TIME WAITS FOR NO ONE: ICD-10-CM CODING FOR HOME HEALTH

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CMS says:

- Compliance dates are firm and will not change
  - There will be no delays
  - There will be no grace period
- If not ready, claims will not be paid.
- Penalties may be incurred for non-compliance with HIPAA.

Implementation Date

October 1, 2015

70 days from today!
RAPs vs EOE

- Claims for episodes ending October 1 and later must be coded in ICD-10.
- ICD-10 will not be accepted prior to October 1.
- So that means...
  
  *the real beginning of ICD-10 coding is 12 days from today!*

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**Comparison**

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy and richness of data for analysis</td>
</tr>
<tr>
<td>Codes do not adequately define diagnoses needed for medical research</td>
<td>Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>Doesn’t support interoperability with other countries</td>
<td>Supports interoperability with other countries</td>
</tr>
</tbody>
</table>

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**Comparison**

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V)</td>
<td>First character is alpha (all letters except U)</td>
</tr>
<tr>
<td>Characters 2-5 are numeric</td>
<td>Character 2 is numeric</td>
</tr>
<tr>
<td>Use of decimal required after 3 characters</td>
<td>Use of decimal required after 3 characters</td>
</tr>
<tr>
<td>No placeholders</td>
<td>Use of dummy place holder ‘X’</td>
</tr>
<tr>
<td>Alpha characters are case sensitive</td>
<td>Alpha characters are NOT case sensitive</td>
</tr>
<tr>
<td>Incomplete code titles</td>
<td>Complete code titles</td>
</tr>
<tr>
<td>14,315 diagnosis codes (Volumes 1,2)</td>
<td>69,099 diagnosis codes (Volumes 1,2)</td>
</tr>
<tr>
<td>3,838 procedure codes (Volume 3)</td>
<td>71,957 procedure codes (Volume 3)</td>
</tr>
</tbody>
</table>

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**Increase in Number**

- Codes related to musculoskeletal care make up > 50% of ICD-10 codes.
- Approximately one-third of ICD-10 codes are related to fractures
- 25,000 due to laterality
Changes Vary by Clinical Area

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures</td>
<td>747</td>
<td>17099</td>
</tr>
<tr>
<td>Poisoning and toxic effects</td>
<td>244</td>
<td>4662</td>
</tr>
<tr>
<td>Brain injury</td>
<td>292</td>
<td>574</td>
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<tr>
<td>Pregnancy-related</td>
<td>1104</td>
<td>2155</td>
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<tr>
<td>Diabetes</td>
<td>69</td>
<td>239</td>
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<tr>
<td>Migraine</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Bleeding disorders</td>
<td>26</td>
<td>29</td>
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<tr>
<td>Mood-related disorders</td>
<td>78</td>
<td>71</td>
</tr>
<tr>
<td>Hypertensive disease</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>End-stage renal</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Chronic respiratory failure</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

Coding 3 to 7 Characters

Alpha (Except U) → 2 - 7 Numeric or Alpha → Additional Characters

3 – 7 Characters

Alphabetical Index

- Index to Diseases and Injuries
  - No hypertension table
- Neoplasm table is separate
- Table of Drugs and Chemicals
- Index to External Causes

Tabular List

- Within a number of ICD-10-CM chapters, category restructuring and code reorganization have occurred resulting in the classification of certain diseases and disorders different than what is currently seen in ICD-9-CM.
- Example: Gout moved to musculoskeletal system chapter
- Example: Eyes and ears separated from the Nervous system chapter
Why does diagnosis selection and coding matter?

- Payment / HHRG calculation (HH)
- Support medical necessity and care planning
  - For payment intermediaries and surveyors
- Risk Adjustment (OBQI and HH-CAHPS)
- Resource allocation based on patient acuity
- Completes the patient picture started by your comprehensive assessment and OASIS or HIS responses

OASIS-C1 Changes

- **OASIS-C1/ICD-9** was implemented Jan. 1, 2015
- **OASIS-C1/ICD-10** will be implemented when the ICD-10-CM coding set is implemented on Oct. 1, 2015
  - M1011, M1017, M1021, M1023, M1025 will be implemented when ICD-10-CM coding set goes into effect

CMS Regulation

The clinician that makes the home visit and performs the comprehensive assessment must complete all OASIS items, including identifying the primary and secondary diagnoses for M1020 and M1022. A reviewer or coder in the office may add the ICD-9-CM numerical codes, but may not change the diagnoses or sequencing in M1020-M1022 without the approval of the author of the assessment.

On the other hand, coding has to be compliant with professional guidelines (Official Guidelines for Coding and Reporting AND CMS)
**M1010: Inpatient Diagnoses**

- Only include diagnoses actively treated during the inpatient facility stay within the past 14 days
- “Actively treated” = receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition
- OASIS-C1/ICD-10 = M1011

CMS OCCB April 2010 Q&A #5

**M1011: Inpatient Diagnoses**

- No surgical procedures or Z-codes
- May list diagnoses that are only allowed in acute care settings (7th character for injuries, acute CVA)
- “Within the past 14 days” = treated at any facility pt was discharged from any time between day 0 and day 14 prior to SOC or ROC

**M1016: Diagnoses requiring Med/tx Regimen Change Within Past 14 Days**

- Any changes in treatment regimen, health care services, or medications within past 14 days
- Not always the same as M1010/M1011
- Mark NA if changes were made because a diagnosis only showed improvement within past 14 days
- Identifies patients that are more unstable or at higher risk of complications
- OASIS-C1/ICD-10 = M1017

**M1017: Diagnoses requiring Med/tx Regimen Change Within Past 14 Days**

- Used in risk adjustment of outcomes to identify patient’s recent history, and new or exacerbated diagnoses over past 2 weeks.
- If at any time in the last 14 days the patient requires a medical or treatment regimen change due to development of a new condition or lack of improvement/worsening of an existing condition, the diagnosis should be reported in M1017, even if the condition also showed improvement or stabilization during that time, or is improved at the time of the SOC / ROC
### M1020 and M1022

- Report the diagnoses, symptoms, and conditions that relate to the patient’s current plan of care, affect patient’s response to treatment or prognosis.
- All reported diagnoses must be supported by documentation in the medical record or verified by physician.
- OASIS-C1/ICD-10 = M1021 and M1023

### M1021: Primary Diagnosis

- Main reason for home care: *the focus of care for the home care episode*
- Most acute condition requiring the most intensive services and visit frequency.
- May or may not be the reason for the most recent hospitalization.
- No surgical codes, no V,W,X,Y-codes or conditions that have been resolved or eliminated by treatment (use Aftercare Z-codes when appropriate).

### Therapy Only: using V57.x

- ICD-9: If therapy is the **ONLY** discipline ordered, *must* use Encounter for Therapy (V57.x) in M1020.
  - V57.1 = encounter for P.T.
  - V57.89 = encounter for multiple therapies.
  - V57.x is *never* used as a secondary diagnosis (never in M1022).
- **ICD-10:** no equivalent to V57 codes for M1021 or M1023!

### M1023: Other (Secondary) Diagnoses

- Include **co-morbidities:** diagnoses that affect patient’s response to treatment and prognosis, even if the conditions are not the focus of the current home health treatment.
- Do **not** list conditions that have resolved, have no current impact on patient progress or outcome, and will not impact or be addressed in the plan of care.
M1023: Co-morbidities to include

- Diabetes, HTN, COPD, CHF, CAD, PVD
- MS, Parkinsons, Alzheimers, dementia, chronic systemic diseases
- Blindness
- Status amputation or ostomy
- History of neoplasm when care directed at current neoplasm

Sequencing of Secondary Diagnoses

- The Symptom Control Rating should **not** be used to determine order of secondary diagnoses in M1023
- The sequencing of secondary diagnoses should reflect the seriousness of each condition and support the disciplines and services in the Plan of Care

M1025: Payment Diagnoses

- A case mix diagnosis contributes points in the clinical domain for the Medicare Home Health PPS case-mix group assignment.
- It may be a primary diagnosis, secondary (other) diagnosis, or a manifestation associated with a primary or secondary diagnosis
- Indicated in most coding manuals by a symbol ($), highlighting or color-coding
- *OASIS-C1/ICD-10: M1025 not used for payment, MAY be used for risk adjustment.*

Common Errors Home Health

- Always listing abnormality of gait, muscle weakness, difficulty walking, etc. when therapy is involved in POC
- Listing symptoms instead of identifying and confirming a diagnosis, or separately listing symptoms that are an integral part of a condition
- Listing diagnoses that are not documented in the medical record or confirmed by MD
- Listing diagnoses in M1023 that are not pertinent to the POC (GERD, without s/sx or interventions/goals)
- Listing conditions that are resolved instead of using Aftercare codes
Physician Confirmation

- Verify with physician: you may not list a diagnosis that is not either documented in the medical record by the physician (H&P, F2F, progress note, problem list, referral info) or documented as confirmed by the physician.
- Do not list diagnoses based on medications, treatments, or patient/caregiver report without contacting the physician to confirm – document this confirmation in the record.

One Clinician Rule Reminder

- The clinician that performs the comprehensive assessment is the author of the documentation.
- Responsibilities:
  - Complete all OASIS items based on assessment.
  - Identify the primary and other pertinent diagnoses for POC.
  - Assign the symptom control rating to diagnoses.
  - If the coder makes changes in diagnoses or sequencing based on CMS rules or official coding guidance, CMS requires that the assessing clinician review and agree to the change(s).
  - The original and the changes should be kept by the agency in the chart (EHR) per OASIS correction policy.

Overview

- Conventions & Official Guidelines

Hierarchy of Importance

- Convention
- General Guidelines
- Chapter Specific Guidelines
### Placeholder ‘X’

- Addition of dummy placeholder ‘X’ is used in certain codes to:
  - Allow for future expansion
  - T42.0x1D Poisoning by hydantoin derivatives, accidental, subsequent
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
  - W11.xxxD Fall from ladder, subsequent
  - Upper or lower case ‘x’

### Addition of 7th Character

- Used in certain chapters to provide information about the characteristic of the encounter
- Must always be used in the 7th position
- Can be a letter or a number
  - S02.110B
  - O65.0xx1
- If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid

### 7th Character—Injuries

- A, initial encounter, is used while the patient is receiving active treatment for the injury.
- D, subsequent encounter, is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase.
- S, sequelae, is used for complications or conditions that arise as a direct result of an injury (ICD-10-CM coding guideline I.C.19.a).

### 7th Character for 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

**StAy AwAy from A**

**D is Default**

**S is for Sometimes**

**D is the Default**
Conventions—Dashes

- ICD-9-CM 250.xx
- ICD-10-CM alpha index utilizes a dash at the end of the code number to indicate the code is incomplete
  - Fracture, pathologic ankle M84.47-
- A dash preceded by a decimal point
  - (.-) indicates an incomplete code in the tabular list. J44.-

Inclusion Notes

Inclusion notes contain terms that are the condition for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of various conditions assigned to that code. The inclusion terms are not necessarily exhaustive (ICD-10-CM coding guideline I.A.11).

‘Includes’ appears at the category level and applies to the entire category.
Inclusion notes also appear at subcategory and code levels but ‘includes’ is not there. K31.5

Excludes Notes

- Excludes 1:
  - An excludes 1 note is a pure excludes note. It means “NOT CODED HERE”
  - Indicates the code excluded should never be used at the same time as the code above the Excludes 1 notes.
  - Is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

Excludes 2
- An excludes 2 note represents “not included here”. Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time

Excludes Note Examples

J18.Ø Bronchopneumonia, unspecified organism
- Excludes1:
  - hypostatic bronchopneumonia (J18.2)
  - lipid pneumonia (J69.1)
- Excludes2:
  - acute bronchiolitis (J21.-)
  - chronic bronchiolitis (J44.9)
Laterality

- For bilateral sites, the final character of the code indicates laterality.
- If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.
- An unspecified code is also provided should the side not be identified in the medical record.

Laterality Examples

- **M16.Ø** Bilateral primary osteoarthritis of hip
- **M16.11** Unilateral primary osteoarthritis, right hip
- **M16.12** Unilateral primary osteoarthritis, left hip
- **Z90.10** Acquired absence of unspecified breast
- **Z90.11** Acquired absence of right breast
- **Z90.12** Acquired absence of left breast
- **Z90.13** Acquired absence of bilateral breasts

Sequela

Residual effect (condition produced) after the acute phase of an illness or injury has ended. No time limit on when a sequela code can be used.

Exception: instances where the code for the sequela is followed by a manifestation code, or the sequela code has been expanded (at the 4th, 5th or 6th character levels) to include the manifestation(s).

The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

Sequela

- General Rule: Code what you see first and the sequela code (original injury with an S or original illness, e.g. polio) is listed second.
  - **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**
Other or Other Specified

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM coding guideline I.A.9.a).

NEC—Not elsewhere classified I25.89
Other forms of chronic ischemic heart disease

4th digit 8 usually, but not always

Unspecified

“Unspecified” codes are used when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM coding guideline I.A.9.b).

NOS—Not Otherwise Specified
J12.9 Viral pneumonia, unspecified (contrast that with J12.89)
4th digit 9 usually, but not always

Conventions—Relational Terms

- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list
- With—interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the alpha, or an instructional note in the tabular

Conventions Same as ICD-9

- Parentheses are used in both the Alphabetic Index and Tabular to enclose nonessential modifiers
- Brackets are used in the Alphabetic Index to identify manifestation codes, and in the Tabular List to enclose synonyms, alternative wordings, abbreviations, and explanations
- Colons are used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category
Essential Modifiers

The indented terms are always read in conjunction with the main term.

**Diverticulosis K57.90**
- With bleeding K57.91
- Large intestine K57.30
  - With
    - Bleeding K57.31
    - Small intestine K57.50
      - With bleeding K57.51
- Small intestine K57.10
  - With
    - Bleeding K57.11
    - Large intestine K57.50
      - With bleeding K57.51

The Usual Basics

- Must use the alpha and the tabular
- Read everything; it all means something
- Code to the level of highest specificity
- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter
- All diagnoses must be confirmed in the medical record or verified by physician except...

Three Diagnoses coded based on clinician documentation

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stages

Complications

- Code assignment is based on the provider's documentation of the relationship between the condition and the care and procedure.
- Important to note that not all conditions that occur during or following medical care or surgery are classified as complications.
- There must be a cause and effect relationship between the care provided and the condition and an indication in the documentation that it is a complication. If not clearly documented, query the provider for clarification.
## Syndromes

- Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for documented manifestations of the syndrome.
- Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.
- No code for the syndrome? Code all the symptoms/parts separately.

## Signs/Symptoms and Unspecified

- Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

## Unspecified

- When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).
- Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

## Sequencing

| 56 |  |
Sequencing

- The Code First/Use Additional Code notes provide sequencing order of the codes (underlying etiology code followed by the manifestation code).
  
