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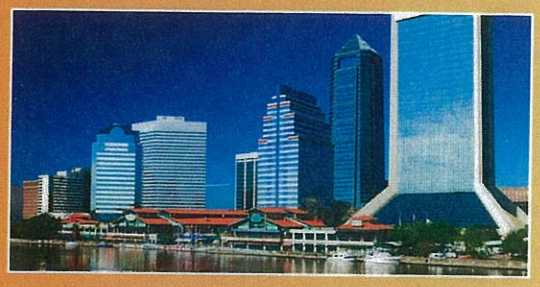

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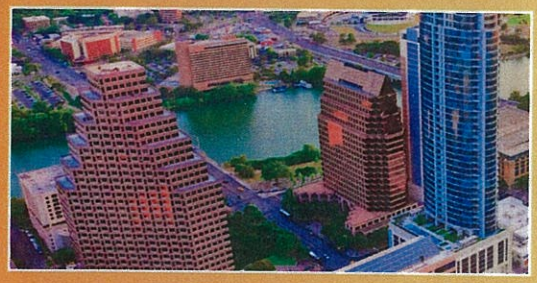

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DecisionHealth®
Two Washingtonian Center
9737 Washingtonian Blvd., Ste. 200
Gaithersburg, MD 20878-7364

Toll-free: 1-855-CALL-DH1
customer@decisionhealth.com
www.decisionhealth.com

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Home Health ICD-10-CM Coding Answers, 2015

Technical Editor and Contributing Author:

Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10-CM Trainer
Owner, Home Care Coding and QA Specialists, Transitions Health and Wellness Solutions

Technical Editor:

Arlynn Hansell, PT, HCS-D, HCS-O, COS-C, owner, Therapy & More, LLC, Cincinnati, Ohio.

Contributing Authors:

Jean Bird, RN, HCS-D, clinical coordinator, Gentiva, Fall River, Mass.

Lori Brancaleone, RN, HCS-D, COS-C, AHIMA Approved ICD-10-CM Trainer

J'non Griffin, RN MHA, WCC, BCHH-C, HCS-D, COS-C, AHIMA Approved ICD-10-CM Trainer/Ambassador, senior consultant, Home Health Solutions, LLC, Carbon Hill, Ala.

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Introduction

On Oct. 1, 2015, you will be expected to start coding in ICD-10-CM. You can't afford to waste any more time, you must start preparing now.

Proper planning and training in ICD-10 will mean big savings down the road. To help you get started, DecisionHealth has produced ***Home Health ICD-10-CM Coding Answers, 2015***

To learn how to accurately code in ICD-10, you must practice coding. Use ***Home Health ICD-10-CM Coding Answers, 2015,*** to practice coding common home health scenarios using ICD-10 diagnoses codes, or to teach others about coding. Work through 90 scenarios that cover home health's most complicated situations, including surgical and trauma wounds, late effects, neoplasms and much more!

You can code each scenario in the separate workbook, and then look up the answer and rationale behind the coding in this Answers Manual. The scenarios are divided into disease sections that match the chapters of the ICD-10 code set. The Manual focuses on the disease chapters most common to home health.

Don't waste your time learning about ICD-10 from a generic book that's cluttered with information for physician practices, hospitals and healthcare businesses of all stripes. Get your ICD-10 education off to a strong, targeted start with the one ICD-10 training resource specific to home health coders: DecisionHealth's ***Home Health ICD-10-CM Coding Answers, 2015.***

Sincerely,

Maria Tsigas

Maria Tsigas
Director of Product Management
Post Acute Care
DecisionHealth

Chapter 1:

Infectious Diseases

Scenario 1

Patient was admitted to the hospital with gram negative sepsis. She was treated with IV antibiotics and will continue to receive IV antibiotics at home for another six days via a PICC line. The physician documented on the H&P she has type 2 diabetes mellitus, which did exacerbate due to the infection. She was receiving insulin in the hospital but will continue on her oral glipizide only at home. Order is for skilled nursing to administer antibiotics and assess blood sugar levels.

Primary:	A41.50	Gram-negative sepsis, unspecified
Secondary:	E11.9	Type 2 diabetes mellitus without complications
Secondary:	Z45.2	Encounter for adjustment and management of vascular access device
Secondary:	Z79.2	Long term (current) use of antibiotic medication

Gram negative sepsis should be coded using the appropriate code from A41.- (Other sepsis) with the organism specified as "gram negative," indicating the use of A41.50. This is the primary purpose for home health and is coded as primary. Diabetes has been exacerbated and is also an important comorbid condition to include in the plan of care, so this is also coded. Since it is not specified as type 1 diabetes or due to another cause, it is coded as type 2 using E11.9. The administration of IV antibiotics is captured using Z45.2 (Encounter for adjustment and management of vascular access device) and Z79.2 (Long term (current) use of antibiotic medication).

Scenario 2

Patient has Lyme disease due to a tick bite. He has developed polyneuropathy as a result which has caused his gait to become unsteady. He is admitted to home health for physical therapy to assess/manage his gait impairment. He currently is receiving treatment for the Lyme disease. He has a past medical history of peripheral vascular disease (PVD) and coronary artery disease (CAD).

Primary:	A69.22	Other neurologic disorders in Lyme disease
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
Secondary:	I73.9	Peripheral vascular disease, unspecified

In this case, the patient has developed a subsequent effect of the Lyme disease. ICD-10 includes a number of combination codes, including many that indicate the effects caused by diseases, both active and sequelae. In this case, A69.22 indicates Lyme disease (which may still be actively treated) with a component of related neurologic disorder. CAD and PVD are important to code as comorbid disease processes, especially in a patient with this type of already problematic polyneuropathy, as additional loss of blood flow to the periphery may further reduce sensation and complicate the patient's condition. Both CAD and PVD also increase the patient's risk for cardiovascular complications, are likely to increase the complexity of the medication regime, and should be addressed in the plan of care as important secondary/comorbid diagnoses.

Scenario 3

Patient is admitted to home health care following hospitalization for UTI with E coli. He is continuing on oral antibiotics and skilled nursing will obtain a urinalysis upon completion of the antibiotics. He also has a diagnosis of hypertension, which is stable, and chronic kidney disease stage 3.

Primary:	N39.0	Urinary tract infection, site not specified
Secondary:	B96.20	Unspecified E.coli as the cause of diseases classified elsewhere
Secondary:	I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Secondary:	N18.3	Chronic kidney disease, stage 3 (moderate)

The UTI (N39.0) is coded as primary since it is the reason for home care. Code B96.20 is the correct infection code for the UTI. Hypertension (HTN) is a comorbid condition, and ICD-10-CM presumes a causal relationship between the chronic kidney disease and HTN, so both conditions are coded.

Scenario 4

Patient has a PEG tube for nutrition. He is taking Keflex via PEG for cellulitis with methicillin susceptible Staph aureus (MSSA) infection to the PEG site. He has dysphagia as a result of a CVA six months ago. Skilled nursing is ordered for monitoring of the cellulitis, wound care and medication instruction.

Primary:	K94.22	Gastrostomy infection
Secondary:	L03.311	Cellulitis of abdominal wall
Secondary:	B95.61	MSSA
Secondary:	I69.391	Dysphagia following cerebral infarction
Secondary:	R13.10	Dysphagia, unspecified

This is a complication of the PEG site and therefore that is the primary diagnosis. The cellulitis and infective organism are coded next followed by the CVA with dysphagia. Coding guidelines state to code the dysphagia in addition to the late effect CVA code. Non-surgical wound care is inappropriate due to the infection as is the status/attention G-tube codes.

Scenario 5

Patient is referred to home health following removal of right knee prosthesis due to a MRSA infection and the insertion of an antibiotic spacer. Orders are for skilled nursing to administer IV antibiotics and physical therapy to see the patient for teaching about limited range of motion, gait abnormality and muscle weakness of both lower extremities and home safety. The patient is expected to return to surgery for a new prosthesis once the infection is resolved. The patient is a Type 2 diabetic who requires daily insulin. The patient also has primary osteoarthritis in the left knee and is awaiting surgery to replace that knee as well.

Primary:	T84.53xD	Infection and inflammatory reaction due to internal right knee prosthesis, subsequent episode
Secondary:	B95.62	Methicillin resistant Staphylococcus aureus infection
Secondary:	E11.9	Type 2 diabetes mellitus without complications
Secondary:	M17.12	Unilateral primary osteoarthritis, left knee
Secondary:	Z45.2	Encounter for adjustment and management of vascular access device
Secondary:	Z79.4	Long-term (current) use of insulin
Other:	Z89.521	Acquired absence of right knee

The infected prosthesis is clearly the most acute condition and is listed first since the infection still is present. Code T84.53xD is a combination code that includes the complication (infection), location (knee), laterality (right) and the episode encounter (subsequent). The cause of the infection is known (B95.62) and is sequenced immediately following the complication code.

Although the osteoarthritis (OA) is resolved from the right knee, the patient is noted to have OA in the left knee that adds to the complexity of the care. The arthritis code includes the type of OA (primary), location (knee) and laterality (left). Use of abnormal gait and weakness are optional and generally inherent when a joint replacement or explantation is present, and generally should not be used when the underlying etiology is known.

The diabetes is an important co-morbidity that will require ongoing monitoring, especially since the presence of infection may impact the patient's insulin dosage.

The Z89.521 is a combination code identifying that a prosthesis has been explanted (removed), the location (knee) and laterality (right). Code Z45.2 identifies the presence of an IV.

ICD-10 official guidelines instruct the coder not to assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

Scenario 6

Patient has streptococcus pneumoniae septicemia.

Primary: A40.3 Sepsis due to streptococcus pneumoniae

In ICD-10, there are infection codes that include the organism. This coding scenario presents one of those situations in which multiple codes are not needed to express the problem and the bacterium.

Also note that septicemia is not a main term in ICD-10. There is no code for septicemia; the Index refers the coder to sepsis. A code from subcategory R65.2- (Severe sepsis) should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

Scenario 7

Patient has a staphylococcus infected left BKA amputation stump.

Primary:	T87.44	Infection of amputation stump, left lower extremity
Secondary:	B95.8	Unspecified staphylococcus

T87.4- codes are used for any infection of the amputation stump. A Z code indicating the amputation site should not be used because the complication code includes site and laterality.

Chapter 2: **Neoplasms**

Scenario 8

A 54-year-old male with a 40-year history of smoking continues to smoke daily. He is admitted to home health following a hospitalization for anemia due to his liver cancer mets. He received a blood transfusion of four units in the hospital and will take ferrous sulfate at home. He also has COPD, PVD and a history of lung cancer. Skilled nursing will assess and instruct regarding the anemia and liver cancer, and will obtain CBC via venipuncture weekly for four weeks.

Primary:	C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
Secondary:	D63.0	Anemia in neoplastic disease
Secondary:	I73.9	Peripheral vascular disease, unspecified
Secondary:	J44.9	COPD
Secondary:	Z72.0	Tobacco use
Secondary:	Z85.118	Personal history of other malignant neoplasm of bronchus and lung

When coding anemia due to a neoplasm in ICD-10, the anemia should be sequenced following the underlying neoplastic disease, according to coding guidelines, which instruct the coder to "code first" the neoplasm (C00-D49).This is a change from ICD-9, which allows the coder to code anemia as primary. For this reason, the secondary neoplasm of the liver (C78.7) is coded first, followed by the anemia due to neoplasm (D63.0). Do not confuse anemia due to a neoplasm with anemia due to chemotherapy.

Additionally, COPD, PVD and the history of lung cancer are important comorbid conditions that will impact how the patient's condition progresses, and may also be subsequently negatively impacted by the impact of the neoplastic disease and anemia. For example, the anemia may cause hypoxemia, which could further compromise the patient's respiratory and cardiopulmonary condition. For this reason, these conditions should also be included.

