous hypertension with ulceration at right ankle (fatty tissue).
  - I87.311 Chronic venous HTN with ulcer of RLE
  - L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed

**Coding Example**

- Mrs. Beasley is an obese female patient who has a non-pressure wound to her left calf. It is draining a large amount of serous fluid, which often drips down into her shoes. The patient has DM, venous hypertension, and edema. The patient is not noted to have varicose veins. The physician is queried and agrees that the ulcer is due to the chronic venous hypertension. She has co-morbidities of CAD and HTN. On admission, the SN noted that the wound was shallow/superficial, with wound bed with some granulation.

**Coding Example**

- I87.312-Chronic venous HTN with ulcer of left LE
- L97.222-Non-pressure ulcer left calf with fat layer exposed
- I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris
- I10-primary HTN
- E11.9-Type II DM without complications
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

Sequencing Late Effects

- **Late Effect CVAs**
  - Combination code (438.21)
  - OR
  - 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
Late effects of strokes should be coded, NOT acute CVA.

- Rarely is one late effect the only terminal diagnosis.
- Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to 430-437.

The Correct Codes for Stroke

- 438.0 Late effects CVD with cognitive deficits
- 438.2x Late effects CVD with hemiplegia
- 438.3x or 4x Late effects CVD with monoplegia
- 438.5x Late effects CVD with other paralytic syndrome (locked in state or quadriplegia)
- 438.82 Late effects CVD with dysphagia 787.20
- 438.89 Other late effects with PVS 780.03

Code It!

- A patient with cognitive deficits related to a CVA with feeding difficulties and 25% loss of body weight. Patient has transient loss of awareness. DNR status.

Answers...Let’s discuss

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>438.89</td>
<td>Other late effects of CVA</td>
</tr>
<tr>
<td>783.3</td>
<td>Feeding difficulty</td>
</tr>
<tr>
<td>783.21</td>
<td>Abnormal loss of weight</td>
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<tr>
<td>438.0</td>
<td>Late effects CVA with cognitive deficits</td>
</tr>
<tr>
<td>780.02</td>
<td>Transient awareness</td>
</tr>
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</table>
### Stroke Exercise

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

M1020/1022 | M1024
---|---

### Stroke Answer

<table>
<thead>
<tr>
<th>M1020/1022 (1)</th>
<th>(2)</th>
<th>M1024</th>
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<tbody>
<tr>
<td>Multiple therapies</td>
<td>V57.89</td>
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<tr>
<td>Dysarthria as LE CVA</td>
<td>438.13</td>
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<td>Dysphagia as LE CVA</td>
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<td>Dysphagia</td>
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<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>
<thead>
<tr>
<th>M1020/1022(1)</th>
<th>(2)</th>
<th>M1024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysarthria</td>
<td>784.51</td>
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</tr>
<tr>
<td>Oral dysphagia</td>
<td>787.21</td>
<td></td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>728.87</td>
<td></td>
</tr>
<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>
Sequela

- General Rule: Code what you see first and the sequela code (original injury with an S or original illness, e.g. polio) comes later.
  - G81.11 Spastic hemiplegia affecting right dominant side
  - S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
- Code the sequela code first when what you ‘see’ cannot go first (manifestation code).
  - E64.3 Sequela of rickets
  - M49.82 Spondylopathy in diseases classified elsewhere
- Sequela of cerebrovascular accidents
  - I69.351

Sequela of CVAs

- NON-traumatic bleeds
  - If CVA is from a subarachnoid hemorrhage—I69.0-
  - If CVA is from an intracerebral hemorrhage—I69.1-
  - If CVA is from an intracranial hemorrhage—I69.2-
  - If NOT a bleed (most strokes are caused by a clot), then:
    - If just documented as a ‘stroke’—I69.3-
    - Do NOT use I69.9
    - Reference ‘Sequela’ in the index

Scenario

- Mr. Jarvis was referred to home care after a stroke for right sided hemiplegia, dysphasia and cognitive changes.
  - I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
  - I69.321 Dysphasia following cerebral infarction
  - I69.31 Cognitive deficits following cerebral infarction

Sequela of Strokes

- I69.3-
  - Which ones require more info?
    - Dysphagia
    - Seizures—how would you code this one?
    - Muscle weakness--how would you code this one?
Coding Orthopedic Conditions

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 5th 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 (not necessary)
  - 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, arthritis in the other hip and a gastric ulcer.