  *In contrast:*
  
- ICD-10-CM coding guideline I.A.17 states a “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

Etiology/Manifestation

- Need to follow coding conventions
- 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

Teenage Buddy

- “Code, if applicable, any associated condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.
  - L97

So what does ‘teenage buddy’ mean?

- If cause is known, code with buddy preceding...
  - E11.621 Type 2 DM with foot ulcer
  - L97.421 non-PU of left heel and midfoot limited to breakdown of skin

- If cause is unknown, sometimes teenagers can be alone.
  - L97.421 non-PU of left heel and midfoot limited to breakdown of skin
Multiple coding for a single condition

- In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code.
- “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
- The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

Sequencing

- “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.
- L89

Multiple coding for a single condition

- A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.
- Find acute cystitis – check instructional note!

Sequencing

- Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition.
- See the specific guidelines for these conditions for further instruction.
Definitions

- **Localized infection**—An infection that is limited to a specific part of the body and has local symptoms.

- **Septicemia**—Septicemia is bacteria in the blood (bacteremia) that often occurs with severe infections. (No separate code in ICD-10)

**Sepsis or Severe Sepsis**

- **Sepsis**—a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammation throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail. If sepsis progresses to septic shock, blood pressure drops dramatically, may lead to death.

- ‘A’ codes for sepsis, then code for local infection; sequencing depends on circumstances
  - A40 Streptococcal sepsis
  - A41 Other sepsis

- R65.2- Severe sepsis with or without septic shock if acute organ dysfunction is documented (SIRS)
  - Septic shock refers to circulatory failure associated with sepsis (cannot be primary)
  - Add code(s) for associated organ failure or dysfunction
Sepsis

Sepsis with localized infection (pneumonia, UTI)
- If admitted with sepsis
  - Assign sepsis code first (A40-41)
  - Then localized infection code
  - Severe? Add R65.2-
- If admitted with localized and develops into sepsis
  - Code localized infection first

Severe Sepsis

- Minimum of two (three) codes
  - Underlying systemic infection ‘A’ code
  - Code from subcategory R65.2-
  - Additional code(s) for associated organ dysfunction

More Sepsis

- Postprocedural sepsis—must be documented by the physician—start with the specific postprocedural infection code
  - T81.4-
  - Use appropriate A40-41 code next.
- Patient with postprocedural sepsis related to infected surgical wound caused by MRSA.
  - T81.4xxD
  - A41.02

Coding HIV and AIDS

- HIV- Code only confirmed cases
  - HIV as principal diagnosis—B20 followed by manifestations of HIV infection
  - If reason for admission not related to HIV, code HIV and related diagnoses as secondary
  - Z21 is code for asymptomatic HIV (no symptoms, no AIDS, no treatment for any condition for HIV-related illness
### Infectious agents as the cause of diseases classified to other chapters

- Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, use an additional code from Chapter 1 to identify the organism.
- **Use an additional code** from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters.
- **DO NOT USE A49 codes!**

### A vs B Simplified

- A codes are generally coded *first* (sepsis)
- B codes 95, 96 and 97 are sequenced *after* what is infected. (These categories are provided for use as supplementary or additional codes to identify the infectious agent in diseases classified elsewhere.)

### Practice

- Strep sepsis with acute kidney failure
  - *Sepsis or severe sepsis? Organism? Organ dysfunction?*
- West Nile Virus
- CMV hepatitis
Answers

- Strep sepsis with acute kidney failure
  - A40.9 Streptococcal sepsis, unspecified
  - R65.20 SIRS (severe) without septic shock
  - N17.9 Acute kidney failure, unspecified
- West Nile Virus
  - A92.30
- CMV hepatitis
  - B25.1

Infections resistant to antibiotics

- Many bacterial infections are resistant to current antibiotics. Identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.
  - Look up resistance, by, name of drug

MRSA

- When a patient is diagnosed with an infection that is due to methicillin resistant Staph aureus and that infection has a combination code that includes the causal organism, assign the appropriate combo code for the condition.
- If a combo code is appropriate, do not use an additional code B95.62.
- Do not assign a code from Z16.11 to MRSA.

MRSA Examples

- Combo codes
  - Sepsis due to MRSA: A41.02
  - Colonization by MRSA: Z22.322
    - Colonization = MRSA screen or nasal swab positive but no active infection (can have active infection at same time)
- Not all are combo codes
  - UTI caused by MRSA: N39.0, B95.62
Patient admitted with infected surgical wound cultured Staph aureus resistant to penicillins and cephalosporins.
- T81.4xxD infected surgical wound
- B95.62 MRSA
- Z16.19 Resistance to specified beta lactam antibiotics

Viral meningitis
- A87.9

Septicemia caused by streptococcus pneumoniae
- A40.3 Sepsis due to Strep pneumoniae

Pneumonia due to MRSA
- J15.212

Intake:
- Infection site, any relation to procedure
- Any sepsis or severe sepsis (identify acute organ failure)
- Identify infectious organism, any resistance

Clinician’s assessment:
- Any current antibiotic treatment
- Fever, response to antibiotics
- S/sx residual from any acute organ failure
Chapter 2 Guidelines C and D
Neoplasms and Blood Disorders

What is a Neoplasm?

- Chapter 2 contains codes for most benign and all malignant neoplasms.
- Neoplasm is an abnormal mass of tissue as a result of neoplasia (the abnormal proliferation of cells). The growth of cells exceeds and is uncoordinated with that of the normal tissues around it. The growth persists in the same excessive manner even after cessation of the stimuli. It usually causes a lump or tumor. Neoplasms may be benign, pre-malignant or malignant.
- In modern medicine, the term "tumor" is synonymous with a neoplasm that has formed a lump.

Identify Neoplasm Behavior

- Benign neoplasms do not transform into cancer
- Potentially malignant neoplasms (pre-cancer) include carcinoma in situ
- Malignant neoplasms are commonly called cancer
- Uncertain—neoplasms where histologic confirmation whether malignant or benign cannot be made
- Unspecified—growth NOS, neoplasm NOS, new growth NOS, tumor NOS
- Mass—not a neoplasm

Neoplasm Table

- Located right after the Alphabetical Index
- The Neoplasm Table should be referenced first (unless histological term documented)
- Classifies by site (topography) with broad groupings for behavior (malignant, benign, etc)
  - Laterality is important!!
- Ex: Lung CA (primary site, right lung) C34.91
Remission

- Leukemia and Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues.
- If the documentation is unclear, as to whether the leukemia has achieved remission, the provider should be queried.
- C90-95, for example
  - 5th digit 0-not having achieved remission, failed remission
  - 5th digit 1-in remission
  - 5th digit 2-in relapse

Guidelines

- If treatment is directed at the malignancy, list the malignancy as principal diagnosis.
- Exception to this guideline: if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

Sequencing

- Focus of care on treatment of primary malignancy: list primary site first, followed by any metastatic sites.
- Focus of care directed toward the metastatic (secondary) site(s) only: the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

Malignancy vs History

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
  - Default on the side of coding the cancer unless you have documentation that the cancer is eradicated.
Primary malignancy previously excised and eradicated

- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

Example

- Small cell CA of right lower lobe of lung with mets to intrathoracic lymph nodes, brain
  - C34.31 Malignant neoplasm of lower lobe, right bronchus or lung
  - C77.1 Secondary malignant neoplasm of intrathoracic lymph nodes
  - C79.31 Secondary malignant neoplasm of brain

Morphologic Examples to Code

- Benign carcinoid of the rectum (*Tumor, carcinoid*)
- Subacute monocytic leukemia in remission
- 25 year old received treatment of malignant *melanoma* of skin at right breast and left arm

Answers

- Benign carcinoid of the rectum
  - D3A.026
- Subacute monocytic leukemia in remission
  - C93.91
- 25 year old received treatment of malignant melanoma of right breast and left arm
  - C43.52
  - C43.62
Diagnostic Statements to Code

- Astroglioma of brain
- Lymphosarcoma of head, face, and neck (diffuse large cell)
- Merkel cell carcinoma of left eyelid

Answers

- Astroglioma of brain
  - C71.9
- Lymphosarcoma of head, face, and neck (diffuse large cell)
  - C83.31
- Merkel cell carcinoma of left eyelid
  - C4A.12

Diagnostic Statements to Code

- Squamous cell carcinoma of right ear
- Cancer of the labia majorum and minorus

Answers

- Squamous cell carcinoma of right ear
  - C44.222
- Cancer of the labia majorum and minorus
  - C51.8 Malignant neoplasm of overlapping sites of vulva
Example

Mr. Lakeford is admitted with Grade 4 colon cancer excised and eradicated from ascending and transverse colon with metastasis to liver. He has a colostomy, can manage ostomy care, no further treatment to colon. Currently has chemo treatment directed to liver mets.

Answer

Mr. Lakeford:
- C78.7 Secondary malignant neoplasm of liver
- Z85.038 Personal history of other malignant neoplasm of large intestine
- Z93.3 Colostomy status

Primary malignant neoplasms overlapping site boundaries

- A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion') unless the combination is specifically indexed elsewhere (colon w/rectum-C19).
- For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

Disseminated malignant neoplasm, unspecified

- Code C80.0, Disseminated malignant neoplasm, unspecified, is for use only in cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. Neoplasm table under “disseminated”
- It should not be used in place of assigning codes for the primary site and all known secondary sites.
Malignancy Site Unknown

- Code C80.1, Malignant (primary) neoplasm, unspecified, should only be used when no determination can be made as to the primary site of a malignancy.
  - Cancer NOS, Malignancy NOS
  - Neoplasm Table under “unknown” site
- Cancer of left kidney but cell type indicates the cancer originated elsewhere (unknown primary): C79.02, C80.1

Symptoms, Signs, and Ill-Defined Conditions

- Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.
  - Example: weakness

Neoplasm Related Pain

- Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether:
  - Tumor is malignant or benign
  - Pain is acute or chronic

Pathologic fracture due to a neoplasm

- When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.
- If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.
Neoplasm Example

- Mr. West has a history of prostate cancer with mets to the right femur, now has pathological fx of that femur with routine healing. He is admitted to home care for PT for transfer training and strengthening, and SN for pain management and assessment. He continues on Morphine for pain due to the bone mets.

Neoplasm Answer

- M84.551D Pathological fracture in neoplastic disease, right femur, routine healing
- C79.51 Secondary malignant neoplasm, bone
- G89.3 Neoplasm related pain
- Z85.46 History of prostate ca
- Z79.891 Long term (current) use of opiate analgesic

Complications Associated with a Neoplasm

- When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.
  - Exception: Anemia

Anemia due to Cancer

- Patient admitted for management of anemia due to cancer. Anemia is the focus of care.
- Guideline: With anemia due to cancer, the cancer is coded first even if the anemia is the focus of care
  - Malignant neoplasm is coded first, then:
    - D63.0 Anemia in neoplastic disease
Anemia due to Chemo

- Patient has anemia due to chemotherapy. Is HH treatment for anemia? Or cancer?
  Guideline: When admission is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect...
- D64.81 Anemia due to antineoplastic therapy
- T45.1x5D Adverse effect of antineoplastics
- Cancer, by site

Complications Associated with a Neoplasm Surgery

- When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm:
  - Designate the complication as the principal/first-listed diagnosis.
  - Then code the neoplasm, if not resolved
    - History of neoplasm should be coded if documentation states CA resolved

Code these...

- Right female breast cancer with mets to R lung
- Right female breast cancer with mets to R lung, treatment directed at lung
- Patient with emphysema has history of lung ca and pneumonectomy of left lung
- Subacute monocytic leukemia in remission

Answers

- Right female breast cancer with mets to R lung
  - C50.911
  - C78.01
- Right female breast cancer with mets to R lung, treatment directed at lung
  - C78.01
  - C50.911
Answers

- Patient with emphysema has history of lung cancer and pneumonectomy of left lung
  - J43.9 Emphysema
  - Z85.118 History of lung cancer
  - Z90.2 Acquired absence of lung
- Subacute monocytic leukemia in remission
  - C93.91

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Z Codes Used with Neoplasms

- Z85.- for personal history of neoplasm
  - 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?
  - Surgical removal – Absence (partial, complete)

Prophylactic Organ Removal

- For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be:
  - Z40.0- Encounter for prophylactic surgery
  - Followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

Prophylactic Organ Removal

- If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0-, Encounter for prophylactic surgery for risk factors related to malignant neoplasms.
- A Z40.0- code should not be assigned if the patient is having organ removal for treatment of a malignancy.
Example

The patient was admitted to home care after mastectomy of right breast for cancer. The left breast was removed prophylactically because of genetic susceptibility. She will continue chemotherapy. Aftercare is the focus of care with dressing changes.
- Z48.3 Aftercare following surgery for neoplasm
- C50.911 Malignant neoplasm right female breast
- Z40.01 Encounter for prophylactic removal of breast
- Z15.01 Susceptibility to malignant neoplasm of breast
- Z48.01 Surgical dressing changes
- Z90.13 Acquired absence of bilateral breast and nipple

Malignant Neoplasm of Transplanted Organ

- A malignant neoplasm of a transplanted organ should be coded as a transplant complication.
  - Assign first the appropriate code from category T86.-, Complications of transplanted organs and tissue
  - Followed by code C80.2, Malignant neoplasm associated with transplanted organ.
  - Use an additional code for the specific malignancy site

Example

- CA in transplanted pancreas
  - T86.891 Other transplant tissue failure
  - C80.2 Malignant neoplasm assoc. w/transplanted organ
  - C25.9 Malignant neoplasm of pancreas, unspecified

Practice

- Mrs. Tolson is admitted to home care after hospitalization for heart failure. She has a history of right breast cancer and is taking Tamoxifen. She is on hold for reconstructive surgery until her heart failure symptoms have resolved.
Mrs. Tolson:
- I50.9 Heart failure, unspecified
- Z79.810 Long term (current) use of SERMs
- Z85.3 Personal history of malignant neoplasm of breast
- Z90.11 Acquired absence of right breast and nipple

Mrs. Tolson has now been resumed for aftercare following breast reconstruction surgery. She is still taking Tamoxifen and her heart failure is stable at this time. SN will provide dressing changes and monitor healing status.