Finally, since the patient continues to smoke, tobacco use should be coded. Coding clinic (Q2, 2014) has clarified that when the physician reports tobacco dependence, that dependence upon tobacco may be coded. However, when the frequency or amount of cigarette use is unknown, only Z72.0 (Tobacco use) should be coded. The use of a code to report tobacco use or exposure in patients with lung disorders or history of lung disorders is required in ICD-10.

Chapter 2: Neoplasms

Scenario 9

A 68-year-old female is admitted to home health post mastectomy due to breast cancer of the lower outer quadrant of her left breast. She will begin chemotherapy once the incision is healed. Medical records state she is estrogen receptor positive. She quit smoking two years ago and has COPD. Focus of skilled nursing care is incisional care and instruction related to the breast cancer.

Primary:	Z48.3	Aftercare following surgery for neoplasm
Secondary:	C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
Secondary:	J44.9	COPD, unspecified
Secondary:	Z87.891	Personal history of nicotine dependence
Secondary:	Z48.01	Encounter for change or removal of surgical wound dressings
Secondary:	Z17.0	Estrogen receptor positive status [ER+]
Other:	Z90.12	Acquired absence of left breast and nipple

This is routine wound care and the malignancy remains under treatment so it is still present. Following the coding rules, all the Z codes need to be assigned. The co-morbid conditions, COPD and history of smoking, also should be coded.

Scenario 10

A 75-year-old male with inoperable brain cancer is admitted to home health. He has altered mental status and abnormal gait stated by the physician to be due to the malignancy. Orders are for PT and OT assessment and instruction regarding mental status and gait issues. He also has PVD that resulted in a right below the knee amputation (BKA) several years ago and is now stable per medical records.

Primary:	C71.9	Malignant neoplasm of brain, unspecified
Secondary:	I73.9	Peripheral vascular disease, unspecified
Secondary:	Z89.511	Acquired absence of right leg below knee

Coding guidelines state not to code the signs and symptoms associated with a malignancy. Both altered mental status and gait issues are associated with brain cancer so it is incorrect to include these codes. PVD and amputation status are co-morbid conditions that should be included when present.

Scenario 11

Patient admitted for aftercare following resection for colon cancer. The history and physical states colon cancer resolved with surgery, no further treatment planned.

Primary:	Z48.3	Aftercare following surgery for neoplasm
Secondary:	Z85.038	Personal history of other malignant neoplasm of large intestine

Aftercare Z codes are utilized following surgery. If the neoplasm has resolved, a personal history code is required. In ICD-10 however, the personal history codes have an instructional note matching the Z code to 'the condition classifiable to.' In the above example, the condition classifiable to instruction indicates the neoplasm code should be classifiable to C18.

Note, resolved conditions are not reported as they are not eligible for clinical points.

Scenario 12

Patient is admitted to home care for management of anemia due to malignant carcinoid tumor of stomach.

Primary:	C7A.092	Malignant carcinoid tumor of stomach
Secondary:	D63.0	Anemia in neoplastic disease

When the admission/encounter is for management of an anemia associated with the malignancy and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal for first-listed diagnosis followed by the appropriate code for the anemia. The sequencing is opposite in ICD-10 from ICD-9. The coder will see 'code first' neoplasm sequencing instructions in the Tabular section under the anemia code.

Scenario 13

Patient is post lung transplant and is being admitted to home care for management of cancer in the lower right lobe of his transplanted lung, and pain management due to excessive pain.

Primary:	T86.818	Other complications of lung transplant
Secondary:	C80.2	Malignant neoplasm associated with transplanted organ
Secondary:	C34.31	Malignant neoplasm of lower lobe right bronchus or lung
Secondary:	G89.3	Neoplasm related pain

C80.2 deals specifically with cancer in transplanted organs. It takes three codes to fully code this situation. One code indicates the complication (T86.818), one code indicates it's a malignant neoplasm associated with a transplanted organ (C80.2), and one code indicates the location of the cancer (C34.31). **Note:** the neoplasm code includes site and laterality.

Remember that pain is only coded when it is out of the ordinary.

Chapter 3:

Diseases of the Blood and Blood-Forming Organs

Scenario 14

A 67-year-old female is admitted to home health following a right total knee replacement for osteoarthritis. She had increased bleeding during surgery, which resulted in acute postoperative anemia for which she is taking ferrous sulfate. She has osteoarthritis to her left knee that is pending replacement surgery, smokes one pack of cigarettes daily, and has emphysema. Orders are for skilled nursing for wound care and CBC weekly x4 weeks, and PT and OT for gait training and strengthening.

Primary:	Z47.1	Aftercare following joint replacement surgery
Secondary:	D62	Acute posthemorrhagic anemia
Secondary:	M17.12	Unilateral primary osteoarthritis, left knee
Secondary:	J43.9	Emphysema, unspecified
Secondary:	Z72.0	Tobacco use
Secondary:	Z96.651	Presence of right artificial knee joint
Other:	Z48.01	Encounter for change or removal of surgical wound dressing

In the case of this patient, aftercare is appropriate to code since the patient is admitted following a joint replacement. While she did experience some postoperative anemia, this is not considered a complication and does not prevent the coder from assigning the Z code for aftercare. Note that, like in ICD-9, ICD-10 also has a specific Z code for aftercare of a joint replacement (Z47.1). Coding guidelines instruct the coder to use an additional code to identify the joint replaced when assigning this Z code. Category Z96.6- indicates codes for the presence of an artificial joint and includes choices for laterality. In this case, Z96.651 indicates that the right knee was replaced.

Code M17.12 also is assigned to indicate osteoarthritis of the left knee, which is still pending replacement and will impact the patient's pain levels and ability to move about safely.

Since the treatment for the anemia continues, D62 (Acute posthemorrhagic anemia) is coded to report the continued attention to this condition. Emphysema should also be coded as this respiratory condition will result in reduced energy levels and endurance and can impact the patient's recovery post operatively.

Finally, when coding respiratory/pulmonary conditions in ICD-10, it is necessary to code any tobacco use, dependence or exposure. Since the patient smokes daily, tobacco use should be coded.

Scenario 15

Patient is admitted to home health for skilled nursing to administer B12 injection once a month, instruct family member on how to give injection, and instruct patient and caregiver about pernicious anemia. Patient was just discharged from the hospital following staph pneumonia and his antibiotics are now completed. He is legally blind, has peripheral neuropathy for which he has had a recent medication change, and GERD which is stable at this time.

Primary:	D51.0	Vitamin B12 deficiency anemia
Secondary:	H54.8	Legal blindness, as defined in USA
Secondary:	G62.9	Polyneuropathy, unspecified
Secondary:	Z87.01	Personal history of pneumonia (recurrent)

The B12 injections for the pernicious anemia is the focus of care so that is coded primary. Also code the co-morbid conditions, which include his recent medication changes for neuropathy and his legal blindness, which will impact his ability to administer his own injections. Although the pneumonia is resolved, you should still assign the history code (Z87.01), as this is what he was just hospitalized for, and most likely the cause of any current debility.

Scenario 16

Patient has post-operative, acute blood loss anemia following coronary artery bypass x3 for CAD. She is taking Ferrous Sulfate and skilled nursing will monitor CBC weekly and perform wound care. She has hypertension (HTN) and congestive heart failure (CHF) which are both stable.

Primary:	Z48.812	Encounter for surgical aftercare following surgery on the circulatory system
Secondary:	D62	Acute Posthemorrhagic anemia
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
Secondary:	I50.9	Congestive heart failure
Secondary:	I10	Essential hypertension
Secondary:	Z48.01	Encounter for surgical wound dressings
Other:	Z95.1	Presence of aortocoronary bypass graft

Focus of care is the wound care. Due to lab draws and iron supplement dosing, anemia is the next area of focus. HTN and CHF are co-morbid conditions that should be included when present.

Scenario 17

Patient admitted to home care for anemia due to antineoplastic chemo given to treat primary liver cancer. Per the physician, anemia is the focus of care.

Primary:	D64.81	Anemia due to antineoplastic chemotherapy
Secondary:	T45.1X5D	Adverse effect of antineoplastic and immunosuppressive drugs subsequent encounter
Secondary:	C22.8	Malignant neoplasm of liver primary, unspecified type

D64.81 is the appropriate code for chemotherapy-induced anemia caused by antineoplastic and immunosuppressive drugs, and it should be sequenced first if it is the focus of care.

In ICD-9, a separate E code to indicate the drug was used therapeutically is not required since the information was contained within the code title. However, in ICD-10, the sequencing of the anemia code is the same but the coder is instructed to follow it with the code for the neoplasm and the adverse effect (T code), in this example; T45.1X5D. Notice the T code is a 7 character code, with the 5th character of X being utilized as a placeholder because a 7th character is required to indicate the encounter. In this example, it is a subsequent encounter denoted by the letter 'D.'

Remember that if anemia is the focus of care, the anemia is coded first, and the neoplasm of the liver (C22.8) is coded secondary.

Scenario 18

Home health is seeing a patient for anemia due to blood loss from a chronic gastric ulcer.

Primary:	D50.0	Iron deficiency anemia secondary to blood loss (chronic)
Secondary:	K25.7	Chronic gastric ulcer without hemorrhage or perforation

Category D50 does not instruct the coder to use an additional code, but the gastric ulcer certainly should be on the record independently as a secondary diagnosis. The diagnostic statement does not mention hemorrhage, perforation or obstruction in relation to the gastric ulcer. Bleeding could be associated with a chronic ulcer without actual hemorrhage. Hemorrhage cannot be assumed on the basis of the term "blood loss."

Scenario 19

Patient is admitted for skilled nursing and monitoring for anemia in chronic kidney disease (stage 4).

Primary:	N18.4	Chronic kidney disease stage 4 (severe)
Secondary:	D63.1	Anemia in chronic kidney disease

The sequencing is reversed in ICD-10. When the coder reads the sequencing instructions under D63.1 (Anemia in chronic kidney disease), the note instructs to 'code first' the underlying chronic kidney disease.

Chapter 4:

Endocrine, Nutritional and Metabolic Diseases

Scenario 20

Patient is admitted to home health with diabetes, type 2 with angiopathy and a diabetic ulcer to his left heel specified as due to diabetic angiopathy. He has a right foot amputation due to a prior diabetic ulcer. He has HTN and CHF which are well controlled at present. Skilled nursing is ordered for wound care to the diabetic arterial ulcer.

Primary:	E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
Secondary:	L97.429	Non-pressure chronic ulcer of left heel and midfoot with unspecified severity
Secondary:	I50.9	Heart failure, unspecified
Secondary:	I10	Hypertension
Secondary:	Z48.00	Encounter for change or removal of nonsurgical wound dressing
Secondary:	Z89.431	Acquired absence of right foot

Diabetic ulcers may be attributed to several specific manifestations of diabetes, such as Charcot arthropathy, neuropathy or angiopathy, when this information is provided specifically by the physician. In this case, the physician has specified the origin of the ulcer as diabetic and due to angiopathy of diabetes. This indicates coding the ulcer specifically as a manifestation of diabetic angiopathy rather than an unspecified diabetic ulcer.

Code E11.51 (Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene) is a combination code in ICD-10 that indicates that the patient has diabetic angiopathy but that no gangrene is present. For this patient, E11.51 is the most appropriate code to capture the diabetic angiopathy. Following this code with the correct code from L97.- to indicate the ulcer location and severity indicates that it is diabetic and due to angiopathy. Keep in mind when coding non pressure chronic ulcers that the severity of the ulcer may be taken from nursing documentation, which will need to be sufficient in conveying the level of tissue destruction present in the wound.