M1020/1022
- V57.1
- 781.2 abn of gait (not necessary)
- V54.81 AC joint replacement
- 715.35 Localized OA hip
- 401.9 HTN
- 531.90 gastric ulcer
- V43.64 hip

Osteoarthritis

- Most common DJD
- Breaks down the cartilage causing pain, swelling, and reduced motion in the joints.
- Many differences between ICD-9 and ICD-10
- Types
  - Polyosteoarthritis (generalized)
  - M16.-OA of hip
  - M17.-OA of knee
  - And so on...

Quiz

- Physicians document polyosteoarthritis all the time. True or False
- Primary osteoarthritis is:
  - A. the origin of the OA
  - B. the first joint affected by the inflammation
  - C. related to the age of the patient
  - D. the first diagnosis listed

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.
- 1st quarter Coding Clinic 2011
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

Joint Replacement

- Patient returns home after joint replacement to the right hip for bilateral primary OA.
- Z47.1 Aftercare following joint replacement surgery
- M16.12 Unilateral primary OA, left hip
- R26.89 Other abnormalities of gait and mobility (optional)
- Z96.641 Presence of right artificial hip joint

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

Scenario

- Patient admitted for surgical aftercare for a right shoulder joint prosthesis insertion following an explantation of a prosthesis due to mechanical failure.
Scenario

Patient admitted for surgical aftercare for a left shoulder joint prosthesis insertion following an explantation of a prosthesis due to mechanical failure.

- Z47.31 Aftercare following explantation of shoulder joint prosthesis
- Z96.612-Presence of left artificial shoulder joint

Check out excludes 1 note at Z47.31

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! (No M1024)
- Stress fractures are a different story!
- ICD-10: No ‘V’ codes for fractures
- Code the fx with 7th character extension

- Code the fx with 7th character extension

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

Osteoporosis with Fractures

- The most common osteoporotic fractures are of the wrist, spine, shoulder and hip.
- The symptoms of a vertebral collapse ("compression fracture") are sudden back pain, often with radicular pain (shooting pain due to nerve root compression) and rarely with spinal cord compression or cauda equine syndrome.

Osteoporosis with current pathological fracture

- Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Osteoporosis without pathological fracture

- Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow the code from M81.
Osteoporosis With Fracture Example

- Mrs. Boniva admitted for aftercare of pathological fractured vertebra due to age related osteoporosis. Documentation indicates patient had previous healed pathological fracture of humerus due to osteoporosis.

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

- Classifications of fractures:
  - Open or closed
    - Default is closed
    - Gustilo grade, if open
  - Displaced or non-displaced
    - Default is displaced
- Traumatic or pathological
  - Traumatic: bone breaks due to fall or injury
  - Pathological: bone breaks due to a disease of the bone, a tumor or infection

Osteoporosis With Fracture Answer

- M8Ø.Ø8xD Age related osteoporosis with current pathological fracture, vertebra subsequent encounter
- Z87.31Ø Personal history of healed osteoporosis fracture

Note: Age related osteoporosis is separate category from other osteoporosis

Note: Pathological fracture is separate category from osteoporosis fracture
Gustilo Grade

I  Open fracture, clean wound, wound <1 cm in length
  Open fracture, wound > 1 cm in length without extensive soft-tissue damage, flaps, avulsions
  Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment
  Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage
  Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)
  Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.

II

III

III A

III B

III C

Types of Fractures

Traumatic Hip Fracture Example

- Patient admitted for aftercare of traumatic right hip (neck of femur) fracture after falling out of wheelchair
**Traumatic Hip Fracture**

**Answer**

S72.ØØ1D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing

WØ5.ØxxD Fall from wheelchair (optional)

- **Note:** A fracture not indicated as opened or closed should be coded to closed
- **Note:** A fracture not indicated as displaced or non-displaced is coded to displaced

**Fracture**

- Mr. Acro Bat fell down 7 stairs at home twisting his right leg which resulted in fractures at the proximal and distal ends of the right tibia (medial malleolus). He has a non-wt bearing cast on the right leg. The doctor expects to increase to wt bearing within 10 days. He has a history of type II diabetes (insulin dependent) with neuropathy and has had 4 toes (all except great toe) previously amputated on his left foot as a result. He is receiving home health physical therapy for gait training.

**Trauma vs Fragility Fracture**

- A code from M80, not a trauma fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma if that fall or trauma would not usually break a normal, healthy bone.