Mrs. Tolson for ROC:
- Z42.1 Encounter for breast reconstruction following mastectomy
- Z79.810 Long term use of SERMs
- Z85.3 Personal history of malignant neoplasm of breast
- I50.9 Heart failure, unspecified
- Z48.01 Encounter for surgical dressing changes

Mrs. White is admitted to home care after a right TKR for OA. She had increased bleeding during surgery, resulting in acute post-op anemia. She still has OA in the left knee and will have surgery for it after her H&H returns to normal. SN for wound care, assessment, weekly CBC; PT for gait training and strengthening.
Answer

Mrs. White:
- Z47.1 Aftercare following joint replacement
- D62 Acute post-hemorrhagic anemia
- M17.12 Unilateral primary OA, left knee
- Z96.651 Presence of right artificial knee joint
- Z48.01 Encounter for surgical dressing changes

Information needed

- Intake:
  - Neoplasm site(s) including laterality
  - Behavior of neoplasm
  - Primary, metastatic
  - If post-op, was neoplasm eradicated? Any further treatment or follow up?
  - Remission? Failed remission? Relapse?
- Clinician assessment:
  - Focus of care
  - Pain associated with neoplasm

Guidelines

Chapter 4 Guidelines E -- Endocrine, Metabolic and Nutritional

- The diabetes mellitus codes are combination codes that include:
  - the type of diabetes mellitus,
  - the body system affected, and
  - the complications affecting that body system.
- Use as many codes within a particular category as are necessary to describe all of the complications of the disease
- Sequence based on the reason for a particular encounter. Assign as many codes from categories E08 –E13 as needed to identify all of the associated conditions that the patient has.

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Guidelines

- If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2.
- If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, assign code E11, Type 2.
- Code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be assigned if the patient has Type 1, or if insulin is given temporarily to bring a Type 2 patient's blood sugar under control during an encounter.

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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
  - Notice difference between adverse effect and poisoning.
  - Use additional code to identify insulin use
- E10 Type 1 DM
- E11 Type 2 DM
  - Use additional code to identify insulin use
- E13 Other specified DM
  - Use additional code to identify insulin use

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 Adverse Effect

- 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.

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E09 Drug or chemical induced DM Poisoning

- 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.

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E10 Type 1 DM

- Type 1 diabetes is caused by a lack of insulin due to the destruction of insulin-producing beta cells in the pancreas. In type 1 diabetes—an autoimmune disease—the body’s immune system attacks and destroys the beta cells.
- Genetic susceptibility

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E11 Type II DM

- Caused by a combination of factors, including insulin resistance, a condition in which the body’s muscle, fat, and liver cells do not use insulin effectively. Type 2 diabetes develops when the body can no longer produce enough insulin to compensate for the impaired ability to use insulin.
- The role of genes is suggested by the high rate of type 2 diabetes in families and identical twins and wide variations in diabetes prevalence by ethnicity. Type 2 diabetes occurs more frequently in African Americans, Alaska Natives, American Indians, Hispanics/Latinos, and some Asian Americans, Native Hawaiians, and Pacific Islander Americans than it does in non-Hispanic whites.

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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
- Specific guideline postpancreatectomy DM
- E89.1 Postprocedural hypoinsulinemia
- E13 code(s)
- Z90.41- Acquired absence of pancreas

Diabetes 4th characters 0 and 1

- Diabetes with hyperosmolarity
  - Does not occur with Type 1 DM
    - No choice in Type 1 diabetics (no E10.0-)
- Diabetes with ketoacidosis
  - Does not occur with Type 2 diabetics
    - No choice in Type 2 diabetics (no E11.1-)

Diabetes 4th Characters

- 2 as 4th character
  - R- Renal/Kidney complications
- 3 as 4th character
  - O- Ophthalmic
- 4 as 4th character
  - N- Neurological
- 5 as 4th character
  - C- Circulatory
- 6 as 4th character
  - O- Other—arthropathy, skin complications, oral complications, hypoglycemia, hyperglycemia and other

Diabetes 4th characters 7, 8, 9

- 7—no 4th character 7
- 8—unspecified complications (do NOT use)
- 9—without complications (equivalent to 250.0x)
**Diabetic Manifestation Notables**

- **E11.22**
  - Use additional code note: need stage of CKD
- **E11.3-** Macular edema includes the type of retinopathy
- **E11.4-** includes neuropathy unspecified, mononeuropathy, polyneuropathy, etc
  - **E11.43** Use additional code note for gastroparesis
- **E11.5** DM with gangrene includes the peripheral angiopathy
- **E11.610** Includes Charcot’s

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**Diabetic Manifestation Notables**

- **E11.6--**
  - Use additional code for ulceration
- **E11.64** Hypoglycemia
- **E11.65** Hyperglycemia
- **E11.69** Other manifestations of diabetes
  - Use additional code to identify the specific manifestation

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**Examples to Code**

- Diabetic macular edema
- Diabetic neuralgia
- Diabetic gangrene
- Diabetic foot ulcer on toes (rt foot)
- Diabetic with high blood sugars
- Diabetic chronic osteomyelitis of right foot

**Answers**

- **Diabetic macular edema**
  - **E11.311**
- **Diabetic neuralgia**
  - **E11.42**
- **Diabetic gangrene**
  - **E11.52**
- **Diabetic foot ulcer on toes (rt foot)**
  - **E11.621**
  - **L97.519**
Answers

- Diabetic with high blood sugars
  - E11.65
- Diabetic osteomyelitis (chronic) of the right midfoot
  - E11.69
  - M86.671 Chronic osteomyelitis, right ankle and foot

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Practice

- Mr. Hudson is admitted with Type 2 DM with angiopathy, and a diabetic ulcer on left heel that is due to the diabetic angiopathy. He has a history of right foot amputation due to a prior diabetic ulcer. SN for wound care to the diabetic arterial ulcer. SOC notes ulcer has fat layer visible in wound.

Answer

Mr. Hudson:
- E11.51 Type 2 DM with diabetic peripheral angiopathy (no gangrene)
- L97.422 Non-pressure ulcer left heel and midfoot, fat layer exposed
- Z48.00 Encounter for non-surgical dressing changes
- Z89.431 Acquired absence of right foot

Other types of Diabetes

- Cystic fibrosis with MRSA pneumonia and diabetes as a result of the CF
  - E84.0 CF with pulmonary manifestation
  - J15.212 MRSA pneumonia
  - E84.8 CF with other manifestation
  - E08.9 Diabetes due to underlying condition
Special guideline

- Pancreatic cancer and postpancreatectomy diabetes
  - C25.9 pancreatic cancer
  - E89.1 Postprocedural hypoinsulinemia
  - E13.9 Other specified diabetes
  - Z90.41 Absence of pancreas
  - Z79.4 Long term use of insulin

E15-E16 Other disorders of glucose regulation and pancreatic internal secretion

- Drug induced hypoglycemia E16.0
- Hypoglycemia E16.2
  Consider that this hypoglycemia is not in a diabetic. (See E11.649)

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Overweight, obesity and other hyperalimentation

- Overweight with BMI of 27
  - E66.3
  - Z68.27 BMI 27.0-27.9, adult
- The physician must document obesity, overweight before it can be coded. BMI can be coded based on clinician’s documentation.

Information needed

- Intake:
  - Type of diabetes, any underlying cause
  - Any complications or manifestation associated with or due to diabetes, stage of CKD (1-5, not unspecified stage)
  - Specific diagnosis of obesity or morbid obesity
- Clinician assessment:
  - Blood sugar
  - Insulin use
  - Height and weight
Chapter 5 Guidelines
F -Mental and Behavioral

F = Freud

FØ1-FØ9-Mental Disorders due to known physiological reasons

- Disorders that have an etiology in cerebral dysfunction (cerebral disease or injury)
- Can be primary or secondary
  - If there is a ‘code first’ note then these conditions must be coded secondary.

Vascular Dementia

Sudden post-stroke changes in thinking and perception may include:
- Confusion
- Disorientation
- Trouble speaking or understanding speech
- Vision loss
- Changes in a “ladder” fashion

Vascular dementia F01.5-

- Being rejected as primary diagnosis in HH & hospice
- Occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease
  - Autoregulation may be lost in individuals with severe hypertensive arteriosclerotic vascular disease, abrupt lowering of blood pressure may lead to infarct.

Coding conventions:
- Code first the underlying physiological condition or sequelae of cerebrovascular disease. (ICD-10)
- Use additional code to identify cerebral atherosclerosis (ICD-9 instruction no longer at the code for the underlying cause)
Vascular dementia and behavioral disorders

- F01.50 Without behavioral disturbances
- F01.51 With behavioral disturbances
  - Aggressive behavior
  - Combative behavior
  - Violent behavior
  - …and wandering (use additional code)
- Besides those listed:
  - Vascular dementia with delirium
  - Vascular dementia with depression
  - Vascular dementia with delusions

Example

Dementia post CVA, with HTN
- I69.31 Cognitive deficits following cerebral infarction
- F01.50 vascular dementia
- I10 Hypertension

FØ3.9- Unspecified Dementia

- Includes:
  - Presenile dementia, NOS
  - Presenile psychosis, NOS
  - Primary degenerative dementia, NOS
  - Senile dementia, NOS
  - Senile dementia depressed or paranoid type
  - Senile psychosis, NOS

Unspecified Dementia FØ3.9-

- FØ3.9Ø- without behavioral disturbances
  - Dementia NOS
- FØ3.91- with behavioral disturbances
  - Unspecified dementia with aggressive behavior
  - Unspecified dementia with combative behavior
  - Unspecified dementia with violent behavior
Senile Dementia

Senile dementia is actually a group of several different diseases.
- Alzheimer's disease,
- Vascular dementia,
- Parkinson's disease, and
- Lewy body disease.

FØ2-Dementia in other diseases classified Elsewhere

- Excludes 1- dementia with Parkinsonism (G31.83) is a problem.
- Code first the underlying physiological condition
- FØ2.80- Without behavioral disturbances
- FØ2.81- with behavioral disturbances

This code is a manifestation code and REQUIRES an etiology code

Alzheimers G30.-/FØ2.-

- Patient admitted for worsening dementia related to early onset Alzheimer's, including wandering.
  - M1Ø21: G3Ø.Ø Alzheimer's disease early onset
  - M1Ø23: FØ2.81 Dementia in diseases classified elsewhere with behavioral disturbances
  - M1Ø23: Z91.83 Wandering in diseases classified elsewhere

Personality and behavioral disorders due to...

- Code first the underlying physiological condition
- F07.0 Personality change due to known physiological condition
- F07.81 Post concussional syndrome
Example

- The patient has explosive personality disorder due to a TBI 3 years ago. Upon further questioning, the physician says she doesn’t have the specific information regarding the head injury.
- S06.9x0S Sequela, unspecified intracranial injury
- F07.0 Personality change due to known physiological condition
- F60.3 Borderline personality disorder

Psychoactive Substance Use, Abuse And Dependence

- When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:
  - If both use and abuse are documented, assign only the code for abuse
  - If both abuse and dependence are documented, assign only the code for dependence
  - If use, abuse and dependence are all documented, assign only the code for dependence.

Practice

- Chronic alcohol abuse with dependence
- Bipolar disorder, moderate manic episode
- Mild recurrent major depressive disorder

Answers

- Chronic alcohol abuse w/dependence
  - F10.20- Alcohol dependence, uncomplicated
- Bipolar disorder, moderate manic episode
  - F31.12
- Mild recurrent major depressive disorder
  - F33.0
Mrs. Allen is admitted with vascular dementia, query to physician identifies she had a recent CVA that has caused her cognitive changes and resulting dementia. SN assessment notes patient tried to bite nurse when attempting to check BP, family reports she bites at them when she doesn’t want to participate in care.

Mrs. Allen:
I69.31 Cognitive deficits following cerebral infarction
F01.51 Vascular dementia with behavioral disturbance

Cannot accept “dementia” as a terminal diagnosis for hospice
Cannot accept senile dementia or vascular dementia as a primary diagnosis for home health or hospice
ASK: What caused the dementia?
- Alzheimer’s early or late onset
- Parkinson’s vs Parkinsonism

Chapter 6 Guidelines
G – Nervous System
G = Ganglion
General Guidelines

- Hemiplegia/hemiparesis/Monoplegia/ Monoparesis
  - When right or left is specified but dominant side is not specified
  - Default to dominant for the ambidextrous patient
  - Left side defaults to non-dominant
  - Right side defaults to dominant

Example

Mrs. Edwards is admitted to home health to treat an extradural intraspinal abscess due to MRSA. SN ordered for 6 weeks of bid IV antibiotics via PICC.

  - G06.1 Intraspinal Abscess
  - B95.62 MRSA
  - Z45.2 Encounter for adjustment and management of vascular access device
  - Z79.2 Long Term (current) use of antibiotics

G00-G09: Inflammatory Diseases of the Nervous System

- Includes Meningitis, Encephalitis, Abscesses of the CNS, Sequelae of CNS inflammatory disease
- Bacterial Meningitis (G00.0-G00.9) includes causative organism, if known
- Sequelae of inflammatory diseases of central nervous system (G09) includes conditions whose cause is classifiable to G00-G08

G10-G14: Systemic Atrophies primarily affecting the Nervous System

- Includes Huntington’s, Spinal Muscular Atrophy, Other Motor Neuron diseases, Post Polio Syndrome
- Post-Polio syndrome excludes sequelae of poliomyelitis (B91)
- Huntington’s disease includes chorea & dementia
- Hereditary ataxia include cerebellar ataxia, which are further specified as early vs. late onset or with defective DNA repair
Example

Mr. Jackson is admitted for progressive Huntington's Chorea. He's had several falls recently while wandering and his dementia is worsening, with behavior changes

- G10 Huntington's Disease
- F02.81 Dementia with behaviors
- Z91.83 Wandering
- R29.6 Repeated Falls

Drug induced Neuro Conditions

A 56 year old male patient is referred to home health for speech and occupational therapy to treat tardive dyskinesia that has begun to significantly impair his speech and self care abilities. The patient has a long-standing diagnosis of schizophrenia with use of phenothiazine class antipsychotic medications, which have resulted in the tardive dyskinesia.

- G24.01 Tardive Dyskinesia
- T43.3X5D Adverse Effect of phenothiazine
- F20.9 Schizophrenia

G20-26: Extrapyramidal Movement disorders

- Includes Parkinson's, Parkinsonism, Basal Ganglia disorders, and other movement disorders
- Dementia with Parkinson's Disease and Dementia with Parkinsonism remain different/separate
  - Parkinson's Disease excludes dementia with parkinsonism
    - G31.83 Dementia with Parkinsonism F02.80
    - G20 Parkinson's Disease, F02.80 Dementia without behavioral disturbance

G35-37: Demyelinating diseases of the CNS

G40-47: Episodic and paroxysmal disorders

- G35-37 includes multiple sclerosis and other demyelinating disorders
- G40-47 includes epileptic disorders, headaches, and sleep disorders
- TIA included under G45 and is not found in the circulatory (I) chapter
Mr. Parker is referred to home health for increased BLE weakness due to MS. He is no longer able to transfer to toilet or bath without assistance. SN will provide cath changes for neurogenic bladder.

- G35- Multiple Sclerosis
- N31.9 Neurogenic Bladder
- Z46.6 Encounter for fitting/adjustment of urinary device

Mr. Jones has new onset seizures and is admitted to home health for instruction, assessment and monitoring of anticonvulsants. H&P states he has idiopathic general epilepsy. His medication is still being monitored and adjusted because he continues to have seizures.

- G40.319- Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus

What does intractable mean?