CHF and hypertension should both be coded as comorbid diagnoses as these will impact the overall cardiovascular function of the patient, and will be impacted over time by the condition of the patient's diabetic control as well. Optionally, a Z code to report the non-surgical dressing changes may be used by reporting Z48.00 (Encounter for change or removal of nonsurgical wound dressing). Since the patient has a history of a prior amputation due to diabetic ulceration, the previous foot amputation status should also be coded using Z89.431 (Acquired absence of right foot).

Scenario 21

Patient has Type 1 diabetes with both retinopathy and end stage renal disease. He attends dialysis three times a week. He has hypertension and has just been discharged from the hospital for an exacerbation of acute on chronic diastolic and systolic heart failure. Skilled nursing is ordered to monitor the CHF, medication compliance, obtaining weights, assessing lung sounds and edema, and teaching.

Primary:	I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
Secondary:	E10.22	Type 1 diabetes with diabetic chronic kidney disease
Secondary:	I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Secondary:	N18.6	End stage renal disease (ESRD)
Secondary:	E10.319	Type 1 diabetes with unspecified diabetic retinopathy without macular edema
Secondary:	Z99.2	Dependent on renal dialysis

The CHF is the focus of care so it is coded primary. The link between HTN and ESRD is assumed, and it is stated with the diabetes. Instructions state to sequence the ESRD after both the HTN and diabetes. Instructions also state to code dialysis when the patient receives it. Also, note that insulin is not coded with Type 1 diabetes.

Scenario 22

Patient was a lifelong smoker and quit five years ago when he started using oxygen. He has COPD and emphysema for which he has been taking steroids for years. He also has PVD with claudication. He is admitted to home health with a new diagnosis of secondary diabetes due to steroid use. Skilled nursing is ordered for diabetes teaching, assessment and management.

Primary:	E09.9	Drug or chemical induced diabetes mellitus without complications
Secondary:	T38.0X5D	Adverse effect of glucocorticoids and synthetic analogues
Secondary:	J44.9	COPD
Secondary:	I73.9	Peripheral vascular disease, unspecified
Secondary:	Z99.81	Dependence on supplemental oxygen
Secondary:	Z87.891	Personal history of nicotine dependence
Other:	Z79.52	Long-term (current) use of systemic steroids

The focus on home health will be the new diagnosis of secondary diabetes due to steroid use (E09.9). Additional codes are required for the history of smoking and for the adverse reaction to the steroids. A 7th digit D (subsequent encounter) is added to the adverse effect code (T38.0X5D). COPD with emphysema (J44.9) and PVD are co-morbid conditions that also need to be coded because they impact the plan of care.

Scenario 23

Patient is referred to home care due to pain in legs, unable to ambulate, and falling due to diabetic angiopathy. He has diabetes due to having his entire pancreas removed. He requires insulin.

Primary:	E89.1	Post procedural hypoinsulinemia
Secondary:	E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
Secondary:	Z90.410	Acquired absence of pancreas
Secondary:	Z79.4	Long-term (current) use of insulin
Secondary:	Z91.81	History of falls

Several coding guidelines come into play in this scenario. The patient has diabetes caused by another factor, a pancreas removal. The diabetes is secondary diabetes, coded from Category E13. There is a specific guideline that deals with diabetes caused by a pancreatectomy, and that guideline instructs to code E89.1 first, followed by a code from E13 for secondary diabetes, which is a combination code that includes any manifestations that may be present. A separate code for angiopathy is not required.

The Z codes can be sequenced based on coder's preference to further describe the situation. Z90.410 is a status code describing the removal of the pancreas. Note, in ICD-10, there are separate codes for total or partial removal of pancreas. Code Z79.4 (Long-term (current) insulin use) should be used for a patient with Type 2 or other specified diabetes to provide additional information on management of the diabetes. You could consider sequencing Z91.81 higher since it can be used to designate risk of falls as well as history of falls without injury and involves a safety risk vs. just a status of condition.

Scenario 24

Your patient has Type 2 diabetes with acute osteomyelitis of the right foot, stated as `due to diabetes'. The patient is receiving IV Vancomycin and skilled nursing for wound care, IV administration of antibiotics and to draw labs, peak and trough.

Primary:	E11.69	Type 2 diabetes mellitus with other specified complication
Secondary:	M86.171	Other acute osteomyelitis right ankle and foot
Secondary:	Z45.2	Encounter for adjustment and management of vascular access device
Secondary:	Z51.81	Encounter for therapeutic drug level monitoring
Secondary:	Z79.2	Long-term (current) use of antibiotics

This is an excellent example of where giving thought to sequencing can greatly affect the way you code. Acute diseases, in this case diabetes and the osteomyelitis that has resulted from it, should trump Z codes in sequencing. The skilled nursing is there because of the disease.

Z51.81 is a code to carefully watch in home health. Although there isn't a guideline restriction, it should not be used primary since it indicates blood draws to monitor medications. The code should always be used in tandem with a Z79.- code to identify the category of drug being monitored, and cannot be used just for medication management. Medication management is not skilled care by itself, although it can be used when assessing the effectiveness of a medication through labs.

This particular diabetes code (E11.69) is not a combination code and requires a second code to identify the manifestation. In this example, it is osteomyelitis. There is no Tabular instruction to use an additional code to identify the bone involvement.

In contrast to ICD-9-CM, osteomyelitis cannot be assumed to be a manifestation of diabetes mellitus without physician confirmation in the ICD-10-CM code set. This was confirmed by Coding Clinic in January 2014, which noted that a physician must establish the relationship between osteomyelitis and diabetes when coding in the ICD-10-CM code set. As noted in this scenario, the physician has established that the osteomyelitis is due to diabetes. The use of the term "due to" establishes a relationship.

When osteomyelitis is a manifestation of diabetes, the coder must identify which bone is infected to accurately choose the code. In this example, the coder's knowledge of anatomy and physiology is important. When looking up the code for osteomyelitis of the foot, the essential modifier is the word 'metatarsus,' not the word 'foot.' Laterality is a part of the coder's decision-making process as well. The code (M86.171) is a combination code that includes whether the infection is acute or chronic, and the site of the infection.

Scenario 25

A Type 2 diabetic is admitted with an infected open wound on his lower left leg, as a result of the lawn mower hitting a piece of metal. The mower bumped his leg and the metal bounced up and punctured his left lower leg. The infection has led to gangrene.

Primary:	S81.842D	Puncture wound with foreign body, left lower leg subsequent episode
Secondary:	I96	Gangrene, not elsewhere classified
Secondary:	E11.9	Type 2 diabetes without complications
Secondary:	W28.xxxD	Contact with a powered lawnmower subsequent episode
Secondary:	W45.8xxD	Foreign body entering through skin subsequent episode

Here, the open wound is the focus of care, so it is coded primary, with a 7th character of 'D' indicating subsequent episode. The gangrene is specifically linked to the open wound, so it is listed second and is not considered a manifestation of diabetes. We have no other information on diabetes except that it is Type 2, so it is coded from the E11 category without complications. Since diabetes is a condition that nearly always impacts the plan of care, it should be coded as a pertinent co-morbidity and ongoing monitoring should be addressed in the plan of care. External cause codes (the W codes in this scenario) are not required in ICD-10, but are encouraged to indicate how the injury occurred. All external cause codes require a 7th character.

Chapter 5:

Mental and Behavioral Disorders

Scenario 26

Patient has just been hospitalized for an exacerbation of his chronic alcohol induced pancreatitis. He also has peripheral neuropathy due to his alcohol dependence, hypertension and COPD. Skilled nursing is ordered for assessment and medication monitoring, and physical therapy is ordered for gait issues related to the neuropathy.

Primary:	K86.0	Pancreatitis due to alcohol
Secondary:	F10.20	Alcohol dependence
Secondary:	G62.1	Alcoholic polyneuropathy
Secondary:	J44.9	COPD
Secondary:	I10	I10 Hypertension

Pancreatitis that is stated as due to alcohol should be specifically coded to K86.0. Coding guidelines note that the coder should assign an additional code for any alcohol dependence, which also is noted here. The patient also has alcoholic peripheral neuropathy, which should also be coded, but does not have a specific guideline to code the dependence before or after the neuropathy. For this reason, the F10.20 (Alcohol dependence) may be coded after the K86.0 (Pancreatitis due to alcohol), but before G62.1 (Alcoholic polyneuropathy).

COPD and hypertension should also be included as comorbid diagnoses as these are likely to impact the patient's overall recovery, as well as be impacted by the current, exacerbated conditions. There is no need to use any additional code for gait abnormality since the cause of the gait abnormality is known (due to the peripheral neuropathy).

Scenario 27

Patient was admitted to the hospital following a fall in which she suffered a fracture to the head of her right femur. She underwent a joint replacement. Her husband died two months ago and the physician has diagnosed her with grief depression and has prescribed Zoloft since her hospital admission. She also has hypertensive heart disease with CHF. Physical therapy is ordered for gait and strengthening, and psychiatric skilled nursing is ordered to assess and monitor her depression, the effect of the Zoloft and instruction on the grief process.

Primary:	Z47.1	Aftercare following joint replacement surgery
Secondary:	F43.21	Adjustment disorder with depressed mood
Secondary:	I11.0	Hypertensive heart disease with heart failure
Secondary:	I50.9	Congestive heart failure
Secondary:	Z96.641	Presence of right artificial hip joint
Secondary:	Z91.81	History of falls

Abnormal gait is integral to fractures and joint replacements and is therefore not coded separately. Additionally, the fracture does not need to be coded since the joint replacement has resolved the fracture so it is no longer present. The HTN and heart disease/CHF are linked per the physician so I11.0 with I50.9 are the appropriate codes. Instructions state to identify the joint replaced.

Scenario 28

Patient with paranoid schizophrenia is admitted to home health. The skilled nurse will be providing Haldol® injections B.I.D. as a new treatment for the schizophrenia, until the caregiver is proficient in administering the drug. Patient also has congestive heart failure, hypertension and Type 2 diabetes.

Primary:	F20.0	Paranoid schizophrenia
Secondary:	I50.9	Congestive heart failure
Secondary:	I10	Essential primary hypertension
Secondary:	E11.9	Diabetes mellitus Type 2 without complications
Secondary:	Z79.899	Other long-term drug therapy

The home health focus of care is to administer and teach on the Haldol® injections to treat the paranoid schizophrenia. Congestive heart failure, diabetes and hypertension should be coded as pertinent co-morbidities. The Z code for long-term drug therapy may be added to provide additional information.

Scenario 29

Patient with a diagnosis of major recurrent depression is admitted to home health for medication teaching and monitoring.

Primary:	F33.9	Major depressive disorder, recurrent, unspecified
Secondary:	Z79.899	Other long-term drug therapy

Be careful with mental disorder codes. Make sure there is a physician diagnosis for what you are coding. Category F33 (Depressive disorder recurrent) is found in the Alpha Index under 'disorder' not 'depression.'

A code for long-term (current) drug use (Z79.899) is added to show the focus on medication monitoring. This code is selected since there is not a code specific for psychiatric drugs. The Z79.- codes are secondary only and cannot be listed as the primary diagnosis. While a psychiatric nurse is often required when using a psychiatric diagnosis as the first-listed diagnosis, it does not require a psychiatric nurse to teach or monitor medications. A psychiatric nurse is required if the plan of care involves counseling for the psychiatric condition.

Scenario 30

Patient admitted for memory care program related to diagnosis of late onset Alzheimer's disease with behavioral disturbances. Patient has wandering episodes and lives with his elderly wife who has limited mobility due to rheumatoid arthritis.

Primary:	G30.1	Alzheimer's disease with late onset
Secondary:	F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
Secondary:	Z91.83	Wandering in diseases classified elsewhere
Secondary:	Z74.2	Need for assistance at home and no other household member able to render care

Alzheimer's disease has separate codes for early vs. late onset in ICD10. A manifestation code is required as a secondary code to describe the level of dementia. If wandering is part of the behavioral disturbance, it must be listed as an additional Z code.