**Analysis**

- Therapy code? ICD-9 vs. ICD-10
- Aftercare for fracture in ICD-10? What difference is there?
  - ICD-10 7th character
- External cause code required in ICD-9? ICD-10?
**Answers in ICD-10!**

<table>
<thead>
<tr>
<th>M1020/22</th>
<th>Description</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>M1021</td>
<td>Tibia upper end unspecified closed</td>
<td>S82.101D</td>
</tr>
<tr>
<td>M1023</td>
<td>Tibia medial malleolus closed</td>
<td>S82.51XD</td>
</tr>
<tr>
<td>M1023</td>
<td>Fall down steps, stairs</td>
<td>W10.8xxD</td>
</tr>
<tr>
<td>M1023</td>
<td>Diabetes type 2 with unspecified neuropathy</td>
<td>E11.40</td>
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<tr>
<td>M1023</td>
<td>Amp status toes, left</td>
<td>Z89.422</td>
</tr>
<tr>
<td>M1023</td>
<td>Use of insulin</td>
<td>Z79.4</td>
</tr>
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<td></td>
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</tr>
</tbody>
</table>

**Fracture**

- The patient broke her right humerus at mid shaft (comminuted) in a go cart accident when riding with her grandson who was demonstrating how he could ‘drift’ when it turned over. She has an ORIF.
- S42.351D Displaced comminuted fracture of shaft of humerus, right arm, subsequent encounter for routine healing
- V86.69xD Passenger of other special all-terrain or other off road motor vehicle injured in nontraffic accident

**Complication of Internal Fixation Device**

- The patient broke her right humerus at mid shaft (comminuted) in a go cart accident when riding with her grandson who was demonstrating how he could ‘drift’ when it turned over. She has an ORIF and the fixation device has come loose resulting in a nonunion of the fracture.
- Should you code the nonunion or the complication first??
- Use additional code to identify the specified condition resulting from the complication.
Complication of Internal Fixation Device

- T84.120D Displacement of internal fixation device of right humerus
- S42.351K Displaced comminuted fracture of shaft of humerus, right arm, nonunion
- V86.69xD Passenger of other special all-terrain or other off road motor vehicle injured in nontraffic accident

Fracture of the Hip

- Patient fell off the bed when his foot got caught in the covers and he has a fracture of the right greater trochanter.
- S72.111D Fracture of greater trochanter of right femur, subsequent encounter for closed fracture with routine healing
- W06.xxxD Fall from bed, subsequent encounter

Fracture of the Hip

- The patient with the broken hip refused a joint replacement. His fracture has healed but his right leg is significantly shorter than his left.
- M21.751 Unequal limb length (acquired), right femur
- S72.111S Fracture of greater trochanter of right femur, sequela
- W06.xxxS Fall from bed, sequela

Respiratory Conditions
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.

Scenario
Patient with ALS has dysphagia resulting in loss of weight, decreased respiratory function and dependence on respirator along with emphysema. She is bedbound and has a stage III pressure ulcer on the coccyx.
Code this one as a hospice patient.

Diagnoses
Terminal diagnosis—335.20
Related Diagnoses
- Dysphagia 787.20
- Loss of weight 783.21
- Pressure ulcer coccyx 707.03
- Stage III 707.23
- Bed confinement V49.84
- Ventilator dependence V46.11
Co-morbidity: Emphysema 492.8
## Scenario

Mrs. Winston is admitted for IV antibiotic and PICC line care to treat pneumonia due to MRSA. She also has a history of COPD with chronic obstructive bronchitis, and is oxygen dependent.

- MRSA pneumonia is specifically coded
- COPD codes do not discriminate as they did in ICD-9, include Chronic Bronchitis
- May use additional Z code for oxygen use

## Scenario Coded

- J44.0 COPD with lower respiratory infection
- J15.212 MRSA pneumonia
- Z99.81 Oxygen dependence
- Z45.2 Fitting and adjustment of vascular catheter
- Z79.2 Long term current use of antibiotic medication

- Note that J15.212 is inclusive of MRSA
- COPD code used indicates presence of lower respiratory infection
  - This is coded first as coding guidelines within J44.0 state to use additional code to identify infection

## New Info

- Patient has acute bronchitis due to Strep and COPD.

## Other Notes

- A patient with COPD (of any type) who also has a lower respiratory infection is not assumed exacerbated. If Mrs. Winston is also documented as exacerbated, then:
  - J44.0 COPD with lower respiratory infection
  - J15.212 MRSA pneumonia
  - J44.1 Exacerbation of COPD
    - See Excludes 2 note
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®))

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

Z Codes

- Z85.- for personal history
  - Also history, personal, benign neoplasm and History, personal, in situ neoplasm
- Z48.3 Aftercare, following surgery, neoplasm
  - Is the neoplasm resolved after the surgery?
    - If resolved, do not code the neoplasm as current diagnosis.
    - If not resolved or unknown at that time, continue to code the neoplasm.
  - Is aftercare the focus or the neoplasm the focus?