Cranial nerve disorders are included here

- Also includes phantom pain, mononeuropathies, palsy, and neuralgia
- Facial nerve palsies and disorders must be distinguished from disorders of the cranial nerve

One more reason that diagnoses and documentation MUST be specific!

Neuralgia vs. Neuropathy

- Neuralgia = Nerve Pain
- Neuropathy = Nerve damage

These are not the same or interchangeable terms!
G60-65 - Polyneuropathies and other disorders of the PNS

- Includes neuropathies, polyneuropathies and other disorders.
- Causes of neuropathic conditions must be determined
  - Hereditary
  - Idiopathic
  - Drug induced
  - Inflammatory
- Do not code these when caused by diabetes! See G63

Scenario

Johnny Walker is referred for home health due to alcoholic polyneuropathy. He is 67 years old and was drinking daily until last week. His physician lists “alcohol dependence and use”. He has also received a concurrent diagnosis of alcoholic cirrhosis and withdrawal.

- G62 1 Alcoholic Polyneuropathy
- K70.30 Alcoholic cirrhosis of liver - no ascites
- F10.230 Alcohol dependence with withdrawal
- F10.288 Alcohol dependence with other alcohol-induced disorder??

Pain Codes (Category G89)

General Guidelines

- Provide more specific info on pain in a patient when the POC is addressing pain management
  - Must be specified as Acute, Chronic, Post-Thoracotomy, Post-Procedural, or Neoplasm-related
- DO NOT assign when an underlying cause of the pain is known (i.e. a more specific, definitive dx like osteoarthritis)
- Assign when nature of pain is not part of the definitive diagnosis, i.e. acute, chronic.

More Pain Coding Specifics

- Pain codes (G89) may be used as primary when a focus of care
- Pain codes (G89) may be used in conjunction with site specific codes when pain code provides greater detail
- Sequencing is dependent on focus of care
  - If pain control is focus of care then G89 code is assigned first
Mr. Smith is admitted to the agency for therapy (PT & OT) to treat a decline in mobility related to primary osteoarthritis of the bilateral knees. He has pain daily that ranges from 2-7 in the joints.
- Code only the osteoarthritis M17.0
- The pain is related to the osteoarthritis condition—will not code the pain separately.

Mrs. Smith fell off the porch and hurt her neck. PT and OT will treat her decreased mobility and SN will manage pain.
- M54.2 Pain in the neck
- G89.11 Acute pain due to trauma
- The pain code adds information regarding the nature and cause of the pain.

- Coding Postoperative Pain
  - Default is acute when not specified
  - Used alone when NOT associated with a post-operative complication; may use with complication code if related to complication
    - i.e.- Post-operative pain alone is not a complication
- Coding Neoplasm-Related Pain
  - Pain documented as being related, associated with or due to cancer, primary or secondary malignancy or tumor.
  - May be acute or chronic
  - May be used as a primary code if pain is focus of care

- Coding Chronic Pain (subcategory G89.2)
  - Time frame not defined, but physician must specify as “Chronic”
- Chronic Pain Syndrome (G89.4) and Central Pain Syndrome (G89.0) require that the physician specify the syndrome.
When Pain is a Complication

- T code is used first to report the complication
- Pain is post procedural and G code is used to provide additional information
  - Default to acute
- Must use a Z code to define the presence of joint replaced
  - With complication of joint replaced, Z code may still be used if complication code doesn’t identify the joint

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Scenario

- Mrs. Williams has had a bilateral knee replacement performed 6 weeks ago. She is admitted to home health for therapy and pain management. Despite orders for Percocet, she reports ongoing pain in the joints replaced of 8-10 at all times, which impairs mobility. Physician documents pain due to the prosthesis.
  - T84.84xD Pain due to internal orthopedic prosthetic devices...
  - G89.18 Other acute post-procedural pain
  - Z96.653 Presence of Artificial Knee joint, bilateral
  - Use additional code to identify the specified condition resulting from the complication (found at the beginning of the complication codes above T80).

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Scenario

- Sam Adams is referred to hospice with a terminal diagnosis of anoxic brain damage following an extended submersion when his sailboat overturned. He is in a persistent vegetative state and expected to live less than 1 month.
  - G93.1 Anoxic brain damage
  - V90.04xS Drowning and submersion due to sailboat overturning, sequelae
  - R40.3 Persistent vegetative state

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Information needed

- Intake:
  - For meningitis, encephalitis, CNS abscess: identify infectious organism
  - For drug-induced neuro conditions, identify drug causing adverse effect
  - For seizures, identify if intractable
  - Neuralgia vs neuropathy
  - For pain, identify if acute/chronic, post-op, neoplasm related, etc.
Information needed

- Intake, con’t:
  - For neuropathies, identify cause: hereditary, drug-induced, inflammatory, idiopathic (do not code here when caused by diabetes)

- Clinician assessment:
  - For MS, identify if treating overall condition or one aspect
  - For hemiplegia/monoplegia, identify if side affected is dominant or non-dominant side

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Hypertension

- Includes Essential Hypertension, Hypertensive Heart Disease, Hypertensive Chronic Kidney disease, and secondary hypertension
- No Hypertension table in ICD-10
  - No distinction between malignant and benign hypertension in ICD-10
- Guidelines are unchanged from ICD-9-CM

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Chapter 9 Guidelines

I - Circulatory System

- I = Ischemia

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Hypertension

- I10 Essential hypertension
- I11 Hypertensive heart disease
  - I11.0 with heart failure
  - I11.9 without heart failure
- I12 Hypertensive chronic kidney disease
  - I12.0 with stage 5 or ESRD
  - I12.9 with stage 1-4 or unspecified
- I13 Hypertensive heart and chronic kidney disease
  - I13.0-I13.2 Variety with or without heart failure and stage of CKD
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, if present.
  - 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

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 stage.

Name that category

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

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Heart Failure

When the right side of the heart starts to fail, fluid collects in the feet and lower legs. As the heart failure becomes worse, the upper legs swell and eventually the abdomen collects fluid (ascites). Weight gain accompanies the fluid retention.

Systolic HF: pumping action of the heart is reduced or weakened measured by the left ventricular ejection fraction (LVEF); typically, systolic heart failure has a decreased ejection fraction of less than 50%.

Diastolic HF: heart can contract normally but is stiff and less able to relax and fill with blood. This impedes blood flow into heart chambers, produces backup into the lungs and CHF symptoms. Diastolic heart failure is more common in patients older than 75 years, especially in women with high blood pressure. LVEF is normal.

Heart Failure

428.0 = congestive heart failure, unspecified (I50.9)
428.1 = I50.1 = left ventricular heart failure
428.2 = I50.2 = systolic HF (includes CHF in ICD-10)
428.3 = I50.3 = diastolic HF (includes CHF in ICD-10)
428.4 = I50.4 = combined HF (includes CHF in ICD-10)
428.9 = I50.9 = HF unspecified
429.0 = I51.4 = myocarditis unspecified
429.1 = I51.5 = myocardial degeneration
429.3 = I51.7 = cardiomegaly
429.9 = I51.9 = heart disease, unspecified
Mr. Richards is admitted to hospice following an exacerbation of his chronic systolic heart failure. He has Stage IV CKD. Physician documented hypertensive systolic heart failure.
- I13.0 Hypertensive heart and chronic kidney disease with heart failure and Stage IV CKD
- I50.23 Acute on chronic systolic heart failure
- N18.4 CKD Stage IV

The patient has a history of CHF and now is documented as having acute systolic failure.
- 2 codes OR
- 1 code??

Angina is considered integral to ASHD unless otherwise noted
- Angina alone = I20.-
- Angina with dx of ASHD = I25.-

Post infarction angina is considered a complication of the MI if specifically documented in medical record

Mr. Parker is referred to home health due to increased recurrent chest pain related to angina and increased use of nitroglycerine tablets. He has a comorbid diagnosis of hypertension.
- I20.9 Angina pectoris, unspecified
- I10 Hypertension
Angina Example

Mr. Kinsey has new onset chest pain with pre-existing diagnosed CAD and hypertension.

I25.119 – Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I10- Hypertension

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MI I21 vs. I22

- Initial MI coded to I21 for 4 weeks
- Any subsequent MI within the same 4 weeks is coded to I22
  - Sequencing by plan of care
  - Site is more important than STEMI/non-STEMI
  - Care setting does not change code
- Old MIs not requiring further care—code to I25.2

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STEMI vs non-STEMI

- NSTEMI account for about 30% and STEMI about 70% of all myocardial infarction.
- NSTEMI occurs by developing a complete occlusion of a minor coronary artery or a partial occlusion of a major coronary artery previously affected by atherosclerosis. This causes a partial thickness myocardial infarction (partial thickness damage of heart muscle).
- STEMI occurs by developing a complete occlusion of a major coronary artery previously affected by atherosclerosis. This causes a transmural myocardial infarction (full thickness damage of heart muscle).

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STEMI vs non-STEMI

- NSTEMI does not show ST segment elevation in ECG (due to partial thickness damage of heart muscle) and later does not progress to a Q-wave pattern on ECG. For this reason, it is also called a non–Q-wave myocardial infarction (NQMI).
- STEMI shows ST segment elevation in ECG (due to full thickness damage of heart muscle) and later progress to a Q-wave myocardial infarction (QWMI).
- Cardiac markers including CK-MB (creatine kinase myocardial band), troponin I and troponin T, all elevate both in cases. But the elevation of these markers is often mild in NSTEMI compared with STEMI.
I21 vs. I22 Defaults

- I21.3 STEMI of unspecified site (also AMI NOS)
- I21.4 non-STEMI of unspecified site
- I22.2 Subsequent non-STEMI
- I22.9 Subsequent STEMI of unspecified site (Subsequent MI NOS)

Scenarios to Code

Michael Isaac was referred to the agency 3 weeks after he was diagnosed with an inferior wall MI. Mr. Isaac has a diagnosis of post infarction angina. Mr. Isaac was resumed after hospitalization 2 days later with another inferior wall MI. Codes for inpatient diagnoses (M1011)?

Answers

Michael Isaac was referred to the agency 3 weeks after he was diagnosed with an inferior wall MI. Code? I21.19

Mr. Isaac has a diagnosis of post infarction angina. I23.7, I21.19

Mr. Isaac was resumed after hospitalization 2 days later with another inferior wall MI. Codes for inpatient diagnoses (M1011)? I23.7, I21.19, I22.1

Scenario to Code

Mrs. Lambert is referred to home care after a STEMI involving the LAD coronary artery and subsequent CABG. CAD is documented. She also has atrial fibrillation and hypertension.
**Answers**

- Z48.812 Aftercare following surgery on the circulatory system
- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
- I21.02 STEMI involving left anterior descending coronary artery
- I10 Hypertension
- I48.91 Unspecified atrial fibrillation
- Z95.1 Aortocoronary bypass status

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**Home Health MI Example**

- Mrs Sepulveda is admitted to home health for nursing and therapy following a Non-ST elevation Myocardial Infarction (NSTEMI) occurring 3 weeks prior to admission. The patient has a longstanding history of coronary atherosclerosis and angina but no coronary bypass surgery. She had angioplasty with stent.

- MIs are sequenced prior to ASHD when admitted for the MI.

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**Hospice MI Example**

- Patient was treated for an inferior wall MI in the last 14 days and then was readmitted to hospital for anterior wall MI. He is being admitted to hospice for unstable angina and his ASHD because he is not a surgical candidate.

---

**Home Health Answer**

Mrs Sepulveda is admitted to home health for nursing and therapy following a Non-ST elevation Myocardial Infarction (NSTEMI) occurring 3 weeks prior to admission. The patient has a longstanding history of coronary atherosclerosis and angina but no coronary bypass surgery. She had angioplasty with stent.

- I21.4- NSTEMI
- I25.119-Atherosclerosis with Angina
- Z95.5 Presence of coronary angioplasty implant and graft

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Hospice MI Answers

- I25.11Ø AHD with unstable angina
- I21.19 MI other coronary artery inferior wall
- I22.Ø MI of anterior wall

- It is most important to code location.

Category I69, Sequelae of Cerebrovascular disease

- Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits).
- The neurologic deficits, or “late effects” caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition.
- Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)

Sequela of CVAs

NON-traumatic bleeds

- CVA due to subarachnoid hemorrhage—I69.0-
- CVA due to intracerebral hemorrhage—I69.1-
- CVA due to 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

Sequela of Strokes

- I69.3-
  Which ones require more info?
  □ Other paralytic syndrome
  □ Dysphagia
  □ Seizures
  □ Muscle weakness
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

Mrs. Parker is admitted from a 3 week stay in rehab for a CVA with infarction. She has right side hemiplegia, dysphagia (pharyngeal phase), and a peripheral visual field deficit (right eye).

Mrs. Parker:
- I69.351 Hemiplegia following CVA affecting right dominant side
- I69.391 Dysphagia following CVA
- R13.13 Dysphagia, pharyngeal phase
- I69.398 Other sequela of CVA
- H53.451 Other localized visual field defect, right eye

Atherosclerosis is coded with or without complications, such as ulceration:

- I70.2- requires identification of artery affected, native or graft, site of ulcer, and depth of tissue damage

Venous stasis disease, insufficiency, chronic venous hypertension, varicose veins, with or without ulceration

- I87.- requires site, depth of ulcer
Venous Stasis Example

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

I95-99: Other and unspecified disorders of the vascular system

- Includes hypotension, gangrene (not elsewhere classified), Intraoperative and post-procedural complication, post-mastectomy lymphedema
- Note that the gangrene listed in I95-99 is for gangrenous cellulitis not classifiable to other causes such as atherosclerosis or diabetes.

Example

Mr. Tripper admitted following repeated falls and progressively worsening orthostatic hypotension. He has severe volume depletion causing the orthostasis, related to his reduced oral intake. He has no appetite.

I95.1 Orthostatic hypotension
E86.9 Volume depletion
R63.0 Anorexia
R29.6 Repeated falls
Z91.81 History of falls

Information needed

- Intake:
  - For HTN and heart disease, identify if related and if heart failure present
  - For HTN and CKD, identify CKD stage
  - For heart failure, identify type of HF
    - CHF? Query if systolic/diastolic
  - For AMI, identify date, site of infarction, STEMI or NSTEMI
Information needed

- Intake, con’t:
  - For ASHD, identify if native coronary artery or graft, if angina present
  - For CVA, identify specific artery affected, site of infarction, cause (bleed, thrombosis, embolism), and the residual deficit present
  - Etiology of any circulatory ulcerations

- Clinician assessment:
  - Any angina present
  - For CVA, any residual deficits present, if patient is left or right side dominant
  - For CVA with dysphagia, identify type of dysphagia
  - Depth of tissue damage for any non-pressure ulcers

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General Guidelines

- ICD-10 removes instructions related to the classification of COPD
  - All components covered under J44-

- For infectious disease processes, coder is to include infectious organism
  - Use additional code for the causative microorganism if known

---

Chapter 10 Guidelines

J – Respiratory System

J = Junk in the lungs
General Guidelines

- COPD J44.-
  - ICD-10 coding broken up into exacerbated, not otherwise specified, and with acute lower respiratory infection
  - Extremely important to note the excludes 1 and excludes 2 notes

What is an exacerbation?