Chapter 6:

Diseases of the Nervous System

Scenario 31

A 68-year-old woman with multiple sclerosis is referred to home health for physical therapy, skilled nursing and occupational therapy following a number of recent falls related to progression of the disease. She has additional related diagnoses of neurogenic bowel and bladder, and requires intermittent catheterization, but is not incontinent. Nursing is needed to assess the patient's competency and teach safe self-catheterization techniques, as the patient has had several recent UTIs. She also has a diagnosis of hypertension.

Primary:	G35	Multiple sclerosis
Secondary:	N31.9	Neurogenic bladder
Secondary:	K59.2	Neurogenic bowel, NEC
Secondary:	I10	Benign essential hypertension
Secondary:	Z46.6	Fitting and adjustment of urinary device
Secondary:	Z87.440	Personal history of urinary (tract) infections
Other:	Z91.81	History of falls
Other:	R29.6	Repeated falls

The focus of care in this scenario is the multiple sclerosis (MS), which is noted as the cause of the falls. The patient's gait issues that have progressed and resulted in falls are an integral component of the MS and are consequently not coded separately.

The neurogenic bowel and bladder are both resulting from but not integral to the diagnosis of multiple sclerosis. These are coded separately. Since the nursing services will be addressing catheterization skills and management of the neurogenic bladder, this is coded second. The encounter for fitting/adjustment of urinary catheter is also coded, in addition to the Z code for history of urinary tract infections.

Falls are reported in this scenario and both the code for history of falls (Z91.81) and repeated falls (R29.6) are used. In the ICD-10-CM code set, these two codes provide different information regarding the patient's pattern of falls and are not excluded from use in the same sequence of codes. History of falls (Z91.81) indicates that a patient has a relevant history of falls that will impact the plan of care. Repeated falls (R29.6) is used to indicate the need for home health to investigate and treat the repeated falls. These two codes each have an "Excludes 2" note in the ICD-10-CM code set providing information to the coder that the two codes may be coded together as they each exclude the other. In addition, ICD-10-CM coding guidelines state, "This code is assigned 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." (*Section I.C.18.d*)

Hypertension is coded as a co-morbid diagnosis.

Scenario 32

A 56-year-old male patient with a left below the knee amputation (BKA) has a history of severe peripheral artery disease secondary to diabetes mellitus, and is admitted to the home health agency for severe phantom limb pain. He is an insulin-dependent diabetic. His physician has ordered physical therapy and skilled nursing.

Primary:	G54.6	Phantom limb syndrome with pain
Secondary:	E11.51	Type 2 diabetes with diabetic peripheral angiopathy without gangrene
Secondary:	Z79.4	Long-term (current) use of insulin
Secondary:	Z89.512	Acquired absence of left leg below knee

The phantom pain is the focus of care in this scenario. Code G54.6 is used here to specify that the phantom limb syndrome is "with pain." ICD-10-CM includes codes for both phantom limb syndromes both with and without pain. As this patient's primary home health need is the pain related to phantom limb syndrome, G54.6 is used. The appropriate Z code to report the left below the knee amputation is added to specify the amputated limb site.

Diabetes mellitus is coded as a comorbid disease process. As the severe peripheral artery disease is specified as related to/secondary to diabetes, the code E11.51 is reported to note the peripheral artery disease as a manifestation of diabetes. As the record does not report the diabetes as specifically due to a secondary cause, or as type 1, the code for type 2 diabetes is used as default. The Z code for insulin use must be added as the diabetes is coded to type 2.

Scenario 33

Patient is referred to home care for therapy for gait training due to Parkinson's disease, and skilled nursing to perform wound care to a stage 2 pressure ulcer of the right buttock. Patient also has Parkinson's dementia.

Primary:	G20	Parkinson's disease
Secondary:	F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
Secondary:	L89.312	Pressure ulcer right buttock, stage 2

There are no rehab codes in the ICD-10 classification system. Therefore, when therapy is ordered, the reason for therapy should be coded. Since the patient's pressure ulcer is not reported as worsening, the Parkinson's disease is the major focus of care.

Although abnormal gait was the specified focus for therapy in this situation, abnormal gait is inherent in Parkinson's disease and should not be coded separately.

The therapy evaluation needs to address the presence of specific functional diagnoses/ deficits (e.g., gait) that will require therapy interventions to support the medical necessity for therapy. If dementia is present and due to Parkinson's disease a second code should be listed to describe the level of dementia.

Pressure ulcer coding requires one combination code in ICD-10: one code (L89.312) includes both the site, laterality and the stage.

Scenario 34

Secondary Parkinson's due to Thorazine.

Primary:	G21.11	Neuroleptic-induced Parkinsonism
Secondary:	T43.3x5D	Adverse effect of phenothiazine antipsychotics and neuroleptics subsequent encounter

Secondary Parkinson's disease is more specific in ICD-10. The coder will need to choose between Neuroleptic-induced Parkinson's and 'other' drug-induced Parkinson's. Both codes include a Tabular note to 'use additional code' to identify the drug involved. In this example, adverse effect of Thorazine can be found in the Table of Drugs and Chemicals. The T43.3x5D code is a combination code describing the drug, intent and encounter of the adverse effect.

Scenario 35

Your patient is having an acute exacerbation of multiple sclerosis with increased gait problems. Skilled nursing, PT and OT will assess the patient's neurological status, medication regimen and Foley catheter change due to neurogenic bladder.

Primary:	G35	Multiple sclerosis
Secondary:	N31.9	Neurogenic bladder
Secondary:	Z46.6	Fitting and adjustment of urinary device

Because this is an acute exacerbation of multiple sclerosis (MS), and that's the reason for care, it is coded primary. Abnormality of gait is not required to be coded since there are a number of MS aspects being addressed in this scenario. The reason for the Foley also should be coded with the Z code for the urinary device.

Chapter 7:

Diseases of the Eye and Adnexa

Scenario 36

An 88-year-old female is admitted to home health for assessment and observation, as well as medication safety and instruction after discharge from a brief hospitalization for retinal hemorrhage of her right eye related to excessive use of aspirin not prescribed by her physician. The patient is also diabetic and uses insulin. The patient has discontinued the use of aspirin but the retinal hemorrhage is not fully resolved.

Primary:	T39.011D	Poisoning by aspirin, accidental (unintentional)
Secondary:	H35.61	Retinal hemorrhage, right eye
Secondary:	E11.9	Type 2 diabetes without complications
Secondary:	Z79.4	Long-term (current) use of insulin

The primary indication for home health is follow up on a retinal hemorrhage related to aspirin use. As the aspirin was being used "excessively" in the case of this patient, the code for poisoning is used. ICD-10-CM guidelines report that in the case of poisoning to "use additional code for" the manifestation of poisoning. Consequently, the T39.011D code for poisoning is coded first, followed by the appropriate code for retinal hemorrhage.

Diabetes is coded as a co-morbid condition, and the Z code for insulin use is ongoing with a type 2 diabetic.

Chapter 8:

Diseases of the Ear and Mastoid Process

Scenario 37

A 45-year-old female patient is admitted to home health for IV antibiotics via PICC line in order to treat acute mastoiditis of the right ear caused by MRSA. She will receive a 45-day treatment of Zosyn. The patient is wheelchair bound due to quadriplegia with progressive muscular weakness related to multiple sclerosis.

Primary:	H70.001	Acute mastoiditis without complications, right ear
Secondary:	B95.62	MRSA
Secondary:	G35	Multiple sclerosis
Secondary:	G82.50	Quadriplegia, unspecified
Secondary:	Z45.2	Encounter for IV therapy
Secondary:	Z79.2	Encounter for antibiotic use

Home health will be providing antibiotic therapy via PICC line IV for the mastoiditis that is unresolved. It is important to note that the first coded diagnosis should be the infection, not the encounter (Z codes) for the antibiotic therapy. Since the causative organism is known (MRSA), this should be coded following the mastoiditis to report the specific organism. Do not confuse codes from category B95-96 with codes from category A40-41. Codes from category A40-41 indicate systemic infection and should not be used to indicate the cause of infection specified elsewhere. Z codes to indicate the encounter for IV therapy (Z45.2) and antibiotic use (Z79.2) may also be assigned but should not be sequenced as primary.

Chapter 9:

Diseases of the Circulatory System

Scenario 38

A 76-year-old patient is admitted to home health following an exacerbation of malignant accelerated hypertension requiring hospitalization and multiple medication changes. The history and physical states resolved acute kidney failure on chronic kidney disease stage 4, as well as chronic obstructive bronchitis and coronary atherosclerosis. The patient has no history of coronary bypass surgery.

Primary:	I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Secondary:	N18.4	Chronic kidney disease stage 4 (severe)
Secondary:	J44.9	COPD
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina

ICD-10-CM does not include codes that further specify malignant versus benign hypertension. In this scenario, the patient is reported to have stage 4 chronic kidney disease, and ICD-10-CM coding guidelines report that coders may assume a relationship between hypertension and chronic kidney disease. Consequently, in this scenario, the appropriate I12.- code is used.

Chronic obstructive bronchitis is coded as a comorbid diagnosis. ICD-10-CM includes the diagnosis of chronic obstructive bronchitis within the J44.- codes in addition to other chronic obstructive pulmonary diseases. Coronary atherosclerosis is also coded as a comorbid diagnosis. Within the ICD-10-CM code set, angina is assumed to be related to coronary atherosclerosis, and the coder must use a specific code to specify the coronary atherosclerosis as with or without angina.

Scenario 39

Patient referred to home care for monitoring new episode of chest pain due to coronary artery disease (CAD). Patient requires teaching on new and changed medications. Patient also has been diagnosed with Merkel cell carcinoma of left ear, diabetes and benign hypertension. She requires insulin for the diabetes.

Primary:	I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
Secondary:	C4A.22	Merkel cell carcinoma of left ear and external auricular canal
Secondary:	E11.9	Type 2 diabetes without complications
Secondary:	I10	Benign essential hypertension
Secondary:	Z79.4	Long-term (current) use of insulin

The CAD code (I25.119) is a combination code that includes the type of artery, and the presence or absence of angina. Code I25.1- is used if the patient has never had a coronary bypass graft (CABG). If the patient has had a CABG, I25.7- should be listed. Merkel cell carcinoma should be listed as a secondary diagnosis and also is a combination code that includes the histology and location, including laterality. Diabetes and hypertension are comorbidities that should be coded and addressed in the plan of care. In ICD-10, the one hypertension code includes benign, malignant and unspecified.

Because the diabetes is not specified as Type 1, the coder should default to Type 2 and the insulin code (Z79.4) should be added.

Scenario 40

Patient referred to home care s/p acute CVA and requires skilled nursing and PT/OT/ST due to residuals of right-sided hemiplegia, dysarthria and stuttering. Nursing is ordered for teaching disease process and new/changed medications. Patient also has hypertension and uncontrolled diabetes mellitus, and requires sliding scale insulin. The focus of care is the hemiplegia.

Primary:	I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
Secondary:	I69.322	Dysarthria following cerebral infarction
Secondary:	I69.323	Fluency disorder following cerebral infarction
Secondary:	I10	Essential hypertension
Secondary:	E11.65	Type 2 diabetes with hyperglycemia
Secondary:	Z79.4	Long-term (current) insulin use

The CVA with hemiparesis is the focus of care, however, the scenario does not indicate if the right side was dominant or non-dominant. The ICD-10 coding guideline states "should the affected side be documented but not specified as dominant or non-dominant; if the right side is affected it should default to dominant; if the left side is affected it should default to non-dominant."

The uncontrolled diabetes comes next. In ICD-10 there is no character that indicates controlled or uncontrolled. If the diabetes is documented as uncontrolled, the Alpha Index instructs to 'code to diabetes, by type, with hyperglycemia.' The Z code for insulin use should be used in this example as the diabetes defaults to Type 2. The hypertension also is important to assign as a comorbidity.