More Z Codes

- Surgical removal—Absence (partial, complete)
- Tobacco Use Z72.0
- Tobacco Dependence—Dependence, drug, nicotine (F17.20-)

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

Answers

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<tr>
<th>ICD9</th>
<th>ICD10</th>
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<tr>
<td>153.9</td>
<td>C18.9</td>
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<td>197.7</td>
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<td>Z85.21</td>
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<td>larynx</td>
<td>larynx</td>
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</tbody>
</table>

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
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!

Neoplasms Associated with Transplants

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>5th Digit Code</th>
</tr>
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<td>M1020/1022 (1)</td>
<td>Comp of transplanted organ, Kidney</td>
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<td>M1020(a)</td>
<td>996.81 T86.11 (rejection)</td>
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<tr>
<td>M1022(b)</td>
<td>199.2 C80.2</td>
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</tr>
<tr>
<td>M1022(c)</td>
<td>189.0 C64.1</td>
<td></td>
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</table>

Remission

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

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

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.

January 1, 2013
Place the wound next after the primary V code!
Example Trauma Wound—Patient was mowing lawn and ran over wire hanger which penetrated his R 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.

Trauma Wounds

- Traumatic injury codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.
- NO aftercare
- 7th character
- What kind of trauma wound?
- S81.831D Puncture wound without foreign body, right lower leg, subsequent care

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-Martain 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.

Illustration: Jan Rice, Wound Foundation of Australia

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)

Surgical Wounds

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

Complications of surgical and medical care, NEC
- T81 Complications of procedures, NEC
- T84 Complications of internal orthopedic prosthetic devices, implants and grafts
- T86 Complications of transplanted organs and tissue
- T87 Complications peculiar to reattachment and amputation

Complication of Joint Prosthesis

- The patient’s new right hip prosthesis is infected with Staph aureus.

- Complication, joint prosthesis, infection, hip

- T84.51xD Infection and inflammatory reaction due to internal right hip prosthesis
- B95.61 Staph aureus

Infected and Dehisced (external) Surgical Wound

- Codes _______________, ____________.

- Infected and Dehisced (external)
  Surgical Wound T81.31xD, T81.4xxD
Non Healing surgical wound

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

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.

Quiz—Match the Aftercare following Surgery Code

- Bowel obstruction
- Breast reconstruction
- Repair of traumatic tear to meniscus
- Colon polyp removal
- Repair mitral valve stenosis
- Investigative surgery to treat epilepsy
- TURP
- Liver transplant
- Gastric band surgery
- V58.73
- V58.43
- V58.42
- V58.44, V42.7
- V51.0
- V58.75
- V58.72
- V58.76
Quiz—Match the Aftercare following Surgery Code

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- Breast reconstruction
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- Liver transplant
- Gastric bypass surgery

- Colon polyp removal
- Repair mitral valve stenosis
- Investigative surgery to treat epilepsy
- TURP
- Liver transplant
- Lumbar disectomy

Ostomies—Assuming No Complications

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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>
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<td>V44.6 Other urinary</td>
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<td>V44.7 artificial vagina</td>
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<tr>
<td>V44.8 other artificial opening</td>
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Ostomies—Assuming No Complications

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<th>Status</th>
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<td>Z93.4 Other GI</td>
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<td>Z43.7</td>
</tr>
<tr>
<td>Z93.8 other artificial opening</td>
<td>Z43.8 other art openings</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.
- L02—Abscesses and L03--Cellulitis

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

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.
**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
Pressure Ulcer Guidelines

- Pressure ulcers (L89.-)
  - Combination codes that indicate location (laterality) and staging of ulcer. They do not require a second code to describe the stage. The 6th character of the code indicates the stage.
  - ICD-10-CM classifies pressure ulcers from stages 1-4, unspecified, and unstageable.
  - Assign as many codes in L89.- category that are needed to identify all the pressure ulcers the patient has.
  - If documentation that pressure ulcer is completely healed (not closed), then do not code the pressure ulcer.

- Pressure ulcers, on admission, described as “healing” should be assigned the appropriate pressure ulcer stage based on the documentation in the clinical record. If the documentation is unclear as to whether the patient has a new pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
  - Interpretation: Do not reverse stage. May have to ask what stage pressure ulcer was at its worst.