- Increased s/sx of COPD for 3+ days
  - Coughing, sputum production, change in color or consistency, drop in O2 sat, more shortness of breath, decreased activity tolerance
- Requires change in treatment
  - Additional medication, using inhaler or O2 more, curtailed activity level

Acute exacerbation of chronic obstructive bronchitis and asthma

- An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.
- See difference between J44.0 and J44.1

J44 Other chronic obstructive pulmonary disease

- J44.0 COPD with acute lower respiratory infection
  - Coded by location (if multiple areas, code to the lowest anatomical site)
  - Use additional code to identify the infection
- J44.1 COPD with (acute) exacerbation
  - Decompensated COPD
  - Decompensated COPD w/acute exacerbation
- J44.9 COPD, NOS
Although asthma is included, if information is provided on type of asthma, code also the specific J45 code.

Use additional code to report tobacco use, history of use, or exposure.

Remember guidance

May add additional code for oxygen dependence when known.

Scenario

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

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

COPD code used indicates presence of lower respiratory infection

Note sequencing instruction at J44.0

Other Notes

A patient with COPD (of any type) who also has a lower respiratory infection is not assumed exacerbated. If Mr. 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
An 80 year old female is admitted due to a recent onset of bronchitis caused by streptococcus. She has been discharged home with 10 days of antibiotics and oxygen. In addition, she has a history of Alzheimer’s dementia and is bedbound.

Note the difference between chronic and infectious bronchitis

Use additional code...

- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco use (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

Mr. Mathers has been admitted due to recently diagnosed chronic obstructive asthma, with use of oxygen. His history and physical states he has been hospitalized for an exacerbation and has exercise induced bronchospasm. SN will assess and instruct in disease process and medication. The patient has no history of tobacco use, but his wife of 35 years is a smoker. His history reports he also has congestive heart failure.
**Answers**

- J44.1 Chronic Obstructive Asthma Exacerbated
- J45.990 Exercise Induced Bronchospasm
- I50.9 Congestive Heart Failure
- Z77.22 Contact with and exposure to environmental tobacco smoke
- Z99.81 Dependence on supplemental oxygen

Chronic Obstructive asthma classified under J44.-
Type of asthma is specified
ICD-10 requires the additional coding of any exposure to tobacco smoke, if known

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**Scenario**

- Mrs. Green is admitted following diagnosis of a pseudomonas lung abscess. She is on 30 days of oral antibiotic therapy and will receive skilled nursing and therapy. She has also been a smoker for 30 years.

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**Scenario Coded**

- J85.2 Abscess of the lung without pneumonia
- B96.5 Pseudomonas
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- Z79.2 Long Term use of antibiotic
- B96.5 additional code is used for pseudomonas
- Additional code for tobacco use as the patient is a smoker
- Excessive length of antibiotic therapy so use of antibiotic also coded

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**J95 Intraoperative and postprocedural complications and disorders of the respiratory system, not elsewhere classified**

- Includes pulmonary insufficiency following surgery, tracheostomy complications, pneumonitis due to anesthesia, Intraoperative hemorrhage of a respiratory organ.
- Post operative infections of respiratory organs coded here including tracheostomy infection

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**J95 Intraoperative and postprocedural complications and disorders of the respiratory system, not elsewhere classified**

- Excludes 2: aspiration pneumonia, emphysema resulting from procedure, hypostatic pneumonia, pulmonary manifestations due to radiation

**Excludes 2 means these conditions should be additionally coded if they exist concurrently. They are not considered included under J95 block**

**J96-J99: Other diseases of the Respiratory system**

- Includes Respiratory Failure, Pulmonary collapse, Compensatory emphysema
- Respiratory Failure Excludes (1) ARDS, Cardiorespiratory Failure, Respiratory Arrest, Post Procedural Respiratory Failure
  - *These should not be concurrently coded*

---

**Scenario**

Mr. James is referred to home health for skilled nursing care following hospitalization for acute respiratory failure with hypoxia. He has just been started on oxygen. He has additional diagnoses of chronic respiratory failure and COPD which is noted as exacerbated in the clinical record.

**Scenario Coded**

J96.21 Acute and Chronic Respiratory Failure with Hypoxia
J44.1 COPD exacerbated
Z99.81 Dependence on Supplemental Oxygen
- Acute condition is superimposed on chronic.
- Physician has specified both the acute and chronic respiratory failure
- Physician has specified “with hypoxia”
- COPD is reported as exacerbated so J44.1 code is used.
Information needed

- Intake:
  - For infectious processes, identify causative organism
  - Any exacerbation
  - For asthma and bronchitis, identify type
  - Tobacco abuse or dependence
- Clinician assessment:
  - If s/sx, query for exacerbation
  - Any tobacco use or exposure
  - Any supplemental oxygen

Chapter 11 Guidelines
K - Digestive

K = Special K is good for the digestive system!

Guidelines

- General guidelines for this chapter are reserved for future expansion
- Laterality and specificity guidelines are in effect in this chapter.
- Pay close attention to use additional code when documentation present, Excludes 1 and Excludes 2 notes.
- The indented terms are always read in conjunction with the main term.

Ulcers of the GI System

- The following indicates the specific site of the ulcer, with or without hemorrhage and perforation
- Esophageal ulcer K22.-
- Gastric Ulcer-K25.-
- Duodenal Ulcer- K26.-
- Peptic Ulcer- K27.-
- Gastrojejunal ulcer-K28.-
- Without bleeding vs with bleeding (case mix)
K31.84 Gastroparesis

- Gastroparesis: delayed gastric emptying, consisting of partial paralysis of the stomach, resulting in the food staying in the stomach longer than normal
  - Code first any underlying disease, if known such as:
    - Anorexia nervosa (F50.0-)
    - Diabetes Mellitus (E08.43, E09.43, E10.43, E11.43, E13.43)
    - Scleroderma (M34.-)

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Hernias (K40-K46)

- Includes acquired hernias, congenital hernia (except hiatal), and recurrent hernias.
- Remember, if a hernia is noted to have obstruction (strangulation) and gangrene, code to the gangrene. These would likely be used in the acute conditions in M1011 and M1017.
- Location includes type of hernia and laterality.

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Code the Scenario

- Patient admitted to home health with a diagnosis of GERD with esophagitis for teaching and observation and assessment.

- Patient was admitted to home health with acute gastric ulcer with perforation which resulted in bleeding and SN to monitor for continued bleeding and teach s/s of exacerbation and medication teaching.

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Answers

- Patient admitted to home health with a diagnosis of GERD with esophagitis for teaching and observation and assessment.
  - K21.0-GERD with esophagitis

- Patient was admitted to home health with acute gastric ulcer with perforation which resulted in bleeding and SN to monitor for continued bleeding and teach s/s of exacerbation and medication teaching.
  - K25.2-Acute gastric ulcer with both hemorrhage and perforation
K50.- Crohn’s Disease

- Also known as Crohn syndrome or regional enteritis
- 4th, 5th, and 6th character identifies small intestine, large intestine or both, and any complication manifested.
- Example: K5Ø.812-Crohn’s disease of both small and large intestine with intestinal obstruction

Other diseases of the intestines K55-K64

- K57.- Diverticular disease of the intestine
  - 4th and 5th character identifies the areas of the intestine (small or large), with or without perforation and bleeding.

Diseases of the Liver K70-K77

- K7Ø.- Alcoholic liver disease with specific complications
- K71.- Toxic liver disease
  - Code 1st poisoning due to drug/toxin, if applicable
  - Use additional code for adverse effect, if applicable, to identify drug
- K72.-Hepatic failure, NEC
  - Includes hepatitis, NEC with hepatic failure
  - Hepatic encephalopathy, NOS
  - Yellow liver atrophy or dystrophy
- K73.- Chronic hepatitis, NEC
- K74.- Fibrosis and cirrhosis of the liver
  - Code also, if applicable, viral hepatitis
- K75.- Other inflammatory liver diseases
  - Abscess
  - Phlebitis
  - Autoimmune
  - NASH
  - Hepatitis, NOS

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Hepatitis

Although viruses are the most common cause of hepatitis, other causes include autoimmune liver disease, obesity, alcohol, toxins, or misuse of certain prescriptions drugs and over-the-counter drugs such as Tylenol. These forms of hepatitis can cause the same symptoms and liver inflammation that result from viral hepatitis, but are not contagious. (Viral hepatitis is coded in the infectious disease chapters)

Complications of artificial openings of the digestive system K94.-

Complications include hemorrhage, infection, malfunction, and unspecified
- K94.Ø- Colostomy complications
- K94.1- Enterostomy complications
- K94.2- Gastrostomy complications
- K94.3- Esophagostomy complications

Complications of Bariatric Procedures (K95.-)

- K95.0- Complications of gastric band procedure
  - K95.01: Infection due to gastric band
  - Infection: use additional code to specify type of infection or organism, (bacterial and viral infectious agents) (B95-. B96)
  - Cellulitis of abdominal wall (LØ3.311)
  - Sepsis (A4Ø.-, A41.-)
- K95.8- Complications of other bariatric procedures

Practice

- Patient admitted to home health for B12 injections weekly x 4, then monthly for new diagnosis of malabsorption syndrome
- Chronic bleeding duodenal ulcer
Answers

Patient admitted to home health for B12 injections weekly x 4, then monthly for new diagnosis of malabsorption syndrome.
- K90.9-intestinal malabsorption, unspecified
- Chronic bleeding duodenal ulcer
- K26.4-chronic or unspecified duodenal ulcer with hemorrhage

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Information needed

- Intake:
  - Identify site or part of GI tract affected
  - Identify any bleeding, obstruction, perforation, infection
- Clinical assessment:
  - Any s/sx bleeding or obstruction

Chapter 12 Guidelines

L – Skin and Subcutaneous Tissues

- Includes diseases:
  - Pressure ulcers
  - Non Pressure ulcers
  - Chronic skin ulcers
  - Atypical skin ulcers
  - Cutaneous abscesses
  - Cellulitis

L = you have lovely skin
Infections of the skin and subcutaneous tissue

- Use an additional code to identify any infectious agent.
- LØØ Staphylococcal scalded skin syndrome (SSSS)-also known as Ritter’s disease and localized bullous impetigo
  - Use additional code to identify percentage of skin exfoliation (L49-)
    - Excludes 1- impetigo (LØ1.Ø3)

Abscess

- Collection of pus that has accumulated within a tissue because of an inflammatory process in response to either an infectious process or foreign object. It is a defensive reaction of the tissue to prevent the spread of infectious materials to other parts of the body.

Furuncles and Carbuncles

- Furuncle- (boil)infection of the hair follicle and sebaceous gland, and appears as a pus filled red inflammation.

- Carbuncle-Group of furuncles that extend deeper into the skin.

LØ2-Cutaneous abscess, furuncle and carbuncle

- 4th, 5th, and 6th character identifies whether the area is an abscess, a carbuncle or a furuncle and the area of the body it is located.
- Use additional code to identify organism
LØ5. - Pilonidal cyst and sinus

- 4th and 5th characters define if the patient has a cyst, or a sinus, or both, and with or without an abscess.
- Use additional code to define organism, if known.

Practise

- Staphylococcal boil, left groin
- Pilonidal fistula with abscess

Answers

- Staphylococcal boil, left groin
  L02.224 - Furuncle of groin
  B95.8 - Unspecified staphylococcus as the cause diseases classified
- Pilonidal fistula with abscess
  L05.02 — Pilonidal sinus with abscess

L22 Diaper dermatitis

- Generic term applied to skin rashes in the diaper area that are caused by various skin disorders and/or irritants, often prolonged contact with urine or stool.
L23 Allergic contact dermatitis

- L23.Ø- Due to metals
- L23.1- Due to adhesives
- L23.2- Due to cosmetics
- L23.3-Due to drugs in contact with skin
  - Use additional code for adverse effect, if applicable to identify drug (T36-T5Ø with 5th or 6th character 5)

L23.4- Due to dyes
L23.5- other chemical products
  - Cement, pesticide, plastic, rubber
L23.6- food in contact with the skin
L23.7-due to plant, except foods
L23.8- Due to other allergens
  - L23.81-animal dander
  - L23.89- other agents
L23.9- Unspecified

L27.- Dermatitis due to substances taken internally

- Use additional code for adverse effects, if applicable, to identify drug (T36-T50 with 5th or 6th character 5)
- L27.Ø Generalized skin eruption
- L27.1- Localized skin eruption
- L27.2- Ingested food

L27.1- Localized skin eruption
L27.2- Ingested food

Practice

Dermatitis covering entire body due to antibiotics (penicillin) taken correctly as prescribed.
Answer

Dermatitis covering entire body due to antibiotics (penicillin) taken correctly as prescribed.
- L27.Ø-Generalized skin eruption due to drugs and medicaments taken internally
- T36.Øx5D-Adverse effects of penicillin

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 indicates 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.

Pressure Ulcer Guidelines

- 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 are included in the (L89.-) pressure ulcer category.

Pressure Ulcer Guidelines

- Assignment of stages of pressure ulcers can be based on:
  - Documentation from the provider
  - Documentation from the agency clinician.
- NPUAP and WOCN guidance:
  - Reverse staging is not allowed
  - Stage III and Stage IV ulcers never “heal”, but close, and therefore will always be coded based on interventions the agency may be performing (assessment and prevention are interventions!)
Pressure Ulcer Guidelines

- Unstageable pressure ulcers (L89.- -0)
  - Ulcer whose stage can not be clinically determined due to:
    - 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 on what stage the ulcer is. THIS SHOULD NOT BE USED SINCE YOU CAN DERIVE STAGES FROM THE ASSESSMENT BY AGENCY CLINICIANS!

Pressure Ulcer 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

Practice

- Patient admitted with a stage III pressure ulcer to left heel, stage II pressure ulcer to right heel. Stage III wound is gangrenous

Tip: watch for instructional note!