Scenario 41

A patient had a stroke and is admitted to your agency for hypertension monitoring, diabetes and coronary artery disease (CAD) without any mention of angina. The assessment confirms that there are no residuals from the stroke.

Primary:	I10	Essential hypertension
Secondary:	E11.9	Type 2 diabetes mellitus without complication
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina
Secondary:	Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

Even though the patient has had a stroke, there are no late effects or residual, so Category I69.3- should not be coded. Hypertension is the main focus of skilled care so it's listed as the primary diagnosis.

I25.1- indicates CAD of a native artery. I25.7- is used when a patient has had a bypass and you do not have documentation of which arteries are involved. Make sure to address all comorbidities on the plan of care.

The CVA with no residuals is addressed in home care with Z86.73 (History of transient ischemic attack and cerebral infarction without residual deficits), which includes stroke NOS without residual deficits.

Scenario 42

Patient admitted with hypertension exacerbation. Orders are for observation and assessment, and teaching on new medications. Patient is a long-time smoker and also has PVD. Focus of care is the hypertension.

Primary:	I10	Essential hypertension
Secondary:	I73.9	PVD, unspecified
Secondary:	F17.200	Nicotine dependence

Remember, in ICD-10, unspecified, benign and malignant hypertension all are included in one code I10. There also is a Tabular instructional note to 'use an additional code' to identify tobacco use or exposure at the I10 category.

Scenario 43

Patient admitted to home health with new diagnosis of CAD after acute MI five weeks ago. Patient is no longer having symptoms. The focus of care is the CAD.

Primary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina
Secondary:	I25.2	Old healed MI

The key to remember here is that in ICD-10, the definition of an acute MI is four weeks. While in ICD-9, an acute MI is define as eight weeks.

Scenario 44

Patient was treated for an inferior wall MI in the last three weeks and then was readmitted to hospital for anterior wall MI. He is being admitted to home care for observation and assessment of unstable angina and his CAD, and for teaching on his multiple new cardiac medications.

Primary:	I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina
Secondary:	I21.19	MI other coronary artery inferior wall
Secondary:	I22.0	MI of anterior wall

Angina is considered integral to CAD unless otherwise noted by the physician. An AMI is coded as I21.- in the first four weeks. If the patient has a second MI in the first four weeks, it is coded with I22.-. The sequencing of the I21 and I22 codes depends on the circumstances of the encounter.

Scenario 45

Patient admitted for CVA with right-sided hemiparesis. Patient also has hypertension and rheumatoid arthritis. Both nursing and therapy will be seeing patient. PT/INRs have been ordered. The focus of care is the stroke.

Primary:	I69.351	Hemiplegia following cerebral infarction affecting right dominant side
Secondary:	I10	Essential primary hypertension
Secondary:	M06.9	Rheumatoid arthritis
Secondary:	Z51.81	Encounter for drug monitoring
Secondary:	Z79.01	Long-term use of anticoagulants

Should the affected side be documented, but not specified as dominant or non-dominant and the classification system does not indicate a default, code selection in ICD-10 is as follows:

- For ambidextrous patients, the default should be dominant
- If the left side is affected, the default is non dominant
- If the right side is affected, the default is dominant

Note: In ICD-9, if dominant or non dominant is not documented, you must query the patient, caregiver or physician.

Scenario 46

Patient admitted with exacerbation of congestive heart failure (CHF) and chronic systolic heart failure. The focus of care is the CHF.

Primary: I50.22 Chronic systolic (congestive) heart failure

In ICD-10, if systolic or diastolic heart failure is documented and CHF is documented on same record, both types of heart failure are included in same code.

Chapter 10:

Diseases of the Respiratory System

Scenario 47

An 80-year-old female is admitted due to a recent onset of bronchitis caused by streptococcus. She has been discharged home with oxygen and 10 days of antibiotics. In addition, she has a history of Alzheimer's dementia and is bedbound.

Primary:	J20.2	Acute bronchitis due to streptococcus
Secondary:	G30.9	Alzheimer's disease, unspecified
Secondary:	F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
Secondary:	Z74.01	Bed confinement status
Secondary:	Z99.81	Dependent on supplemental oxygen

The focus of care in this scenario is the bronchitis. Within the ICD-10-CM code set, acute bronchitis should be coded to the appropriate indicated code that specifies the causative organism. Within the J20.- codes, various causative organisms are specified. Because the J20.2 code specifies the bronchitis as due to streptococcus, no additional code for a causative organism is required.

The Alzheimer's dementia is additionally coded as this will impact the plan of care. Coding of Alzheimer's dementia within ICD-10-CM requires the use of an etiology/ manifestation coding pair. The coder must select the appropriate F02.8- code to specify the dementia as with or without behavioral manifestations.

The long-term ongoing use of oxygen is additionally coded. No code for antibiotic use is required due to the short duration of antibiotic therapy.

Scenario 48

A 66-year-old male has been admitted to home health 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. Nursing will be assessing the patient and instructing in disease process and medication. The patient has no history of tobacco use; however his wife is a smoker. His history reports he also has congestive heart failure.

Primary:	J44.1	Chronic obstructive pulmonary disease with acute exacerbation
Secondary:	J45.990	Exercise induced bronchospasm
Secondary:	I50.9	Congestive heart failure
Secondary:	Z77.22	Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Secondary:	Z99.81	Dependence on supplemental oxygen

In this scenario, the patient has been diagnosed with chronic obstructive asthma, which is reported to be exacerbated. Due to the exacerbation, the code J44.1 is indicated to specify the exacerbation. ICD-10-CM coding guidance for J44.- codes note that the coder should "code also" to specify the type of asthma. As a result, the code for exercise induced bronchospasm is additionally used and coded following the J44.1 code.

ICD-10-CM guidelines additionally require the coder to "use additional code" for any associated or known tobacco exposure. The code for exposure to environmental tobacco smoke is added with Z77.22.

The congestive heart failure is additionally coded as a comorbid diagnosis and the code for dependence on supplemental oxygen is added.

Scenario 49

Patient is admitted for exacerbation of her chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). She has ESRD but refuses to go to dialysis as ordered. She also has hypertension and requires oxygen.

Primary:	J44.1	Chronic obstructive pulmonary disease with acute exacerbation
Secondary:	I50.9	Congestive heart failure
Secondary:	I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Secondary:	N18.6	End stage renal disease
Secondary:	Z91.15	Patient's non-compliance with dialysis status
Secondary:	Z99.81	Dependence on supplemental oxygen

COPD is an umbrella term that can encompass many respiratory issues. Exacerbated COPD is coded to J44.1. The heart failure is captured with I50.9.

There are only a few instances in which automatic linkages occur in ICD-10 coding. Hypertension and chronic kidney disease is one of those situations. When a patient has chronic kidney disease and hypertension, the hypertension is assumed to cause the CKD and a code from I2.- (Hypertensive kidney disease) is coded first, followed by a code from N18.- to indicate the stage of CKD present. An informational note reminds coders to add an additional code from N18- to identify the stage of CKD. A note at N18 also states to code first hypertensive kidney disease.

Official coding guidelines direct that if both a stage of CKD and ESRD (CKD requiring chronic dialysis) are documented, only assign code N18.6.

Status codes usually are considered "optional" codes, but in this case, they greatly help to show that extra care may be needed. Z91.15 indicates that the patient is not going to dialysis, so the patient's health will be adversely affected. The oxygen use also indicates potential respiratory status issues or a more severe level of respiratory disease.

There also is a Tabular instructional note to 'use an additional code' to identify tobacco use or exposure at the J44 category and I12 category. In this example, tobacco use or exposure is not identified and thus is not coded.

Scenario 50

Emphysema is causing the patient to be severely decompensated. Therapy is ordered for strengthening and skilled nursing for assessing, monitoring and medication management. Patient also started on 3L/M oxygen continuously.

Primary:	J43.9	Emphysema
Secondary:	Z99.81	Dependence on supplemental oxygen

Most coders think of COPD with decompensation, but emphysema stands by itself as a diagnosis. Excludes 1 note at J44 category (Chronic airway obstruction (COPD)), specifically excludes emphysema.

If the reason for the deconditioning (weakness) is known, you should code the underlying cause, not the code for deconditioning.

Adding the Z code for dependence on supplemental oxygen helps to show more detail about the seriousness of the patient's health status. There also is a Tabular instructional note to 'use an additional code' to identify tobacco use or exposure at the J43 category. In this example, tobacco use or exposure is not identified and thus is not coded.

Scenario 51

Patient is admitted to home care with diagnosis of extrinsic asthma exacerbation. Patient also has dementia, essential hypertension, secondary diabetes due to long-term use of oral steroids and long-term insulin use.

Primary:	J45.901	Unspecified asthma with acute exacerbation
Secondary:	F03.90	Dementia unspecified
Secondary:	I10	Essential hypertension
Secondary:	E09.9	Drug or chemical induced diabetes mellitus without complications
Secondary:	T38.0x5D	Adverse effect of glucocorticoids and synthetic analogues
Secondary:	Z79.4	Long-term (current use) insulin
Other:	Z79.52	Long-term (current use) of systemic steroids

Extrinsic asthma does not have a separate code in the ICD-10 respiratory chapter. Both intrinsic and extrinsic asthma are included in the J45 category. Do ***not*** assume asthma is linked to COPD.

There is no mention of behavioral issues associated with the dementia in this scenario, so the correct code is F03.90. When coding dementia, read all of the entries, including the instructional notes in the Tabular, before selecting your code.

Secondary diabetes and hypertension are comorbidities that should be coded and addressed in the plan of care.

Because the steroids were taken correctly, the adverse effect 'T' code should be listed as an additional code as well as the insulin code. For this patient, the Z code for steroid use also is important information and should be listed as an additional code.

There also is a Tabular instructional note to 'use an additional code' to identify tobacco use or exposure at the J45 category and I10 category. In this example, tobacco use or exposure is not identified and thus is not coded.

Chapter 11:

Diseases of the Digestive System

Scenario 52

Patient referred to home health for colostomy management and assistance. The patient has had the colostomy for almost one year. Recently, the area around the colostomy became red and inflamed, and the physician diagnosed the patient as having cellulitis. Orders read: skilled nursing to monitor the area for worsening and call the physician if further deterioration. The patient is bedbound and also has a Foley catheter for urinary retention that the home health agency will change.

Primary:	K94.02	Colostomy infection
Secondary:	L03.311	Cellulitis of the abdominal wall
Secondary:	Z46.6	Encounter for fitting and adjustment of urinary device
Secondary:	R33.9	Urinary retention
Secondary:	Z74.01	Bed confinement

When breakdown and cellulitis occur around the area of an ostomy, this should be coded as a complication of the ostomy. Guidelines indicate to code first the ostomy complication, which in this case is with K94.02 (Colostomy infection), which directs the coder to use an additional code for the specific infection. This leads to the necessary sequencing with the ostomy complication coded first, followed by code L03.311 (Cellulitis of the abdominal wall), which describes the specific type of infection. No Z code should be assigned for ostomy care when the colostomy is complicated as Z codes are used to indicate routine care only.

Code Z46.6 may be used to address the need for the Foley catheter care that the agency will provide, followed by the urinary retention (R33.9), which is the indication for the Foley catheter. An additional Z code, Z74.01, may be assigned to indicate bed confinement status and provide additional information regarding the patient's mobility and care environment.

Scenario 53

Patient was admitted to the hospital with abdominal pain and acute cholecystitis, and diagnosed with gallstones in the gallbladder and the bile duct. The tests reveal there is no obstruction. She was unable to have surgery due to her severe COPD, and was sent home with home care for diet management and teaching of new medications. Patient is morbidly obese at 5'5" and 245 lbs.