- If a patient is admitted with a pressure ulcer at one stage, and it progresses to a higher stage, assign the code for the highest stage reported for that site.

- Also a new category of pressure ulcers of contiguous sites (back, buttock and hip) are included in the (L89.4-) pressure ulcer category.

- Assignment of stages of pressure ulcers can be based on:
  - Documentation from the provider
  - Documentation from the agency clinician.
Pressure Ulcer Guidelines

- Unstageable pressure ulcers (L89.- -0)
  - Ulcers should be coded as unstageable when the stage cannot be clinically determined because of:
    - Eschar
    - Skin or muscle graft
    - Deep tissue injury (not due to trauma)

- Do not confuse this with unspecified stage (L89.- -9)
  - When there is no specific documentation regarding stage.
  - THIS SHOULD NOT BE USED SINCE YOU CAN CODE STAGE BASED ON DOCUMENTATION FROM AGENCY CLINICIANS!

Coding Example

- The patient has a pressure ulcer to the sacrum with an area that is to the bone. The remainder of the area is shown to be full thickness with good granulation tissue. SN for wound care 2-3x week for wound vac placement.
  - L89.154-Pressure ulcer of sacral region, stage IV

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?
- Code definitive diagnosis before associated symptom codes from chapter 18

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.

Will the definitions still stand?

- Abnormality of gait
  - Usually neuro when the definitive diagnosis is unknown or resolved
- Difficulty in walking
  - Chronic condition of the bone and joint
  - (moved from MS chapter)
- But where does that definition come from?**

Abnormality of Gait

- Excludes 1
  - R26.0 Ataxic gait
  - R26.1 Paralytic gait
  - R26.2 Difficulty in walking, NEC
  - R26.8 Other abnormalities of gait and mobility
    - R26.81 Unsteadiness on feet
    - R26.89 Other abnormalities of gait and mobility
  - R26.9 unspecified abnormalities of gait and mobility

Will the definitions still stand?

- Weakness, generalized—R53.1
  - Asthenia NOS (malaise, fatigue, dizziness)
  - Excludes 1
    - age related weakness* R54.1
    - Muscle weakness M62.8- (symptom of a muscular condition)
- Muscle weakness (generalized)—M62.81
Infections

- 041 vs 038
- Resistant infections
  - Do not use V09 for MRSA
- Combination codes for infections
  - Staph aureus pneumonia
- Infections as complications

MRSA and VRSA

- 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.

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<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
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<td>M1020/22 (2)</td>
<td>T81.4xxD</td>
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<td>998.59</td>
<td>MRSA</td>
<td>041.12</td>
<td>B95.62</td>
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<td>With mention of multiple resistance (VRSA)</td>
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<tr>
<td>V58.81</td>
<td>Fitting and adj vascular</td>
<td>Z45.2</td>
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### Mental Disorders

**Psychiatric 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 as Manifestations

- 294.10 Dementia in conditions classified elsewhere
- 294.11 Dementia in conditions classified elsewhere with behavioral disturbance
  - 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

Dementias

- Alzheimers G30.9
- Dementia F02.80
- Dementia with behaviors F03.91
- Sequela of stroke with cognitive deficits I69.31
- Vascular dementia F01.50

Status Codes—Persons with a Condition Influencing Health Status

- V40-49 (V80s-V90s) 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

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

V58.3x

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
V58.3 Attention to Dressings and Sutures

- 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!!!!!!

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

- 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
Chapter 21 “Blocks”

Z14-Z15- Genetic carrier and genetic susceptibility to disease
Z16- Resistance to antimicrobial drugs
Z17- Estrogen receptor status
Z18- Retained foreign body fragments
Z20-Z28- Persons with potential health hazards related to communicable diseases.

Chapter 21 “Blocks”

Z30-Z39- Persons encountering health services in circumstances related to reproduction.
Z40-Z53- Encounters for other specific health care
Z55-Z65- Persons with potential health hazards related to socioeconomic and psychosocial circumstances.

Chapter 21 “Blocks”

Z66- Do not resuscitate status
Z68- Body Mass Index
Z69-Z76- Persons encountering health services in other circumstances
Z77-Z99- Persons with potential health hazards related to family and personal history and certain conditions influencing health status

How to Find Z Codes

- Admission
- Aftercare
- Attention
- Encounter
- Examination
- Exposure
- History
- Observation
- Presence
- Problem
- Resistance
- Status
More on Z codes and M1025

- Is the condition still present?
  - Code it next after Z code
- Is the condition resolved by surgery?
  - Optional use of M1025
  - No payment involved in M1025