Pressure Ulcer Answer

Patient admitted with a stage III pressure ulcer to left heel, stage II pressure ulcer to right heel. Stage III wound is gangrenous

- M1Ø21: I96 Gangrenous cellulitis
- M1Ø23: L89.623 Pressure ulcer of left heel, stage 3
- M1Ø23: L89.612 Pressure ulcer of right heel, stage 2
Non-pressure Ulcer Guidelines

- Non Pressure ulcers (L97.-)
  - Based on site and laterality
  - Based on depth of wound, defined by anatomical depth including: skin only, subcutaneous tissue layer (fat layer exposed), muscle tissue layer necrosis, and bone necrosis. May be coded based on clinician documentation

L97 Non-pressure chronic ulcer of the lower limb, not elsewhere classified

- Code first any associated conditions such as:
  - Any associated gangrene
  - Atherosclerosis of the lower extremities
  - Chronic venous hypertension
  - Diabetic ulcers
  - Postphlebitic syndrome
  - Postthrombotic syndrome
  - Varicose ulcer

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Non pressure ulcer limited to breakdown of the skin

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Non pressure ulcer with fat layer (subcutaneous layer) exposed

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Non pressure ulcer with necrosis of muscle or bone

Ulcer Severity

- L97.22- Non-pressure chronic ulcer of left calf
  - 1Non-pressure chronic ulcer of left calf limited to breakdown of skin
  - 2Non-pressure chronic ulcer of left calf with fat layer exposed
  - 3Non-pressure chronic ulcer of left calf with necrosis of muscle
  - 4Non-pressure chronic ulcer of left calf with necrosis of bone
  - 9Non-pressure chronic ulcer of left calf with unspecified severity

Arterial Ulcer Example

Patient admitted with arterial skin ulcer of left calf due to atherosclerosis
- I7Ø.242 Atherosclerosis of native arteries of left leg with ulceration of calf
- L97.221 Non pressure ulcer of left calf limited to skin

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 physician is queried and agrees that the ulcer is due to the chronic venous hypertension. She has co-morbidities of DM, CAD and HTN. On admission, the SN noted that the wound was shallow, 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
- E66.9 Obesity, unspecified

**Scenario**

- Mr Stubbs presents with edema, redness, and pain of the left big toe. He did not seek treatment because he thought it would improve on its own. He does not remember any injury, but the pain has gotten progressively worse for the past week.
- Diagnosis: Gangrenous abscess of the entire left big toe.

**Answer**

- Mr Stubbs:
  - L02.612-Cutaneous abscess of left foot
  - I96- Gangrene, NEC

**Information needed**

- **Intake:**
  - Site of wound, laterality
  - Etiology of wound, complicating factors
  - If an area is an abscess, carbuncle, furuncle, and infectious organism.
- **Clinician assessment:**
  - Stage of pressure ulcer
  - Depth of tissue damage for non-pressure ulcer
Chapter 13 Guidelines

M – Musculoskeletal

M = Musculoskeletal

Musculoskeletal

- Bone, joint or muscle conditions that are the result of a prior healed injury
- Chronic or recurrent bone, joint or muscle conditions
  - Any current, acute injury should be coded to the appropriate injury code from chapter 19.
- Site by the bone, joint or muscle involved, multiple sites code for some conditions

7th Characters for Pathological Fractures

- 7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.
- 7th character, D is to be used for encounters after the patient has completed active treatment.
- The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

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 current 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

- Patient 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.

### Osteoporosis With Fracture Answer

- M80.08xD Age related osteoporosis with current pathological fracture, vertebra subsequent encounter.

- Z87.310 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

### Osteomyelitis

- Notable Omissions:
  - No mention of osteomyelitis in diabetes in the alpha index or the tabular list.
  - ONE code for unspecified
  - Specify as acute, subacute or chronic
  - Osteomyelitis of vertebra is in different location from other sites.

- Osteomyelitis
  - Use additional code to identify infectious agent
  - Use additional code to identify major osseous defect, if applicable
Osteomyelitis Example

- Acute osteomyelitis of the R thumb cultured Strep D
  - M86.141 Other acute osteomyelitis, right hand
- B95.2 Enterococcus as the cause of diseases classified elsewhere

Osteoarthritis

- Most common DJD
- Many differences between ICD-9 and ICD-10
- Types
  - Polyosteoarthritis (generalized)
  - Osteoarthritis, coded by site
    - M16.-OA of hip
    - M17.-OA of knee
  - Primary or secondary
  - Post-traumatic
  - Unspecified OA M19.90 – don’t use!

Infectious Arthropathies

- Direct infection--invasion by infective organisms (organisms invade the synovial tissue)
- Indirect infection-Microbial infection of the body is established however organisms can not be identified or is inconsistent in the joints.
- What kind of codes are included in M01? M02?

Other Items to Note

- Gout—M10.-
  Code chronic gout with tophi M1A.9xx1
- Charcot’s joint, R foot M14.671
  - Check out the Excludes 1
- Joint derangements and ligament issues are due to OLD injuries or are spontaneous, i.e. without injury
Information needed

- Intake:
  - Site of disease or condition
  - Type of arthritis or osteoarthritis
  - For osteomyelitis, identify if acute or chronic, infectious organism
  - For osteoporosis, identify site, history of any pathological fracture(s)
- Clinician assessment:
  - Obtain history and query physician to verify

Chapter 14 Guidelines
N – Genitourinary

N = Naughty parts

N17-N19-Acute kidney (renal) failure and chronic kidney disease

Acute kidney failure is the rapid loss of the kidneys' ability to remove waste and help balance fluids and electrolytes in the body. In this case, rapid means less than 2 days. Many causes, may include: decreased blood flow due to hypotension, infections that directly injure the kidney, urinary tract blockage, medications, among other reasons.

- If documentation of Acute and chronic kidney failure, code both.
- Code also associated underlying condition

N18-Chronic kidney disease

- Code first any associated:
  - Diabetic chronic kidney disease (does not presume a cause-effect relationship and must be documented)
  - Hypertensive chronic kidney disease (DOES assume a cause-effect relationship and if the patient has HTN and CKD documented, code as such)
- Use additional code to identify kidney transplant status, if applicable (Z94.Ø)
- If ESRD is documented, then use N18.6 (regardless whether receiving dialysis).
- If stage V, use N18.5 unless undergoing dialysis, then use N18.6. (use additional code to identify dialysis status-Z99.2)
N18-Chronic kidney disease

- N18.1- Stage I
- N18.2- Stage II (mild)
- N18.3- Stage III (moderate)
- N18.4- Stage IV (severe)
- N18.5- Stage V without mention of dialysis
- N18.6- ESRD, or Stage V with dialysis
- N18.9- Unspecified degree of chronic kidney disease
  - Uremia NOS

N3Ø-N39-Other diseases of the urinary system

- N3Ø.- Cystitis-has 5 characters to identify specific type of cystitis
- Use additional code to identify infectious agent (B95-B97)

Cystitis refers to inflammation of the bladder, specifically, inflammation of the wall of the bladder. Cystitis usually occurs when the urethra and bladder, which are normally sterile (microbe free) become infected by bacteria - the area becomes irritated and inflamed. More common among females.

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Other Urinary Conditions

- N20-N23: Urolithiasis
  - N20.- Calculus of kidney, ureter, or both, and unspecified (upper tract)
  - N21.- Calculus of bladder, urethra, other lower tract or unspecified (lower)
- N3Ø.- Cystitis-has 5 characters to identify specific type of cystitis
  - Use additional code to identify infectious agent (B95-B97)

N31-Neuromuscular dysfunction of bladder, NEC

- Excludes 1-neurogenic bladder due to cauda equina syndrome, neuromuscular dysfunction due to spinal cord lesion
- Use additional code to identify any associated urinary incontinence (N39.3-N39.4-)

- Neurogenic bladder dysfunction, sometimes referred to as neurogenic bladder is a dysfunction of the nervous system or peripheral nerves involved in the control of urination (micturition).

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N39-Other disorders of urinary system

- N39.0-Urinary tract infection, site not specified
  - Use additional code (B95-B97) to identify infectious agent
- N39.3-stress incontinence (male) (female)
  - Code also any associated overactive bladder (N32.81)
- N39.4- other specified urinary incontinence
  - Code also any associated overactive bladder (N32.81)

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N39.4- other specified urinary incontinence

- N39.41-Urge incontinence
- N39.42-Incontinence without sensory awareness
- N39.43- Post-void dribbling
- N39.44- Nocturnal enuresis
- N39.45- Continuous leakage
- N39.46- Mixed incontinence (urge and stress incontinence)
- N39.490-Overflow incontinence
- N39.498-other specified urinary incontinence
  - Reflex incontinence
  - Total incontinence

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Practice

- Acute suppurative cystitis, with hematuria due to E coli.
- Chronic kidney disease, stage III
- Kidney stone
- CKD Stage V, on dialysis

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ANSWERS

- Acute suppurative cystitis, w/ hematuria due to E coli.
  - N30.01-Cystitis, acute with hematuria
  - B96.20- E Coli, as cause of disease classified elsewhere
- Chronic kidney disease, stage III
  - N18.3
- Kidney stone  N20.0
- CKD Stage V, on dialysis  N18.6, Z99.2

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Information needed

- **Intake:**
  - Any relationship between CKD and underlying HTN, DM, or other condition
  - Stage of CKD
  - History of acute renal failure
  - Specific type of incontinence

- **Clinician assessment:**
  - If eGFR known, query stage of CKD

Chapter 17 Guidelines

**Q** – Congenital Malformations

- **Conventions and Guidelines**
  - May be the principle/first listed diagnosis or secondary diagnosis
  - When a malformation/deformation/or chromosomal activity does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.
  - Components of the anomaly that are inherent should not be separately coded

- **Conventions and Guidelines**
  - If congenital malformation has been corrected, code history code, not the malformation
  - Although present at birth, abnormality may not be identified until later in life, and diagnosed by physician.
  - Codes can be used throughout the life of the patient.
Q00-Q07-Congenital malformation of the Nervous System

- Q05-Spina Bifida
  - Further defined by location
  - Further defined with or without hydrocephalus
  - Use additional code for any associated paraplegia (paraparesis) (G82.2-)

Down Syndrome

- Use additional code to identify any associated physical conditions and degree of intellectual disability
- Down’s syndrome, also known as Trisomy 21 is a genetic disorder caused by the presence of all or part of a third copy of Trisomy 21. It is the most common chromosome abnormality in humans.

Information needed

- Intake:
  - Identify any congenital malformations, deformations and chromosomal abnormalities
  - Verify conditions are congenital and not acquired after birth
- Clinician assessment:
  - Obtain history, query physician to verify

Chapter 18 Guidelines R – Symptoms, Signs, Abnormal Clinical/Lab Findings

R = symptom coding should be rare
Code the Symptoms

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

- Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the s/sx is not routinely associated with that diagnosis.
- The definitive diagnosis code should be sequenced before the symptom code.
- Remember the proximate diagnosis vs underlying condition rule?

Do not code the symptoms

- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.

Syndromes

- Follow the Alphabetic Index guidance when coding syndromes.
- In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome.
- Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

Guideline

- Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
Guideline

When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

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Falls

- Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.
- Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

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Functional quadriplegia

- Functional quadriplegia (code R53.2) is the lack of ability to use one’s limbs or to ambulate due to extreme debility. It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia. It should only be assigned if functional quadriplegia is specifically documented in the medical record.

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SSI Equivalent Codes

- 783.41 (R62.51) Failure to thrive
- 783.7 (R62.7) Adult failure to thrive
- 799.3 (R53.81) Debility Unspecified
- 799.89 Other ill-defined conditions
- 799.9 (R99) Other unknown and unspecified cause of morbidity or mortality
  - (ICD-10—used only for those who have already died)
- R54 Age related physical debility (old age)
  - Don’t use as terminal dx for hospice

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Abnormality of Gait

- R26 Abnormalities of Gait and Mobility
  - 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?

- 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?**

Will the definitions still stand?

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

Information needed

- Intake:
  - If you get a symptom at referral, ask for the underlying condition that is causing the symptom(s)
- Clinician assessment:
  - Do not list symptoms that are integral to the condition on the diagnosis list
This chapter consists of:

- NO aftercare codes.
- All kinds of injuries
- Organized by body part (instead of type of injury) with the exception of burns and corrosions
  - Superficial
  - Contusions
  - Open wounds
  - Fractures

This chapter consists of:

- All kinds of injuries (con’t)
  - Dislocations and sprains
  - Traumatic hemorrhages
  - Traumatic amputations
  - Blast injuries
  - Crushing
- Burns and Corrosions
- Poisoning by, adverse effects of and underdosing

This chapter consists of:

- 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
Application of 7th Characters in Chapter 19

Most (but not all) categories in chapter 19 have a 7th character requirement for each applicable code.

No aftercare code for injuries

- A = Initial encounter
- D = Subsequent encounter
- S = Sequela (p.55)

Different 7th characters for fractures

Guidelines: Trauma Injury

- Traumatic injury codes (S00-T14.9) are not used for normal, healing surgical wounds or to identify complications of surgical wounds.
- Alphabetic index—Wound, open, by site, by type of injury
  - Amputation
  - Bite
  - Laceration--A jagged wound or cut
  - Puncture

External Cause Codes

- In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Trauma Wound Example

Patient admitted for wound care to lacerated right forearm due to falling from moving motorized mobility scooter.

- S51.811D Laceration, without foreign body, of right forearm
- V00.831D Fall from moving motorized mobility scooter
  - look up accident, transport, pedestrian…
**Burn Guidelines**

- Burns = Thermal Burns, except sunburns (see includes note for T20-T32)
- Corrosions = chemical burns
- First degree (erythema), second degree (blistering), and third degree (full-thickness involvement)
- Classify burns of the same local site but different degrees to the highest degree burn identified of that site
- Code the worst (highest degree) burn first

---

**Burn Guidelines**

- Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.
- Do NOT use T30! Assign separate codes for each burn site
- Non-healing burns are coded as acute burns
- Necrosis of burned skin should be coded as a non-healed burn
- If infected, add the ‘B’ code
- No aftercare codes for burns

---

**Burn Guidelines**

- Use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface. Use Rule of Nines
- May code a sequela of a burn and a current burn at the same time
- The external cause code should be used with burns and corrosions

---

**Non-Healing Burn Example**

Patient has an ulcer on his left lower leg where he left a heating pad and burned his leg. Because of his atherosclerosis (with claudication) the second degree burn has never healed. The focus of home care is the care of the ulcer/burn.

- T24.232D Burn of second degree left lower leg
- I70.212 Atherosclerosis of native arteries extremities w/intermittent claudication, left leg
- Y63.5 Inappropriate temp in local application (optional)
Sequela of Burn Example

Patient had a burn of right wrist last year. The burn has healed but the patient has a skin contracture at the wrist. PT/OT are ordered.
- L90.5 Scar conditions and fibrosis of skin
- T23.371S Burn of 3rd degree of R wrist, sequela

*Encounters for treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character “S” for sequela.*

*Remember the sequela sequencing rule?*

Acute burn and sequela of burn

- When appropriate, both a code for a current burn or corrosion with 7th character “A” or “D” and a burn or corrosion code with 7th character “S” may be assigned on the same record (when both a current burn and sequelae of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

Example

Patient had third degree burns on back of right hand and wrist. Burn on back of hand has never healed, burn on wrist has healed but there is a skin contracture. Nursing will provide wound care to burn and OT will work on contracture.
- T23.361D Burn of 3rd degree of R dorsum of hand
- L90.5 Scar conditions and fibrosis of skin
- T23.371S Burn of 3rd degree of R wrist, sequela

Information Needed - Wounds

- Type of injury
- Location, including laterality
- Burns: degree, complications
- Any infection, causative organism
- How injury happened
  - External cause code optional but recommended
- Treatment orders
**Traumatic Fracture Guideline**

- **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

**7th Character for 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

**7th Character Open Fractures**

Look at 7th character for S72

- Type I
- Type II
- Type IIIA
- Type IIIB
- Type IIIC

**Gustilo Grades for Fractures**

<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt; 1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration/damage/loss or an open segmental fracture; also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>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)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury</td>
</tr>
</tbody>
</table>
Traumatic Hip Fracture Example

Patient admitted for aftercare of traumatic right hip (neck of femur) fracture after falling out of wheelchair

- S72.001D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing
- W05.0xxD Fall from wheelchair (optional)

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.