Primary:	K80.62	Calculus of gallbladder and bile duct with acute cholecystitis without obstruction
Secondary:	J44.9	Chronic obstructive pulmonary disease, unspecified
Secondary:	E66.01	Morbid obesity (severe) due to excess calories
Secondary:	Z68.41	Body mass index (BMI) 40.0 – 44.9, adult

The primary diagnosis is a combination code that includes the calculus of the gallbladder and the bile duct ***with*** acute cholecystitis and without obstruction. Also include the diagnosis of morbid obesity with the BMI code. BMI can be determined by the clinician using the formula based on height and weight.

Scenario 54

Patient had a bowel obstruction that was treated with a bowel resection of the descending colon and placement of a colostomy. Nine months after surgery, she developed an enterocutaneous fistula from the ileum to the abdominal wall that still is present. The most recent hospitalization was for nausea and vomiting, which currently is controlled, and the insertion of a triple lumen PICC for TPN due to malabsorption syndrome resulting from her inability to absorb food from the GI tract. Patient has Type 2 diabetes, currently well controlled. Focus of home health is care for fistula, colostomy and PICC line, and to monitor TPN and diabetes. Nursing will provide teaching and training to caregiver for colostomy care since patient refuses to provide any self care for the colostomy.

Primary:	K63.2	Fistula of intestine
Secondary:	K90.9	Intestinal malabsorption, unspecified
Secondary:	Z43.3	Encounter for attention to colostomy
Secondary:	E11.9	Diabetes mellitus Type 2 without complications
Secondary:	Z45.2	Encounter for adjustment and management of vascular access device
Secondary:	Z79.899	Other long-term (current) drug therapy

Focus of care is the enterocutaneous fistula and the malabsorption syndrome. Diabetes will require ongoing monitoring, especially with TPN. Since the home health staff will be caring for the central line initially and teaching the patient/caregiver, the Z45.2 code is required for fitting and adjusting of a vascular catheter.

When deciding whether to use the status code for the colostomy (Z93.3) or the attention to colostomy (Z43.3), it is important to determine if the clinician is doing something to or about the ostomy and it is documented within the assessment and plan of care. A Z code for other long-term medication (Z79.899) should be included for monitoring of the TPN.

Scenario 55

Patient is admitted to home care for medication management and diet teaching for reflux esophagitis. Patient also has Type 1 diabetes and is on an insulin sliding scale.

Primary:	K21.0	Gastro-esophageal reflux disease with esophagitis
Secondary:	E10.9	Type 1 diabetes mellitus without complications

This is a case where a disease is coded, not medication management. Medication management itself is not a skilled service and should not be coded primary. Teaching and diet is aimed at the esophagitis, so that disease is the code that should be assigned.

GERD has separate codes that include the presence or absence of esophagitis.

Diabetes Type 1 is defined by the E10 category. There is not an instructional note to list insulin. All Type 1 diabetics take insulin.

Scenario 56

A patient takes Coumadin correctly for his chronic DVT of the distal lower left extremity, but recently had blood in his stool. Nursing will monitor bleeding and adjustment of Coumadin dose, provide medication teaching and monitor labs for CBC, hematocrit and PT/INRs.

Primary:	K92.1	Melena
Secondary:	T45.515D	Adverse effect of anticoagulant subsequent episode
Secondary:	I82.5Z2	Chronic thrombosis of unspecified deep veins of left distal lower extremity
Secondary:	Z51.81	Encounter for therapeutic drug level monitoring
Secondary:	Z79.01	Long-term (current) use of anticoagulants

In this example, the patient has taken the medication correctly, but is experiencing an adverse event. A 'T' code is required to identify the cause of the adverse event: poisoning or adverse effect (therapeutic use).

The reason for the Coumadin — a chronic deep vein thrombosis of the distal left lower extremity — also is coded as an additional diagnosis. Be careful to read the Excludes 1 note at the I82.5 subcategory (Note, distal DVT has a specific code). The Tabular includes an instructional note to use an additional code for associated long-term (current) use of anticoagulants. In this situation, the code for therapeutic drug monitoring (Z51.81) is sequenced before Z79.01 (Long-term (current) anticoagulant use) since the nurse will be monitoring PT/INRs as the Coumadin dosage is being adjusted.

Chapter 12:

Diseases of the Skin and Subcutaneous Tissue

Scenario 57

The patient is referred to hospice after a lengthy hospital and post-acute stay due to necrotizing fasciitis. She has multiple open areas to the abdomen and upper thigh affected by the condition, with the physician reporting MRSA infection to the thigh location. A wound vac will be placed to the abdomen but held to the thigh until the infection clears. She has additional diagnoses of diabetes and morbid obesity with BMI calculated to 55.6.

Primary:	M72.6	Necrotizing fasciitis
Secondary:	B95.62	MRSA
Secondary:	E11.9	Type 2 diabetes mellitus without complications
Secondary:	E66.01	Morbid obesity
Secondary:	Z68.43	BMI 50-59.9, adult

Necrotizing fasciitis results in severe tissue breakdown so no separate code is used for the open areas. When an infectious organism is stated, it should also be coded following the code M72.6.

Scenario 58

A 69-year-old patient stays in bed most days due to arthritis and feeling "tired" all the time. She also has venous insufficiency. Skilled nursing is ordered to provide wound care to the ulcer on the left ankle. It is a full thickness wound into, but not through, the subcutaneous tissue with the fat layer exposed. When the physician is queried, he states the wound was caused from pressure due to her staying in bed for extended periods, and wants a therapy consult to get her up and moving again.

Primary:	L89.523	Pressure ulcer of left ankle, stage 3
Secondary:	I87.2	Venous insufficiency (chronic) (peripheral)
Secondary:	M19.90	Unspecified osteoarthritis, unspecified site
Secondary:	R53.83	Other fatigue

The physician confirmed that this was a pressure ulcer due to extended period of time in the bed. It is also noted to be a full thickness wound that is **into** the subcutaneous tissue, which would mean this is at least a stage 3 pressure ulcer. If the wound was **through** the subcutaneous layer, it would be a stage 4. The pressure ulcer code includes the stage. The patient was also noted to have venous insufficiency (I87.2), which could complicate the healing of the pressure ulcer. Arthritis is coded M19.90, since it is unspecified to the type and site, and since there is not a diagnosis as to why the patient is "tired" all the time, a symptom code of R53.83 for fatigue is added.

Scenario 59

Patient is admitted to home health for wound care following an I&D of a pilonidal cyst abscess. Once debrided, it was noted the patient had a sinus tract. The patient is still taking oral antibiotics.

Primary: L05.02 Pilonidal sinus with abscess

This is coded as a pilonidal sinus with abscess due to the discovery of the sinus tract, so the correct code is L05.02. It's important to note that an I&D does not create a surgical wound. As this is an abscess, this is a complication, so wound care would be implicitly stated, therefore a wound care code is not needed.

Scenario 60

The patient has a lesion she has had for about six months on her right ankle. She was on a mission trip to New Guinea when the area first developed as a blister. The lesion worsened and had a large amount of slough, and debridement revealed a wound into the muscle. The wound care center determined that the lesion was a tropical ulcer. The patient also has PVD. Skilled nursing is ordered to provide wound care 3x per week to the lesion.

Primary:	L97.313	Non-pressure chronic ulcer of right ankle with necrosis of muscle
Secondary:	I73.9	Peripheral vascular disease, unspecified

The coder will search for ulcer, lower limb, right ankle in the Index to find the correct code (L97.313). There is an Includes note at the L97 category that includes "tropical ulcer NOS."

Scenario 61

Patient is referred to home care s/p muscle flap to treat a stage 4 pressure ulcer of the coccyx. Patient also has a stage 2 pressure ulcer on the left hip and on the right buttock, and a stage 1 on the right hip and left buttock. Wound care is ordered.

Primary:	Z48.817	Encounter for surgical aftercare following surgery on the skin and subcutaneous tissue
Secondary:	L89.150	Pressure ulcer of sacral region, unstageable
Secondary:	L89.222	Pressure ulcer left hip stage 2
Secondary:	L89.312	Pressure ulcer right buttock stage 2
Secondary:	L89.321	Pressure ulcer left buttock stage 1
Secondary:	L89.211	Pressure ulcer right hip stage 1

There are so many pressure ulcers on this patient that it may be hard to remember that the patient is in for aftercare of surgery, which is coded as primary. A muscle flap is considered a surgical wound for OASIS purposes, but is coded as a pressure ulcer with a combination code that includes the location (coccyx) and stage. Since the muscle flap has now covered the original ulcer, it's considered unstageable. This code will follow the routine aftercare code.

Next, code the remaining pressure ulcers in order of worst ulcer to least-skilled. There are four additional pressure ulcers on the buttocks and hips, two are stage 2 and two are stage 1. A combination code for each pressure ulcer should be listed which includes site, laterality and stage.

You may want to code dressing changes as the primary focus of care. It is true that since the care is routine and non-complicated, Z48.00 (Change or removal of nonsurgical wound dressing) and Z48.01 (Change or removal of surgical wound dressings) could be used in this situation. However, think about the skilled care involved with the dressing changes vs. aftercare of surgery or dealing with the issues of pressure ulcers. Would the attention to dressing codes provide the best description of this patient's status? If the dressing change codes are used at all, the most appropriate location would be at the bottom of the list of secondary diagnoses. Remember never to assign a code for dressing changes when the wound is complicated. These codes indicate routine care.

Scenario 62

Patient is seen in home health for a surgical wound infection and cellulitis of the abdominal wall after a hernia repair.

Primary:	T81.4xxD	Infection following a procedure
Secondary:	L03.311	Cellulitis of abdominal wall

The post-operative infection is coded first, as it is a complication and is the most serious condition and the primary focus of home health care. The T81.4 code does not include cellulitis, so that must be coded separately. Note there are two placeholders and a 7th character required for the complication code. As with all diagnoses, the physician must document the diagnosis of cellulitis in order to code it. If the organism causing the infection is known, it also would be coded. Make sure to code all comorbidities that are addressed in the plan of care.

Scenario 63

Patient is admitted for wound care to stasis ulcer of right ankle due to PVD. The fat layer is exposed. Patient has comorbidities of chronic diastolic heart failure, congestive heart failure and age-related osteoporosis with a history of a pathological fracture.

Primary:	I73.9	Peripheral vascular disease, unspecified
Secondary:	L97.312	Non-pressure chronic ulcer of right ankle with fat layer exposed
Secondary:	I50.32	Chronic diastolic (congestive) heart failure
Secondary:	M81.0	Age related osteoporosis without current pathological fracture
Secondary:	Z87.310	Personal history of (healed) osteoporosis fracture

The primary reason for admission is a stasis ulcer, however at the L97 category there is an instructional note to 'code first' any associated underlying condition. Therefore, the PVD is coded as primary followed by the code for the stasis ulcer. Remember the ulcer code is a combination code that indicates the site and severity of the ulcer.

This patient has both diastolic and congestive heart failure; however, in ICD-10, both types of heart failure are included in the same code. You'll be making several choices when you are coding osteoporosis, the code includes whether it is age related and if the patient has a current pathological fracture. There is a Tabular note instructing the coder to list any history of fractures related to the osteoporosis.

Chapter 13:

Diseases of the Musculoskeletal System and Connective Tissue

Scenario 64

Patient admitted to home health for physical therapy related to a pathological fracture due to osteoporosis of the left hip.

Primary: M80.052D Age-related osteoporosis with current pathological fracture, left femur

The 7th character "D" denotes subsequent encounter for fracture with routine healing. Therapy codes (V57 codes in ICD-9) are not applicable in ICD-10.

Scenario 65

A 76-year-old man, originally diagnosed with carcinoid tumor of the left upper lobe of the lung five years ago, is seen for a fracture of the shaft of the right femur. Eight months ago, he was diagnosed with metastatic bone cancer and this fracture is a result of the metastatic disease. This patient's lung cancer was treated with radiation and is stated as resolved. Skilled nursing to admit for teaching, and physical therapy ordered for improvement of gait.

Primary:	M84.551D	Pathological fracture in neoplastic disease, right femur
Secondary:	C79.51	Secondary malignant neoplasm of bone
Secondary:	Z85.110	Personal history of malignant carcinoid tumor of bronchus and lung

The fracture would be a pathological fracture, as further defined in ICD-10 by fracture of osteoporosis, neoplastic disease, and other disease. The appropriate 7th character "D" denotes subsequent encounter for fracture with routine healing. The coder would assign C79.51 for secondary malignant neoplasm of the bone as this is a metastatic cancer, and the original diagnosis of lung cancer would not be included as it is resolved, however you would code the personal history.

Scenario 66

An 86-year-old patient is admitted to home health with a diagnosis of primary osteoarthritis in his knees that his physician said is aggravated from his morbid obesity. His BMI is listed as 47. Other diagnoses that will require intervention include insulin-dependent diabetes with polyneuropathy, congestive heart failure due to hypertension and CAD. The focus of home health care is management of arthritic pain.

Primary:	M17.0	Bilateral primary osteoarthritis of knee
Secondary:	E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
Secondary:	I11.0	Hypertensive heart disease with heart failure
Secondary:	I50.9	Congestive heart failure
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
Secondary:	E66.01	Morbid obesity (severe) due to excess calories
Other:	Z68.42	Body mass index (BMI) 45.0–49.9
Other:	Z79.4	Long-term (current) use of insulin

Primary osteoarthritis is due to hereditary factors or stresses. Secondary osteoarthritis is due to joint surgery, trauma or repetitive joint injury. Post-traumatic osteoarthritis is the wearing out of the joint post physical injury. The ICD-10 classification system does not differentiate between localized and generalized. Osteoarthritis codes are combination codes that include the site, laterality, and whether it is primary, secondary or post-traumatic. Pain is inherent with osteoarthritis and does not require a separate code in this situation, even though it is the focus of care. The osteoarthritis code is a specific location and G89- (Pain) does not provide any additional information for this scenario so a G89- code is not required.

The diabetes, hypertension, CHF and CAD are additional co-morbidities that help describe the situation and would need to be addressed in the plan of care. Although morbid obesity is defined as a Body Mass Index (BMI) of greater than 39, the physician already has verified that the patient has morbid obesity. The E66 category instructs to use an additional code to identify the BMI if known.

The two Z codes for long-term (current) insulin use and BMI of 47 add supplemental information to further "paint the picture" of this patient.

Scenario 67

Physical therapy is ordered to treat Charcot's joint due to diabetes.

Primary: E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy

There are no rehab codes in the ICD-10 classification system. If therapy is the only discipline ordered, list the reason therapy will be working with the patient. If the type of diabetes is not known, it defaults to Type 2 (E11) and in ICD-10, the diabetes code for Charcot's arthropathy is a combination code indicating both the underlying etiology and the manifestation.

How do you know Charcot's is a neurological problem? You can certainly look up the term in a medical dictionary, but the Tabular also specifically lists it as a neurological manifestation.

Scenario 68

The home health agency admitted a patient for OT, PT and skilled nursing for dressing changes, wound care and medication monitoring. The information on the referral says a patient was discharged from the hospital after an ORIF displaced trauma fracture of the right subtrochanteric femur due to her grocery cart tipping over causing her to fall. She also has a stage 2 pressure ulcer on her sacrum and a previous pathological fracture that is now healed due to osteoporosis.

Primary:	S72.21xD	Displaced subtrochanteric fracture of right femur subsequent encounter
Secondary:	L89.152	Pressure ulcer of sacral region, stage 2
Secondary:	M81.0	Age-related osteoporosis without current pathological fracture
Secondary:	Z87.310	History of (healed) osteoporosis fracture
Secondary:	W17.82xD	Fall due to grocery cart tipping over subsequent encounter

Aftercare of fracture codes are not used in ICD-10. Fracture codes in the ICD-10 classification system are combination codes that include the type, site, laterality and encounter. The assignment of an additional external cause code is not required but encouraged to describe the reason for a trauma fracture. Osteoporosis is an important secondary diagnosis and should be addressed in the plan of care. Note that the M81codes are combination codes that describe the type and if a current fracture is present.

It is important to code the stage 2 pressure ulcer and to address it on the plan of care to illustrate additional complexity and best practice. Additional symptom codes for muscle weakness, gait abnormality, etc., are not coded because they are inherent in the diagnosis of the femur fracture. However, therapy needs to document all of the deficits identified during the evaluation.

Chapter 14:

Diseases of the Genitourinary System

Scenario 69

Patient admitted to home care post hospitalization of congestive heart failure with shortness of breath, chest pain and acute renal failure. The patient's comorbidities include hypertension, diabetes and stage 3 chronic kidney disease (CKD). The patient continues to have edema, but other acute symptoms are resolved upon admission to home care. Skilled nursing is ordered to teach disease process and monitor symptoms.

Primary:	I50.9	Congestive heart failure
Secondary:	I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Secondary:	N18.3	Chronic kidney disease, stage 3 (moderate)
Secondary:	E11.9	Type 2 diabetes without complications

The heart failure is not specified as systolic or diastolic, and therefore would be unspecified. Code I12.9 is hypertensive chronic kidney disease with stage 3 CKD (N18.3) as this is an assumed relationship. The patient is also diabetic type 2 without complications.

Scenario 70

Patient is admitted for diabetes with new diagnosis of chronic kidney disease stage 2 due to the diabetes. Patient also has restless leg syndrome and lives alone. The focus of care is the newly-diagnosed kidney disease.

Primary:	E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
Secondary:	N18.2	Chronic kidney disease stage 2
Secondary:	G25.81	Restless leg syndrome

Even though the kidney disease is the main reason for admission, manifestation sequencing rules take precedence so the underlying etiology must be listed primary. Many of the diabetes codes in ICD-10 are combination and do not require and additional code. However, diabetes with kidney disease has an instruction in the Tabular to 'use additional code' to identify the stage of kidney disease. Restless leg syndrome is a pertinent comorbidity and should be addressed in the plan of care.

Scenario 71

Patient admitted with urinary tract infection. Patient has had a Foley catheter for the last several weeks due to urinary retention. The culture revealed the organism to be staphylococcus aureus that is resistant to penicillin.

Primary:	N39.0	Urinary tract infection, site not specified
Secondary:	B95.62	Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere
Secondary:	R33.9	Retention of urine, unspecified
Secondary:	Z46.6	Encounter for fitting and adjustment of urinary device

There is a sequencing instruction in the Tabular to 'use an additional code' to identify infectious agent. Don't confuse the A49 category with the B95 category. Both indicate a staphylococcus aureus infection, but the A49 category denotes an unspecified site; while the B95 category denotes the organism as the cause of diseases classified elsewhere.

The reason for the urinary device should be coded. In this example, it is urinary retention. The Z code for the Foley should be listed as an additional diagnosis.

Scenario 72

Patient admitted with urinary urgency related to enlarged prostate with lower urinary tract symptoms (LUTS). Patient tripped over the pet dog trying to get to the bathroom and fell spraining his left ankle. Therapy also will be seeing the patient for the ankle injury.

Primary:	N40.1	Enlarged prostate with lower urinary tract symptoms (LUTS)
Secondary:	R39.15	Urinary urgency
Secondary:	S93.402D	Sprain of unspecified ligament of left ankle subsequent encounter
Secondary:	W01.0xxD	Tripping over animal with fall subsequent episode

Even though urinary urgency is integral to BPH with LUTS, the classification system instructs the coder to 'use an additional' code to describe symptoms associated with the enlarged prostate. The ankle sprain is a combination code that includes the site, laterality and encounter. Abnormality of gait or other symptom codes are not required as the S93 code includes gait abnormality. In ICD-10, the external cause code is not required but encouraged to explain how the injury occurred.

Chapter 17:

Congenital Malformation, Deformations and Chromosomal Abnormalities

Scenario 73

Patient admitted to home health for increasing mobility and neurologic deficits resulting in severe decline due to spina bifida. He will require PT and OT consults. He is paraplegic due to the spina bifida and also has urinary difficulties requiring new catheter management related to spina bifida, which nursing will manage. His physician reports neurogenic bladder without incontinence as the reason for catheterization.

Primary:	Q05.9	Spina bifida, unspecified
Secondary:	G82.20	Paraplegia, unspecified
Secondary:	N31.9	Neuromuscular dysfunction of bladder, unspecified
Secondary:	Z46.6	Encounter for fitting and adjustment of urinary device

This patient is being seen for primarily PT and OT due to functional decline with neuromuscular deficits related to his spina bifida and resulting paraplegia (unspecified). Code-specific guidelines for the use of spina bifida (Q05.9) instruct to "code also" any paraparesis. For this reason, the paraplegia must be coded following the code for spina bifida. Since the paraplegia is not reported as complete or incomplete, the appropriate code is G82.20. Neurogenic bladder should be assigned prior to the Z code for catheter use in order to indicate the disease process being treated and reason for the catheterization. When coding neurogenic bladder, the coder is instructed to "use an additional code" to identify any incontinence. In this case, no incontinence has been noted. Code Z46.6 indicates routine care of the catheter. This code is appropriate for intermittent, external or Foley catheterization, but should not be used in the case of a suprapubic catheter (cystostomy), which would be assigned to Z43.5 (Encounter for attention to cystostomy).

Chapter 18:

Symptoms, Signs and Abnormal Clinical and Laboratory Finds, Not Elsewhere Classified

Scenario 74

Patient admitted to home care with shortness of breath. Testing didn't show any defined diagnosis at this time. Patient is to have further testing at pulmonologist next week. The physician wants the home health nurse to assess medication compliance with nebulizers and teach patient as needed.

Primary: R06.02 Shortness of breath

In this scenario, the patient has not been given a defined diagnosis. In this type of instance it is appropriate to assign the symptom code for the patient's shortness of breath.

Scenario 75

Patient admitted to home care with pancreatic cancer and malignant ascites. Patient is having left lower quadrant rigidity with palpitations. Nurse notified physician, but no diagnosis explains the rigidity at this time. Patient to see physician tomorrow.

Primary:	C25.9	Malignant neoplasm of pancreas, unspecified
Secondary:	R18.0	Malignant ascites
Secondary:	R19.34	Left lower quadrant abdominal rigidity

Code C25.9 is malignant neoplasm of pancreas, unspecified. The scenario doesn't give enough information to code the cancer to a higher specificity. Code R18.0 is the malignant ascites. Under this code is a note that states to "code first" the malignancy, which is the reason the pancreatic cancer is sequenced first. Finally, code R19.34 is the symptom code for the left lower quadrant rigidity with palpitations. Since there is no diagnosis associated with this symptom, you may assign the symptom code.

Scenario 76

Patient is admitted to the hospital after experiencing a seizure at home. Patient was discharged home with new script for Dilantin; home health ordered for monitoring.

Primary: R56.9 Unspecified convulsions

There is no further information other than the patient experienced a seizure that is presented in this scenario, therefore R56.9 is the most appropriate choice. In this case the code is a "not elsewhere classified" diagnosis found in Chapter 18.

Scenario 77

Patient is referred to home care for skilled nursing and speech-language therapy for treatment of dysphagia, dysarthria and dysphonia. Nursing is teaching on medications and diet. Patient also has a history of MRSA.

Primary:	R13.10	Dysphagia, unspecified
Secondary:	R47.1	Dysarthria and anarthria
Secondary:	R49.0	Dysphonia
Secondary:	Z86.14	Personal history of Methicillin resistant Staphylococcus aureus infection

Because there is no indication these symptoms are from a stroke, they are coded from the signs and symptoms category, not the late effects CVA category (I69). The coder should make an effort to determine the underlying cause of these symptoms to enable coding to the highest level of specificity rather than having to assign only symptom codes. The MRSA, while not active, can have an effect on a patient's health and should be coded as a personal history code.

Scenario 78

Your patient is admitted for PT following replacement of previous right knee prosthesis because of a mechanical complication of the prosthesis. The original joint replacement was due to primary osteoarthritis in the right knee.

Primary:	Z47.33	Aftercare following explantation of knee joint prosthesis
Secondary:	Z96.651	Presence of right artificial knee joint

There are no rehab codes in ICD-10. The reason for therapy should be coded and supported in the therapist's documentation. Since abnormal gait is integral to aftercare for joint replacement, it is not required in this scenario.

The Z47.33 (Aftercare following an explantation of joint prosthesis) is used for a joint prosthesis insertion following explantation of a prior joint prosthesis. Directions in the Tabular instruct coders to 'use an additional code' to identify the joint involved. However, coding guidelines do not require this status code to be sequenced immediately below the aftercare code so sequencing is at the coder's discretion.

Scenario 79

Patient is admitted to home care with coughing, fever and chest congestion. Patient has a history of pneumonia. Physician documentation states probable pneumonia.

Primary:	R09.89	Other specified symptoms involving respiratory systems (chest congestion)
Secondary:	R50.9	Fever NOS
Secondary:	R05	Cough
Secondary:	Z87.01	Personal history of (recurrent) pneumonia

Signs and symptoms that are associated routinely with a disease should not be assigned as additional codes unless otherwise instructed by the classification. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not be established (confirmed) by the provider.

If the diagnosis documented is qualified as "probable," "suspected," "likely," "questionable," "possible" or "still to be ruled out" or other similar terms indicating uncertainty, it may only be coded as if the condition existed or was established in an inpatient setting. Home health must code the symptom(s) only.

Chapter 19:

Injury, Poisoning and Certain Other Consequences of External Causes

Scenario 80

Patient was admitted to the hospital due to a fall that resulted in a torus fracture of the lower end of the right ulna. Home care is ordered for PT and OT.

Primary: S52.621D Torus fracture of lower end of right ulna

In ICD-10, the fracture code includes much more specificity. The 7th character "D" denotes subsequent encounter for fracture with routine healing. In ICD-10 you don't use the aftercare code for fractures, but instead the seventh character indicates the encounter timing. The subsequent encounter is used after the patient has received active treatment for the condition and is receiving routine care during the healing phase of the injury.

Scenario 81

Nurse admitted patient into home care. Patient is a quadriplegic due to a new C4 fracture, which will require nursing care. The patient also will require monthly Foley catheter changes.

Primary:	G82.51	Quadriplegia, C1-C4 complete
Secondary:	S12.300S	Unspecified displaced fracture of fourth cervical vertebra
Secondary:	Z46.6	Encounter for fitting and adjustment of urinary device
Secondary:	Z99.3	Dependence on wheelchair

In ICD-10 the quadriplegia can be more specific to the injury that caused the quadriplegia. Code S12.300S is for unspecified displacement fracture of the fourth cervical vertebra. In ICD-10 a fracture not indicated as displaced or non-displaced should be coded as displaced. The 7th character 'S' denotes sequela. This is used for complications or conditions that happen as a direct result of the condition. The quadriplegia is the sequela of the fracture and that is sequenced first, followed by the injury code. The Z codes indicate encounters for Foley care and wheelchair use.

Scenario 82

Patient has a laceration wound to the left knee sustained from a fall onto a piece of glass. Home care ordered for wound care.

Primary:	S81.012D	Laceration without foreign body, left knee
Secondary:	Z48.00	Encounter for change or removal of nonsurgical wound dressing
Secondary:	W18.30XD	Fall on same level, unspecified

The ICD-10 tabular directs you to the laceration and which knee was injured. The 7th character "D" denotes subsequent encounter. The Z48.00 code is added to signify the wound care. While external cause codes (W18.-) are not required in ICD-10, they can be added to further describe the injury if desired.

Scenario 83

Patient was bitten by a brown recluse spider on the buttock and required an I&D due to an abscess. Open area is 5.0 cm long, 2.0 cm wide and 4.0 cm deep. Wound still is infected with MRSA and cellulitis surrounding the wound. Patient is referred to home health for wound care, IV antibiotics and peak and trough will be performed by the nurse.

Primary:	T63.331D	Toxic effect of venom of brown recluse spider, accidental (unintentional) subsequent encounter
Secondary:	L03.317	Cellulitis of buttock
Secondary:	B95.62	Staphylococcus aureus infection as the cause of diseases classified elsewhere (MRSA)
Secondary:	Z45.2	Encounter for adjustment and management of vascular catheter
Secondary:	Z51.81	Encounter for therapeutic drug level monitoring
Secondary:	Z79.2	Long-term (current) use of antibiotics

While most insect bites are superficial injuries, a venomous spider or snake bite is coded to T63.331- (Toxic effects of venom). A bite by a non-venomous spider is coded to 'injury superficial by site.' This wound is further complicated with cellulitis around the bite, which requires a code for the cellulitis and a code for MRSA infection that still exists. Several Z codes also are needed in this scenario to further describe the home health care to be rendered. The Z45.2, Z51.81 and Z79.2 codes are needed to identify that the agency will be administering and monitoring the effectiveness of IV antibiotics.

Scenario 84

Patient has a second and third degree infected burn on his right forearm from a gasoline can that accidently ignited while he was holding it. Skilled nursing is ordered for wound care.

Primary:	T22.311D	Burn of third degree of right forearm subsequent encounter
Secondary:	T79.8xxD	Other early complication of trauma subsequent encounter
Secondary:	X04.xxxD	Exposure to ignition of highly flammable material subsequent encounter

Burn codes are selected based on their location and worst degree of the burn. Additional codes are not used to describe lesser degree burns to the same location. T79.8xx- is used when there is a post-traumatic wound infection that is not classified elsewhere. Since burn codes do not have options to show complications, this code is used in this situation to describe the infected burn.

Remember, an external cause code (X04.xxxD) indicating how the burn occurred is not required in ICD-10, but its use is encouraged as it provides additional information for the claim on how the injury occurred.

Scenario 85

The patient has a burn on the left lower leg where he left a heating pad and burned the leg causing blisters. Because of atherosclerosis, the second-degree burn has not healed. The focus of the care is the burn.

Primary:	T24.202D	Burn of second degree of unspecified site of left lower limb except ankle and foot subsequent encounter
Secondary:	I70.202	Atherosclerosis of native arteries of extremities, left leg
Secondary:	X16.xxxD	Contact with hot heating appliances subsequent encounter

The location and degree of the burn is the appropriate primary diagnosis since this is the focus of care. A code for the atherosclerosis is added as an additional code to identify a further complication for this patient. The assignment of the external cause code is encouraged as it explains how the wound occurred.

Chapter 21:

Factors Influencing Health Status and Contact with Health Services

Scenario 86

Patient admitted to home care for ongoing care for a bilateral knee replacement. Nurse to remove staples 14 days post op.

Primary: Z47.1 Aftercare following joint replacement surgery

Secondary: Z96.653 Presence of artificial knee joint, bilateral

Secondary: Z48.02 Encounter for removal of sutures

The Z codes in ICD-10 are similar to the V codes in ICD-9. Instructions at code Z47.1 state to use an additional code to identify the joint. Code Z96.653 identifies the joint, presence of artificial knee joint, bilateral knee. The code not only identifies the joint but also the laterality.

Scenario 87

Patient was admitted into hospital for a colon resection and formation of colostomy due to colon cancer. Patient is to start radiation treatment in six weeks. Patient admitted to home health for nursing services.

Primary:	Z48.3	Aftercare following surgery for neoplasm
Secondary:	C18.9	Malignant neoplasm of colon, unspecified
Secondary:	Z43.3	Encounter for attention to colostomy

Instructions at code Z48.3 state to use additional code to identify the neoplasm. Assign C18.9 (neoplasm of the colon, unspecified) since no further detailed documentation is available.

Scenario 88

Patient is admitted to home health for aftercare of a CABG after an MI six weeks ago. Patient has diagnoses of CAD, hypertension and CHF. He smoked cigarettes for 20 years but quit five years ago. Patient has been started on Coumadin and PT/INRs will be performed by the nurse.

Primary:	Z48.812	Encounter for surgical aftercare following surgery on the circulatory system
Secondary:	I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
Secondary:	I10	Essential hypertension
Secondary:	I50.9	CHF
Secondary:	I25.2	Old myocardial infarction (healed)
Secondary:	Z51.81	Encounter for therapeutic drug level monitoring
Other:	Z79.01	Long-term (current) use of anticoagulants
Other:	Z48.01	Encounter for surgical wound dressings
Other:	Z87.891	Personal history of nicotine dependence

Aftercare following surgery on the circulatory system (Z48 category) should be listed as the primary diagnosis. Tabular instructions note these codes identify the body system requiring aftercare. The condition treated also should be coded if still present. In ICD-10, a myocardial infarction is acute if occurred within the last four weeks, hence the code for 'old healed myocardial infarction' is correct in this example. CAD, HTN and CHF should be coded as pertinent diagnoses that should be included in the plan of care.

List the Z codes indicating the patient is on Coumadin and PT/INRs are being monitored as additional diagnoses. The dressing change code is an optional code and may be listed as an additional diagnosis. History of tobacco use is required coding for the I25 category, if applicable.

Scenario 89

Patient fell off the toilet, hitting the side of the toilet with his elbow, fracturing the left elbow requiring an ORIF. Nursing ordered for wound care. Although the wound is not infected, it is healing very slowly due to the patient's Type 1diabetes with angiopathy. Patient takes insulin and lives alone.

Primary:	S42.402D	Unspecified fracture of lower end of left humerus subsequent encounter for fracture with routine healing
Secondary:	E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
Secondary:	Z48.01	Encounter for surgical wound dressings
Secondary:	W18.12xD	Fall off toilet with subsequent striking against object

There are no aftercare codes for trauma or pathological fractures in ICD-10. The coder is directed to the injury chapter and instructed to assign a 7th character to detail the encounter. Despite the slow healing of the ORIF site, the fracture cannot be coded as delayed healing, nor can the surgical wound be coded as complicated, as the physician has not indicated these specific complications. Diabetes is important to code as a secondary diagnosis as it's affecting the wound healing. The manifestation is included in the E10 code and a second code is not required. The dressing change code is an optional code and may be listed as an additional diagnosis. The assignment of the external cause code (W18.12xD) describing the reason for the fracture is not required but encouraged.

Scenario 90

Patient had a right shoulder joint replacement due to secondary DJD of the shoulder. Nursing and therapy are ordered for aftercare.

Primary:	Z47.1	Aftercare following joint replacement surgery
Secondary:	Z96.611	Presence of right artificial shoulder joint

Aftercare following replacement of a joint (Z47 category) should be listed as the primary diagnosis. Tabular instructions note this code identifies that a joint has been replaced but a second code needs to be added to identify which joint was replaced. Even though the Z96 code is a status code, it is categorized in the Alpha Index under the main term 'presence.' The condition treated also should be coded if still present. In this example, the condition (DJD) resolved with the surgery and would not be listed.

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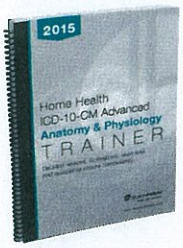

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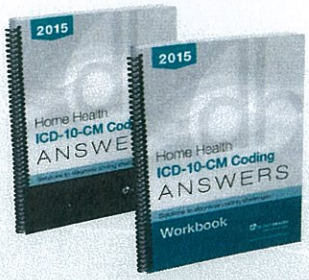

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