Fracture Example

65 year old male 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.

Fracture Answer

<table>
<thead>
<tr>
<th>M1020/22</th>
<th>Description</th>
<th>ICD-10</th>
</tr>
</thead>
<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>
</tr>
<tr>
<td>M1023</td>
<td>Amputation status toes, left</td>
<td>Z89.422</td>
</tr>
<tr>
<td>M1023</td>
<td>Long term use of insulin</td>
<td>Z79.4</td>
</tr>
<tr>
<td>M1023</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 (optional)

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

Patient had an unstable burst fracture of the 1st lumbar vertebra resulting in a complete lesion at L1. He is paraplegic as a result. He is being discharged home after rehab.

- G82.21 Complete paraplegia
- S34.111S Complete lesion of L1 level of lumbar spinal cord
- S32.012S Unstable burst fracture of 1st lumbar vertebra
- Code first any associated spinal cord and spinal nerve injury (S34.-)
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>□ Patient’s right great toe was cut off when mowing the lawn (powered lawnmower).</td>
</tr>
<tr>
<td>□ Z47.81 Aftercare following amputation</td>
<td>□ S98.111D Traumatic amputation of right great toe</td>
</tr>
<tr>
<td>□ E11.51 Diabetes with peripheral angiopathy</td>
<td>□ W28.xxxD Contact with powered lawn mower</td>
</tr>
<tr>
<td>□ Z89.411 Acquired absence of right great toe</td>
<td>□ (Status code for absence is not used because the traumatic amputation code provides the information)</td>
</tr>
</tbody>
</table>

Guideline: Surgical Complications

□ Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure.
□ The guideline extends to any complications of care, regardless of the chapter the code is located in.
□ Not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.
□ Query the provider for clarification, if the complication is not clearly documented.

Amputation Complications

□ Surgical complications are coded to category T81.- complications of procedures NEC
□ Amputation complications are NOT appropriately coded with T81 codes
  □ Alphabetical index: Complication, amputation stump, by type of complication (infection, dehiscence, necrosis, etc.)
  □ Amputation complications are coded to T87.-

Amputation and Surgical Complications

□ Infected R BKA (surgical): T87.43
□ Dehiscence of amputation stump T87.81
□ Previous Toe amputation-Non healing with eschar T87.54
□ Infected and Dehisced (external) Surgical Wound T81.31xD, T81.4xxD
□ Dehiscence (internal) post CABG T81.32xD
□ Non-healing surgical wound - ???
Mechanical Complication

- The patient has a muscle flap on a stage IV pressure ulcer. The flap is not healing and is breaking down.
- Complication, graft, muscle, breakdown
- T84.410D

Complication

The patient’s peritoneal dialysis catheter is infected with MRSA and has been abandoned. Home health is ordered to change dressings to the infected site. The patient has a new AV fistula and a central line (triple lumen). Home health will teach the patient/caregiver how to administer IV antibiotics through new central line.
- Infection, due to…, device, catheter, dialysis, intraperitoneal
- MRSA, infection, as the cause of diseases classified elsewhere
- Admission, adjustment, device, specified NEC, vascular access
  - T85.71xD-infection and inflammatory reaction due to peritoneal dialysis catheter
  - B95.62 MRSA
  - Z45.2 Encounter for adjustment and management of vascular access device

Complication of Transplant

- The patient has a rejection of his bone marrow transplant due to graft-versus-host disease.
- Complication, transplant, bone marrow
  - T86.01 Bone marrow transplant rejection
  - D89.813 Graft-versus-host disease, unspecified

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
Complication of Internal Fixation Device

Patient suffered a comminuted fracture of the right humerus at mid shaft in a 4-wheeler accident when riding with her grandson. She had 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?
  - Instructional note: 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

Intracranial Injury

- Difference between a traumatic intracranial bleed and a CVA type bleed
  - External vs internal
- Coding the acute injury OR the sequela of an injury?
  - What is the focus of your Plan of Care?
  - Seizures, coma and not woken up?
  - Stable?
  - Residual neurological deficits?

Example

Patient fell out of bed and received a subdural hemorrhage. The doctor documented that the wife states that the patient was out for less than 5 minutes. He was admitted for observation and now comes home for further observation.

- Injury, intracranial

- S06.5x1D Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less
- W06.xxxD Fall out of bed
Example

Patient fell off the steps at the WWII Memorial when he was visiting. He sustained a subdural hemorrhage and was comatose for 28 days. He has left dominant spastic hemiplegia and speech problems and is coming home after 2 months in rehab.

- G81.12 spastic hemiplegia affecting left dominant side
- Dysphasia
- S06.5x5S traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
- W10.8xxS Fall from steps

Information Needed – Fractures and Complications

- Fractures
  - Bone affected, laterality
  - Traumatic or pathological etiology
  - Open/closed, displaced/non-displaced
    - Gustillo Grade if open
  - Any complications of healing
- Complications
  - Requires physician documentation

Poisoning Differences

Poisoning, adverse effects, underdosing

Still in the T codes

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning requires 3 codes</td>
<td>Poisoning requires 2 codes</td>
</tr>
<tr>
<td>Therapeutic use</td>
<td>Adverse Effect</td>
</tr>
<tr>
<td>No underdosing</td>
<td>Underdosing a new concept</td>
</tr>
<tr>
<td>Use of external cause codes (E codes)</td>
<td>No use of external cause codes (V,W,X,Y)</td>
</tr>
</tbody>
</table>
Table of Drugs and Chemicals

- Combination codes—no need for external cause code
- Look up by name of drug or chemical
- Determine circumstances or intent
  - Poisoning, accidental (default)
  - Poisoning intentional self-harm
  - Poisoning assault
  - Poisoning undetermined
  - Adverse effect (therapeutic use in ICD-9)
  - Underdosing
- Add appropriate 7th character
  - A - Initial encounter
  - D - Subsequent encounter
  - S - Sequela

Poisoning

- Guideline: When coding a poisoning or improper use of a medication first assign the appropriate code from categories T36-T5Ø. Use additional code(s) for manifestations of poisonings.
- T—code for poisoning, accidental (unless the physician has documented something specific)
- E—Effect(s) of the poisoning

Adverse Effect

- Guideline: When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T5Ø with a 5th or 6th character of 5).
- E—Effect
- T—T code for adverse effect of drug
**Underdosing**

- Guideline: Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.

  - C—Condition
  - T—T code for underdosing of the drug
  - Z—Z code for underdosing reason

**Underdosing Example**

Patient with diagnosis of Hypertension continued to experience elevated blood pressure while taking blood pressure meds. Upon patient interview, it was found the patient was taking medication once daily instead of twice daily because of the cost of the drug.

**Underdosing Answer**

- I1Ø Essential (primary) hypertension
- T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- Z91.12Ø Patient's intentional underdosing of medication regimen due to financial hardship

**Poisoning Example**

Patient has taken his Lasix 4Ømg every morning and night. The prescription bottle reads 4Ømg daily. Patient is dehydrated and hypokalemic.

- T-- T5Ø.1x1D poisoning by diuretics
- E--E86.Ø dehydration
  - E87.6 hypokalemia
Adverse Effect Example

Patient has been taking the prescribed amount of Lanoxin, however his pulse rate is now 42 and he is toxic according to lab values. SN for observation and assessment, teaching and venipuncture for monitoring levels.
- R00.1 Bradycardia
- T46.Øx5D cardiotonic glycosides
- Z51.81 Encounter for monitoring
- Z79.899 Long term (current) use of other high risk medication

Practice

- Mrs. Thompson is admitted after hospitalization for Strep B pneumonia. She is taking penicillin, and at SOC the nurse identifies a raised rash over patient’s trunk, back and extremities. On report, physician diagnoses the rash as due to the penicillin and changes the antibiotic.

Answer

Mrs. Thompson:
- J15.3 Strep B pneumonia
- L27.0 Generalized dermatitis due to drugs and medicaments taken internally
- T36.0x5D Adverse effect of penicillin

Chapter 21 Guidelines
Z – Factors Influencing...
**General Guidelines**

- These codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed.
  - Doesn’t apply for Home Health or Hospice.

**Guidelines**

- May be first listed or secondary depending on circumstances.
- Status—either a carrier or has the sequelae or residual of a past disease or condition:
  - Informative—may affect the course of treatment/outcome
  - Should not be used if diagnosis code includes the info (status transplant with transplant complication)

**General Guidelines**

- These codes are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories AØØ-Y89 are recorded as “diagnoses” or “problems”. They can arise in 2 ways:
  - Patient not sick but requires health services for a specific purpose
  - When problem is present which influences the person’s health status, but is not a current illness/injury

**Guidelines**

- History—past medical condition that no longer exists and is not receiving any treatment, but that has a potential for recurrence and therefore may require continued monitoring.
  - Watch out for personal vs family history
  - History may alter treatment/outcome.
Guidelines

- Aftercare—initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of disease.
  - Aftercare code should not be used if treatment is directed at a current, acute disease.
  - Not to be used for injuries.

Guidelines

- Aftercare codes should be used in conjunction with other aftercare codes (read Z codes) or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit… The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Attention to.....

- Attention Z Codes explain a patient’s medical condition that currently exists, is receiving treatment, and is affecting the plan of care
- Feeding/Cleansing/Teaching

- Must be doing something to or about the condition or sequelae

How to Find Z Codes

- Look for:
  - Absence
  - Admission
  - Aftercare
  - Attention
  - Encounter
  - Examination
  - Exposure
  - History
  - Observation
  - Presence
  - Problem
  - Resistance
  - Status
Common categories in Home Health

- Aftercare
  - Surgical
  - Attention to...
  - Fitting and adjustment...
- Status
- History

Aftercare

- No aftercare codes for aftercare following an injury or fracture
- Certain aftercare (Z) code categories need a secondary diagnosis code to describe the resolving condition or sequelae
  - Z48.3 - Aftercare following surgery for the neoplasm
    - Use additional code to identify the neoplasm
- For other Z codes, the condition is included in the code title.
  - Z43.3 - Encounter for attention to colostomy

Orthopedic aftercare

- Z47.1 - Aftercare following joint replacement surgery
- Z47.3 - Aftercare following explantation of joint prosthesis
  - 5th character designates location
- Z47.81 - Encounter for orthopedic aftercare following surgical amputation
  - Use additional code to identify the limb amputated (Z89.-)

Orthopedic Example

Patient admitted for surgical aftercare for a right 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
Z48.-
- Z48.3 - Aftercare following surgery for neoplasm
  - Use additional code to identify the neoplasm
- Z48.81 - Encounter for surgical aftercare following surgery on specified body systems
  - 6th character to note system
  - No more “Conditions classifiable to…”
  - What happened to musculoskeletal??

Status Codes
- 3 main terms in alphabetical index
  - Status
  - Absence
  - Presence
- Z95.810 - Presence of automatic implantable cardiac defibrillator
  - Not listed under status; but listed under ‘presence’

Status Codes
- Non compliance codes greatly expanded
  - Z91.11 - Patient’s noncompliance with dietary regimen
  - Z91.12 - Patient’s intentional underdosing of medication regimen
    - Z91.12Ø - Patient’s unintentional underdosing of medication regimen due to financial hardship.

History
- Two types of history Z codes
  - Personal
  - Family
- Personal History of Malignant neoplasm codes expanded to specifically capture:
  - Carcinoid tumors
  - Small intestine
  - Pancreas
  - In-situ neoplasms
  - Neoplasm of uncertain behavior
  - Prostatic dysplasia
Z43-Encounter for attention to artificial openings

- Includes:
  - Closure of artificial openings
  - Passage of sounds or bougies through artificial openings
  - Reforming artificial openings
  - Removal of catheter from artificial openings
  - Toilet or cleansing of artificial openings.

Z43 vs. Z93

- Z93 codes are for artificial opening status
- Is the patient receiving treatment or attention to the ostomy site? If so, use a Z43 code instead of Z93
  - Excludes 1 under each category to exclude the other category

Z45 vs Z95

- Cardiac pacemaker attention to OR status
  - Z45.Ø- Agency is reprogramming the device either manually or via computer
  - Z95.- Status or presence: stating as a fact the patient has the device, but agency is not doing anything with it

More Common Z codes

- Z45.2-Encounter for adjustment and management of vascular access device
- Z46.6 Encounter for fitting and adjustment of urinary device
- Z46.82- Encounter for fitting and adjustment of non-vascular catheter
- Z91.83: Wandering in diseases classified elsewhere
- Z66 – Do not resuscitate
Z72.- Problems related to lifestyle

- Z72.0 - Tobacco Use
- Z72.3 - Lack of physical exercise
- Z72.4 - Inappropriate diet and eating habits

Z74.- Problems related to care provider dependency

- Z74.01 - Bed confinement status
- Z74.09 - Other reduced mobility
  - Chair ridden

Z79.- Long term (current) drug therapy

- To indicate any long term current use that affects the plan of care
- Length of time for “long term” is up to clinical judgment

Look up Z63.1
Example

Patient had left BKA for diabetic gangrene. SN is providing aftercare, observation and assessment and dressing changes.

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
<th>M1025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z47.81</td>
<td>Aftercare amputation</td>
<td>E11.52 (optional)</td>
</tr>
<tr>
<td>E11.51</td>
<td>DM w/peripheral angiopathy without gangrene</td>
<td></td>
</tr>
<tr>
<td>Z89.512</td>
<td>Acquired absence of left leg below knee</td>
<td></td>
</tr>
<tr>
<td>Z48.01</td>
<td>Encounter for surgical dressing changes</td>
<td></td>
</tr>
</tbody>
</table>

Same patient, but....

- Amputation site infected (MRSA) necrosed
- Care to surgical wound, dressing changes.

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T87.54</td>
<td>Necrosis of amp stump, LLE</td>
</tr>
<tr>
<td>T87.44</td>
<td>Infection of amp stump, LLE</td>
</tr>
<tr>
<td>B95.62</td>
<td>MRSA (cause of diseases classified elsewhere)</td>
</tr>
<tr>
<td>E11.51</td>
<td>DM with periph angiopathy w/o gangrene</td>
</tr>
</tbody>
</table>

Are you ready to dual code?

- Practice in ICD-10 coding is essential to be prepared for the implementation date October 1, 2015
- Home care will actually start dual coding cases on August 3, 2015 for any episodes that will extend past 9/30/15.
  - RAP will be filed in ICD-9 prior to 10/1/15
  - End of Episode final claim will bill in ICD-10 on or after 10/1/15

OPERATIONAL PREPARATION

What did we do with an extra year?
ICD-10-CM Challenges

- Increased concern for:
  - Claims and denials
  - Documentation
  - Loss of productivity by coders
    - “Unlearning” Coding Clinic rules for ICD-9
    - Time!
- Operational focus:
  - Gap analysis
  - Process updates
  - Back-up plan for cash flow disruptions

What are some of the issues now?

- Little to no clinical information available at referral/intake.
  - More difficult to identify patient issues
  - More difficult to develop POC meaningful to the patient
  - More difficult to provide skilled care that will withstand the scrutiny
- How do we get better information to begin with AND
- How do we get the clinicians to assess/document better?

What are some of the issues?

- Coders will be 20-30% slower even if well trained and practiced.
- What is the productivity level you expect now?
- Hospice coverage and related vs unrelated conditions will compound the reduction in productivity
- What can you do to improve the whole process now and with implementation of ICD-10?

Key Factors on HH Claims

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim “From” date (episode start date);
2. The Outcome and Assessment Information Set (OASIS) assessment completion date (OASIS item M0090 date); and
3. The claim “Through” date.
In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care.

The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode.

In the case where the episode start of care date is before October 1, 2015 and the M0090 date is also before October 1, 2015, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

If the HH episode spans into October 2015, the corresponding final claim for the episode will be required to report ICD-10-CM codes.

HH claims cannot be split into periods before and after October 1, 2015, so these claims will have claim “Through” dates of October 1, 2015, or later.

The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim “Through” date.

On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the “From” and “Through” dates are the same. So if the episode begins in September 2015, the “From” and “Through” dates on the RAP would report the same date in September.

These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

“Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes.”

This means that HHAs do not have to re-group the episode based on the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency.
Episodes Starting Before October 1, 2015, with OASIS Completion Dates Before October 1, 2015

- The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.
- These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2015 but the episode ends in October 2015 (see table below).

Episodes Starting Before October 1, 2015, with OASIS Completion Dates in October 2015

- There may be cases where the episode start of care date is before October 1, 2015, and, due to the 5 day completion window, the M0090 date is in October 2015. For example, an initial episode with a start of care date of September 28, 2015, could have an M0090 date of October 2, 2015. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.
- The RAP for this example would have “From” and “Through” dates of September 28, 2015. As a result, these RAPs would need to report ICD-9-CM diagnosis codes since the “Through” date on the OASIS assessment.
- The ICD-9-CM codes are required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification Episodes Beginning in the First Days of October 2015

- In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2015, could have an M0090 date of September 28, 2015. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code. But in this case, both the RAP and claim will require ICD-10-CM codes since the “Through” date on both will be after October 1, 2015.

- The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system.

CMS Table

<table>
<thead>
<tr>
<th>Type of OASIS Assessment</th>
<th>RAP “From/ Through” Dates</th>
<th>OASIS M0090 Date/OASIS Version</th>
<th>Claim “Through” Date</th>
<th>Diagnosis Coding Used on OASIS</th>
<th>Diagnosis Coding Used on RAP</th>
<th>Diagnosis Coding Used on Claim</th>
</tr>
</thead>
</table>
CMS Table (Revised)

<table>
<thead>
<tr>
<th>Type of OASIS Assessment</th>
<th>RAP “From/Through” Dates</th>
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<th>Diagnosis Coding Used on Claim</th>
</tr>
</thead>
</table>

Combination of SOE and M0090

What is dual coding? And why is it important?

- Coding in ICD-9 and ICD-10
  - Keeping in mind that everything has to be in ICD-9 now
- Faster and more accurate
- Analyze what documentation is needed for better coding/better assessments.
  - Make changes to forms
  - Make list for intake personnel

Dual Coding Plan

- Do you outsource your coding? Are they ready?
- Do NOT depend on the GEMs.
- Cannot dual code until the coders have had training.
  - When will that be?
  - 50 HOURS OF TRAINING AND PRACTICE RECOMMENDED

Sample Dual Coding Plan

- Start by running a report on top 20 diagnoses your agency uses.
  - Not just primary diagnoses.
  - Evaluate whether your list needs to include more than 20.
- Code the top 20 diagnoses in ICD-10-CM
  - Category enough?
  - What additional information do you need from your referral source and your clinicians to code these well?
- Start NOW with a percentage of cases
Sample Dual Coding Plan

- Now: dual code 25-50% of assessments in ICD-9 and ICD-10
- August 3: dual code all assessments that you anticipate will be final billed on or after October 1, 2015
- October: code only in ICD-10
- Quality audits of all coders

Plan Your Journey

- Pinpoint where diagnosis codes are used in your processes
  - Intake
  - Assessment
  - POC
  - Billing
- Prepare an ICD-10 transition budget.
  - Training
  - Software-EMR and billing
  - Forms revision

Identify your Team

- Evaluate the performance of your Transition Team
  - Do you need to make changes?
- Establish accountability for the processes, forms, and information systems affected by ICD-10 and assign specific responsibilities to the members of your team.

Prepare Your Budget

- Budget for the following expenses:
  - EHR, and/or other system upgrades or purchases you may need to help you achieve ICD-10 compliance.
  - ICD-10 code selection support tools, books, and software you intend to purchase.
  - ICD-10 updates to paper forms and documents which reference diagnosis codes.
  - ICD-10 overview, documentation, and coding training for your practice staff.
Prepare Your Budget

- Budget for the following expenses:
  - User training on the ICD-10 functionality included with system upgrades.
  - Temporary staffing if you anticipate a large reduction in productivity. The productivity factors you use are subjective and will vary depending upon the:
    - Proficiency and speed of coders
    - Improvements in clinical documentation

Train Your Team

- Intake personnel on referral information to request
- Coders on coding training
- Physicians and clinicians on documentation required
- Overview training for staff members engaged in administrative functions.

Update Your Processes

- Obtain this information (run reports from your software, ask your billing company)
  - Your claim rejections and denials by ICD-9 diagnosis code and payer.
  - The most common unspecified ICD-9 codes you submit by payer.

Update Your Processes

- Pinpoint the ICD-9 codes with the highest rate of rejections and denials for each of your largest payers:
  - Categorize the primary reasons for the denials and rejections.
  - Note changes you can make to your documentation and billing processes to address the causes for denials / rejections.
  - Identify your commonly billed unspecified ICD-9 codes
Update Your Processes

- Evaluate a sample of your clinical documentation. The sample should include common conditions seen where the underlying ICD-9 codes map to multiple ICD-10 codes. Determine if all key concepts relevant to patient care were captured in sufficient detail within the sample to support the selection of appropriate ICD-10 codes.
- Increase your level of documentation in those instances where key concepts are not being captured in sufficient detail to support the selection of a specific ICD-10 code.

Clinical Documentation

- Clinical Documentation Improvement for ALL KINDS of reasons
- Preliminary assessments of A&P, pathophysiology, pharmacology for clinicians, coders, QA
- Evaluate the documentation details needed to code diagnoses in ICD-10

Revise Paper Forms

- Incorporate ICD-10 codes into paper forms and tools which reference diagnosis codes
  - Patient Intake and History
  - Assessments
  - Care Plans
  - Other forms and templates

Modify Processes

- Track payment delays, denials, and increases in authorization volume for at least (3) months beginning on the compliance date. By logging this information, you will be in a better position to spot and address problems more quickly.
Technology

- Evaluate your technology vendor contracts to understand the type of ICD-10 expenses which may be separate from regular fees. Clarify with each vendor the additional ICD-10 related technology expenses.
- Verify that your key systems are, or will soon be, ICD-10 compliant. Most HIPAA covered entities that receive data from your systems will not translate ICD-9 diagnosis codes into ICD-10. The expectation is that you will be able to submit ICD-10 codes for claims having a date of service greater than or equal to the compliance date.
- Set training dates for software updates.

Medicare

- Review your MAC’s ICD-10 website.
  - Updated LCDs
  - Check results of ICD-10 end-to-end testing
  - Watch for tools and tips for ICD-10 transition plans

Medicaid

- Review ICD-10 information on your state agency’s website
- Note ICD-10 related deadlines, testing information, and FAQs.
- Complete tasks that will ensure compliance and compatibility with the ICD-10 updates your Medicaid agency is instituting.

Gap Analysis

Definition: “...the comparison of actual performance with potential performance. Gap analysis provides a foundation for measuring investment of time, money and human resources required to achieve a particular outcome.”

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Steps in a Gap Analysis

1. Analyze your current situation for each process and system by collecting information and data. (where we are now).
   a. What are we currently doing?
   b. Who has the knowledge that we need?
   c. Is the information documented anywhere?
   d. What is the best way to obtain the information? Software reports? Interviews? Document review? Observation?

2. Identify the objectives that must be achieved to achieve the overall goal. (where we need to be)
   a) What are your goals now for days to POC?
   b) How long does it take to get assessments complete? How many assessments are acceptable when first submitted and how many times does the coder have to go back to the clinician for additional information?
   c) How much time for calls to physician to get POC and med list finalized?
   d) What are achievable objectives for each issue identified?

3. Identify how to bridge the gap from the current situation to the desired outcome (how do we get there). Consider what resources you will need to take to reach the objective, and then take action!
   a. People
   b. Processes
   c. Technology
   d. Time
   e. Materials and Equipment

Areas to be addressed in Gap Analysis

Financial
- Billing/Revenue cycle
- Cash Flow
- Budget

Operational
- Intake/referral
- IT/Outside Vendors

Coding
- Training
- Competency
- Speed
- Determining primary diagnosis and secondary diagnoses with potential to impact care.

Clinical
- Clinical documentation
- POC development
- Case Management
## Sample Gap Analysis--Intake

<table>
<thead>
<tr>
<th>Personnel take information from referral source and directed to ask certain questions if information is not offered, such as demographic info, next of kin, who will sign F2F, etc.</th>
<th>Intake will obtain better clinical information so that assessments, documentation and coding can be more accurate and complete.</th>
<th>Intake needs to have some education in coding to ensure that clinical information is as complete as possible at intake stage. Provide list of questions based on common diagnoses for referral source so that clinical information is as complete as possible, e.g., osteomyelitis—acute or chronic. Query the physicians and discharge planners for additional diagnosis information beginning immediately as part of our ICD-10 Readiness Training. Develop form for querying physicians to identify missing diagnosis information based on description of patient, pharmacology, etc.</th>
</tr>
</thead>
</table>

## Sample Gap Analysis--Clinicians

<table>
<thead>
<tr>
<th>Assessing clinicians complete OASIS and sequence diagnoses based on the proposed POC—assessments are mostly checklists and do not provide a lot of narrative clinical information.</th>
<th>Improved documentation to support skilled care. Improved cues/prompts for gathering information on the assessment.</th>
<th>Have clinician/coder team review current assessments to ensure adequate prompts are in place for improving documentation. Transfer information to new OASIS C-1. Evaluate knowledge of pathophysiology and pharmacology. Develop POC based on diagnosis information and patient need.</th>
</tr>
</thead>
</table>

## Sample Gap Analysis--Coders

<table>
<thead>
<tr>
<th>Review history and physical (when available), assessment and proposed POC to determine appropriate sequencing taking into account coding guidelines. Coding within _______ hours of receipt of OASIS.</th>
<th>Increased amount of information at referral. Compliant, accurate coding based on documentation available. Coding within 24-48 hours of receipt of OASIS.</th>
<th>See above for improved information. ICD-10 comprehensive training. Evaluate knowledge of pathophysiology and pharmacology. Dual coding plan to improve efficiency and accuracy of coders once training has taken place.</th>
</tr>
</thead>
</table>

## Sample Gap Analysis--QA

<table>
<thead>
<tr>
<th>Develop POC based on completed OASIS within _______ hours.</th>
<th>Develop patient centered POC based on completed OASIS within 48 hours (improved individualization of the POC for the patient).</th>
<th>Review the completed OASIS for accuracy and documentation to support skilled care. Ensure that the sequencing has been done correctly to support services provided. Consult with coders on sequencing questions. Ensure that correction policy is followed. Ensure that if F2F is not completed prior to SOC, that POC is available to physician when encountering the patient. (Communicate with physician).</th>
</tr>
</thead>
</table>
Sample Gap Analysis--Billing

<table>
<thead>
<tr>
<th>Days to RAP</th>
<th>Evaluation of coders/QA for speed of completion of coding, 'locking' the OASIS and POC development. Evaluate 'bottle necks' in process and develop plan to resolve any issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7 days to RAP</td>
<td>Final claim within ___ days of EOE except in cases in which the orders are missing or F2F is not present on SOC. Evaluate 'bottle necks' in process and develop plan to resolve any issues.</td>
</tr>
</tbody>
</table>

Final claim within ___ days of EOE except in cases in which the orders are missing or F2F is not present on SOC.

<table>
<thead>
<tr>
<th>Days to RAP</th>
<th>Final claim within ___ days of EOE except in cases in which the orders are missing or F2F is not present on SOC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 days to RAP</td>
<td>Evaluate responsibility for pre-billing audit and identify criteria for pre-billing audit. Identify who will review the coding.</td>
</tr>
</tbody>
</table>

Gap Analysis on Communication

Gathering more information
- Referring physicians
- Indications of other illnesses:
  - Medications
  - Treatments
  - Interview of patient/caregiver
  - And verifying those findings with the physician and/or medical director
  - SBAR

Resources

- ICD-10-CM Coding Manual for Home Health and Hospice
- CMS Final Rule for case-mix diagnoses information
- OASIS-C1/ICD-10 Guidance Manual, quarterly Q&As
- Education on A&P&P, diagnosis selection, assessment, documentation, intake cues, coding in ICD-10, any software upgrades, OASIS updates, SBAR and communication

Resources

- MLN SE 1410
- ICD-10-CM page on cms.gov
- Information is all physician/hospital
- Since coding involves clinical analysis, providers should code accurately and according to the guidelines, rather than depending on code crosswalks or equivalence mapping.
**Tips for Change**

- Make a plan, set very specific goals
- Stay focused on the steps of the plan
- Believe you will succeed, but know success will not come easily
- It’s about making progress, not doing everything perfectly from the start
- You can develop new abilities through work and practice, so push through the setbacks and challenges
- Focus on what you will do, not what you won’t or can’t do

**What questions do you have?**

- Lisa@selmanholman.com
- Teresa@selmanholman.com
- Selman-Holman & Associates, LLC
- Home Health Insight
- CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
- CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice