Disease-specific diagnosis coding

Sequencing

Q How is sequencing decided?

Answer: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician.

Sequencing of other or secondary diagnoses must be based on the seriousness of the diagnoses as they relate to the Plan of Care and the skilled services to be provided. Because the seriousness can be based on many clinical factors, the assessing clinicians' judgement and the development of the POC are key components. There is not an "easy" formula for sequencing.

A clinician or coder should ask:

- Why are we seeing this patient?
- What diagnosis is the focus of care?
- What other diagnoses affect/impact this patient's care?
- What other diagnoses may impact the healing or recovery of the primary diagnosis?
- What medications is this patient taking for acute/chronic conditions?
- What therapies is this patient receiving (i.e., IV therapy, oxygen, renal dialysis), and for what reason?
- What co-morbid conditions should be monitored, evaluated, or treated as part of this patient's POC?

Diagnoses should not be sequenced based on symptom control ratings, per OASIS-C guidance for M1020 and M1022.

Q How can we sequence correctly?

Answer: Sequencing is part art, so even the best coders/clinicians can disagree on certain sequencing issues. In general, these steps will help you sequence:

1. Choose the principal (primary) diagnosis – the diagnosis most related to the current plan of treatment. It must always be related to the services your agency provides.

Don't: Base your choice on which discipline has the most visits.

2. Understand how to code secondary diagnoses. These "other" diagnoses include all conditions that coexisted at the time the Plan of Care was established, those that developed subsequently, or those that affect the treatment of care. If the disease

isn't actively treated, but impacts the patient's responsiveness to treatment, address the diagnosis in the Plan of Care.

Don't: List historic information just to list it. Put history codes, etc., in place if they could have an impact on current care.

3. Always list comorbidities that need to be monitored, evaluated or treated under best practice guidelines or are conditions that would impact the patient's care and responsiveness to treatment if they become out of control. These may include, but are not limited to: diabetes, hypertension, CHF, COPD, Parkinson's Disease, etc.

4. Query the physician if a diagnosis related to the patient's care is not documented or the diagnosis is not clear. Think about how to sequence based on some simple questions like which of the diseases need active intervention beyond the principal diagnosis, which illnesses will affect the recovery from the primary diagnosis.

Think of sequencing as a bull's eye that you want to hit with the primary diagnosis in the center, active diseases in the next ring and comorbid conditions that may affect care as the next level.

Complications

Q I am having a difficult time with complication codes. Can I code any problem that occurs when the patient is in the hospital as a complication?

Answer: Not all problems that occur following medical or surgical care are complications. While coders always have been expected to only code complications if they were stated by the physician, the Oct. 1, 2011, Official Coding Guidelines added clarifications related to coding complications of care in both the general coding guidelines at Section I.B.18 and in the chapter-specific guidelines for Chapter 17 at I.C.17.f.1(a)(b). The general guidelines state:

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

Note: It's important to remember that the introduction to the Official Coding Guidelines states, "In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health practitioner who is legally accountable for establishing the patient's diagnosis."

Example: A patient is referred for PT and OT following the development of spinal cord ischemia with paraplegia following aortic repair surgery.

> M1020: V57.89, Encounter for multiple rehabilitative therapies

M1022: 336.1, Vascular myelopathies (spinal cord ischemia)

M1022: 344.1, Paraplegia

You may be tempted to code this situation with 998.2, Accidental puncture or laceration during surgery, as a complication that occurred as a result of a "slip" of the scalpel during surgery, however that is not what happened in this case. Though this sounds like a complication of surgery, when the clinician/coder contacted the physician, she learned that this is a risk associated with an aortic repair (especially the thoracic portion of the aorta) that occurs approximately once in 400 cases. There were no complications with the actual surgical procedure for this patient.

Section I,C.17,F.1(a) refers the reader back to the general guideline on documentation of complications. The second notation at I.C.17.1(b) requires that "an additional code identifying the complication should be assigned with codes in categories 996-999, Complications of Surgical and Medical Care NEC, when the additional code provides greater specificity as to the nature of the condition. If the complication code fully describes the condition, no additional code is necessary."

Examples of situations that would require an additional code include:

- Subcategory 996.4, Mechanical complication of internal orthopedic device, implant and graft, directs the coder to use an additional code to identify prosthetic joint.
- Subcategory 996.6, Infection and inflammatory reaction due to internal prosthetic device, implant and graft, directs the coder to use an additional code to identify specified infections.
- Subcategory 996.7, Other complications of internal prosthetic device, implant and graft, directs the coder to use an additional code to identify complications such as pain due to the presence of device, implant or graft; or venous embolism and thrombosis.
- Subcategory 996.8, Complications of transplanted organ, directs the coder to use an additional code to identify the nature of the complication.
- Category 997, Complications affecting specified body systems, not elsewhere classified, directs the coder to use an additional code to identify complications.

Comorbidities

Q What is a comorbidity?

Answer: A comorbidity is a secondary diagnosis. Co-morbidities are diagnoses that are "additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, extended stay or increased monitoring." There are some chronic conditions that meet the definition of "other diagnoses" that are almost always reportable, including, *but not limited to:*

- Hypertension

- CHF
- Asthma, emphysema, COPD
- Parkinson's disease
- Diabetes

Source: Coding Clinic references, 2nd Quarter, 2000.

All comorbidities are considered pertinent diagnoses and must be addressed in the Plan of Care.

Q What if we are seeing a patient for PT only and the patient also has HTN, CAD, CHF and DM. Should we code all of these?

Answer: Absolutely.

Your secondary (other) diagnoses should include conditions that have the potential to impact care, so these comorbidities should be coded and addressed in the plan of care and documented in the clinical record. It is within the scope of therapists to monitor and evaluate these conditions if they are stable. Exclusion of nursing does not mean exclusion of care for the patient.

Dementia

Q Can I use the manifestation-only codes for dementia without an underlying cause?

Answer: No. You may not assign a "manifestation only" code without a code for the etiology immediately preceding it. Not all of the codes used for dementia are manifestation-only codes.

When the documentation does not specify an underlying cause for dementia, you may assign a code from 294.2x for dementia, unspecified. Assign code 294.20 for unspecified dementia without behavioral problems and 294.21 for the patient with unspecified dementia with behavioral problems. Code 294.20 includes Dementia NOS (not otherwise specified).

Remember: Do not code dementia or other psychiatric diagnoses unless the physician has documented the diagnosis. Do not code dementia based on medications the patient is taking or a report by caregivers that the patient is "forgetful."

Cancer and organ transplant

Q We're seeing transplant patients who have developed cancer. Is there any special coding if the cancer is in a transplanted organ?

Answer: Yes. The Official Coding Guidelines state:

"A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from subcategory 996.8, Complications of transplanted organ, followed by code 199.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy."

Coding cancer in a transplanted organ takes three codes:

1. Complications of a transplanted organ (996.8x)
2. 199.2, Malignant neoplasm associated with a transplanted organ
3. The current malignancy code

Reference: Official Coding Guidelines for Coding and Reporting, Section I.C.2.i.

Neoplasms

Q How do you know if surgery for a neoplasm results in the neoplasm being fully resolved?

Answer: The physician or medical record must state that the neoplasm is resolved to consider it a resolved condition. In the absence of information in the medical record to this effect, the home health agency must check with the physician and receive a confirmation that the neoplasm is fully resolved to omit coding the neoplasm. Often biopsies and other tests are not back by the time the patient is discharged home so it is unknown if the neoplasm was fully eradicated. In the absence of such confirmation, the coder should document the situation and code the neoplasm as an unresolved condition.

Q Are all neoplasms case mix?

Answer: No. Remember that neoplasms can be benign, malignant, in situ, of uncertain behavior or of unspecified behavior.

Most neoplasm codes are case mix in the Cancer and Select Benign Neoplasms category. Some, like malignancy of the brain or spinal cord, are found in the Neuro 1 case-mix group. Benign growths in the brain and spinal cord also are case-mix. Other neoplasm codes such as benign carcinoid tumors in category 209.4-209.6 are not case-mix codes. Initially many of the codes at 173, Other and unspecified malignant neoplasms of the skin, were determined to not be case mix, but effective Oct. 1, 2012, all of the 173 codes are now considered case-mix codes.

Q Our cancer patients have trouble with dehydration. We have a debate on whether to code the dehydration or the neoplasm first.

Answer: There is a specific Coding Guideline dealing with these cases:

When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

Reference: Official Coding Guidelines, Section I, C.2.c.3

Q How would I code this scenario: My patient was diagnosed with breast cancer two years ago. It has metastasized to the lungs. We will be providing nursing assessment of the patient's respiratory status and management of oxygen therapy. An OT will work with the patient on ways to conserve energy.

Answer: When coding neoplasms always identify the thrust of the treatment being provided to the patient. In this case, the focus of care is the patient's metastatic disease of the lung (secondary neoplasm) rather than her primary neoplasm (breast). The appropriate sequencing for this case is as follows:

M1020: 197.0, Secondary malignant neoplasm, lung

M1022: 174.9, Primary malignant neoplasm, breast

Carcinoid tumors

Q What are neuroendocrine and carcinoid tumors? They have their own category now, and that category keeps growing.

Answer: Category 209, neuroendocrine tumors, was created in FY2009 and expanded in FY2010. The category is not currently found in the Neoplasm Table. The neuroendocrine classification includes carcinoid tumors (both benign and malignant) and Merkel cell carcinomas (a rare type of skin cancer).

Carcinoid tumors arise from stem cells in the gut wall, but can be seen in other organs – lung, ovaries, liver, pancreas, etc. Most are asymptomatic, but can be metastatic. The primary treatment is surgery.

Relapse and remission guidance

Q Do you need physician documentation of remission or relapse to code Categories 203-208?

Answer: Yes, according to the fourth quarter 2008 Coding Clinic guidance.

Coding Clinic defines "relapse" as "the recurrence of the disease after being successfully treated. A relapse can occur at anytime during treatment or after completion of treatment" (Quarter 4, 2008).

Assign the 5th digit "2" indicating relapse "only when the physician specifically describes it as such," the Coding Clinic says. The descriptor for the 5th digit "0" now reads, "without mention of having achieved remission" and the clarifying term, "failed remission" has been added. "Failed remission" refers to patients who have undergone remission induction therapy but failed to achieve complete remission.

Diabetes

Q What is the difference between diabetes mellitus and secondary diabetes mellitus?

Answer: Diabetes mellitus is a group of metabolic diseases characterized by high glucose levels that are the result of defects in insulin secretion or action. In the United States, diabetes affects 8.3 % of the population or about 25.8 million people.

Diabetes is the leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness among adults in the United States.

Diabetes is a significant co-morbid condition that should be coded because it has the potential to impact nearly all of the body systems as well as complicate healing.

Note: An elevated blood sugar does not necessarily mean the patient has diabetes. Do not code diabetes without a diagnosis.

There are 2 types of primary **diabetes mellitus (Category 250):**

- Type 1 (juvenile) diabetes due to an autoimmune process in which insulin-producing pancreatic beta cells are destroyed or not able to produce insulin. As a result, all Type 1 diabetes must take insulin. About 5% to 10% of patients with primary diabetes have Type 1 diabetes.
- Type 2 diabetes occurs when insulin produced is inadequate for body's needs. The vast majority of all diabetic patients have Type 2.

4th digit coding indicates a specific manifestation of Category 250.

The type of diabetes (Type 1 or 2) and the level of control (uncontrolled, controlled, or unspecified) is indicated in the 5th digit of code category 250.

Secondary diabetes (Category 249) is always caused by another condition or event.

Examples of conditions or events which may cause secondary diabetes are: cystic fibrosis, malignant neoplasm of the pancreas, pancreatectomy, the adverse effect of a drug (i.e., steroids), and poisoning.

When coding secondary diabetes, the 5th digit of Category 249 indicates whether the condition is uncontrolled, controlled, or unspecified. Secondary diabetes is not divided into types like primary diabetes.

Fourth digit coding of Category 249 is the same as for Category 250.

When coding secondary diabetes, sequence the diabetes first, then any associated manifestations, then the cause of the diabetes.

However, if the focus of care is the condition causing the diabetes, code the condition first followed by the code for secondary diabetes from Category 249.

Extra!

There is another type of diabetes – gestational diabetes (648.8x), which is related to pregnancy.

Q If a patient has high sugar levels, can we code the diabetes as uncontrolled?

Answer: No.

Only physician documentation of uncontrolled diabetes will allow coding of the 5th digit as uncontrolled. High sugar levels, fluctuating levels, etc., do not constitute uncontrolled diabetes. Physician documentation must say "*uncontrolled*" or "*out of control.*"

Terms such as brittle, insulin-resistant, poorly controlled are not the same as uncontrolled. Query the physician for greater specificity.

Q Our patient has a symptom of diabetes – hyperglycemia – can we code diabetes?

Answer: No.

You cannot code diabetes without the diabetic diagnosis. Use a symptom code 790.2x if the physician has indicated the patient has hyperglycemia and it's pertinent to the plan of care. Do not assign the code based on lab work alone.

Q What do we code if the physician does not document the type of diabetes?

Answer: The first step for proper coding is determining whether the patient has Type 1 or Type 2 diabetes.

Type 1 diabetics produce too little insulin, while Type 2 diabetics cannot properly process the insulin that is produced. Physician documentation will usually indicate

whether a patient has Type 1 or Type 2 diabetes. However, because the overwhelming majority of diabetic patient have Type 2 diabetes, in the absence of such documentation, code the condition as Type 2.

The default code for a patient with diabetes and no manifestations when the type and control are not specified is is 250.00.

Extra!

You may also see the terms "IDDM" or "NIDDM" in the documentation, meaning insulin dependent diabetes mellitus and non-insulin dependent diabetes mellitus respectively. These terms are archaic and have been removed from the ICD-9-CM. It is important to note that these terms do ***not*** indicate diabetes types because it is now known that both Type 1 and Type 2 diabetics may require insulin. Therefore, it is not appropriate to make an assumption about diabetes type based on an indication of insulin-dependence status.

Q When can we code V58.67, insulin use?

Answer: Type 1 diabetics always require insulin.

Their bodies do not produce insulin, and they are dependent on insulin injections or other methods of receiving insulin. If the patient is a Type 1 diabetic (designated with 5th digit of 1 or 3), it is assumed insulin is used, and therefore do not assign V58.67, Long-term use of insulin, in these cases.

However, you should assign V58.67, Long term use of insulin, for Type 2 diabetics (5th digit of 0 or 2) receiving insulin.

Q Is gangrene always a manifestation in a diabetic patient?

Answer: No. This is an example of when documentation and physician queries are incredibly important.

Gangrene is one of only two manifestations that is assumed to be a manifestation of diabetes if no other cause is stated. HOWEVER, gangrene also is a diagnosis that can stand on its own or be associated with another condition, other than diabetes (e.g., associated with injury, osteomyelitis or perpheral vascular disease).

If the physician documents that the gangrene is not caused by diabetes, it should be coded independently **(785.4).** Don't assume that if a patient has gangrene he/she also has diabetes.

If gangrene is a manifestation of diabetes, the proper sequencing is: **249.7x/250.7x,** Diabetes with circulatory manifestation + **785.4,** Gangrene

Extra!

The second manifestation that is an assumed manifestation of diabetes unless otherwise stated is ***osteomyelitis. (730.xx).*** However, another common cause of osteomyelitis is injury or trauma. If in doubt whether the gangrene or osteomyelitis is associated with diabetes or another condition, query the physician.

Q We have a patient with diabetes and several manifestations. Do we code diabetes, then the manifestations, or do we code the most severe manifestation first?

Answer: Diabetes and its manifestations follow the etiology/manifestation sequencing rule: The etiology is coded first, followed by the manifestation. They must be coded together.

When a diabetic patient has multiple manifestations of the diabetes, each diabetes code and its manifestation should be coded together. Remember that the 4th digit of the diabetes code indicates what body system has a manifestation. For example:

Your patient has diabetic gastroparesis and diabetic gangrene. The focus of care is on the diabetic gangrene.

To sequence correctly, put your etiology/manifestation for diabetes/gangrene first. It is the stated focus of care. If the second manifestation requires a different diabetes code, code your second pair as follows:

250.70, Diabetes with circulatory manifestations (etiology)

785.4, Gangrene (manifestation)

250.60, Diabetes with neurological manifestations (etiology)

536.3, Gastroparesis (manifestation)

If a patient has diabetes with multiple manifestations of the same body system, you will need to code the etiology once since ICD-9-CM Coding Guidelines do not allow you to use the same code more than once. The etiology code is followed by the manifestations. Here's an example:

Your patient has diabetic gastroparesis and diabetic polyneuropathy which are both neurological manifestations. Your sequencing would be as follows:

250.60, Diabetes with neurological manifestations (etiology)

536.3, Gastroparesis (neurological manifestation)

357.2, Polyneuropathy (neurological manifestation)

Extra!

Some software may not take 536.3 as the second code since gastroparesis is not a true manifestation. The codes may be sequenced 250.60, 357.2, 536.3.

Q There are so many diabetic manifestation codes ... would complication codes ever be used with the disease?

Answer: Complication codes generally are used when there is a problem that occurs as a result of using a device to treat the patient's diabetes. For example, an infection due to an insulin pump or a pump that is under- or overdosing a patient. The correct diabetes code should be assigned as well as the complication code.

For example, a mechanical complication of an insulin pump is 996.57. Why would you code that? Probably because the patient had insufficient, or too much insulin, because of the complication. In that case, code a complication, poisoning and diabetes:

Overdose of insulin due to insulin pump failure

- 996.57, Mechanical complication insulin pump
- 962.3, poisoning by insulin and anti-diabetic agents
- Diabetes code

Q What are the similarities in Category 249 and Category 250?

Answer: Category 249, Secondary diabetes mellitus is coded in much the same way as Category 250, Diabetes mellitus, but there are some differences - especially with regard to the use of the 5th digit. Here is a quick look at how the categories compare.

- Sequencing: The same etiology/manifestation sequencing rule applies to Category 249 and 250. Always sequence the diabetes first followed by the manifestation.
- 4th digits: Describe manifestations and are the same for both categories.
  - 0 indicates no manifestations (249.0x/250.0x - should never be coded if the patient has diabetic manifestations)
  - 1 indicates ketoacidosis(249.1x/250.1x)
  - 2 indicates hyperosmolarity (249.2x/250.2x)
  - 3 indicates other coma (249.3x/250/3x)
  - 4 indicates renal manifestations (249.4x/250.4x)
  - 5 indicates ophthalmic manifestations (249.5x/250.5x)
  - 6 indicates neurological manifestations (249.6x/250.6x)
  - 7 indicates circulatory manifestations (249.7x/250.7x)
  - 8 indicates other manifestations (249.8x/250.8x). When coded without a manifestation, 249.8x/250.8x = hypoglycemic shock, which usually is not treated in home health.
  - 9 is unspecified manifestations. **Do not use this code. Manifestations always should be specified.**

Important note: The 4th digits of 1, 2 or 3 would rarely, if ever, be used in home health settings.

- 5th digit coding differs for Category 249 and Category 250. Because Category 249 is always caused by another disease or condition, 5th digits for secondary diabetes indicate the level of control – uncontrolled, controlled, or unspecified. There are no 5th digits designations for Type 1 or Type 2 diabetes. Pay attention to the instructions in the Tabular under Category 249 when assigning the 5th digit.

  5th digit choices in Secondary Diagnosis (249.xx) are as follows:

  - 0 = not stated as uncontrolled, or unspecified
  - 1 = uncontrolled

  5th digit for Category 250 indicate both Type 1 or 2 and the level of control - uncontrolled, controlled, or unspecified.

  5th digit choices in Diabetes Mellitus (250.xx) are as follows:

  - 0 = Type II or unspecified type, not stated as uncontrolled
  - 1 = Type I, not stated as uncontrolled
  - 2= Type II or unspecified type, uncontrolled
  - 3 = Type I, uncontrolled

Q Can you recommend some tips for coding diabetes in home health? It's so common, but we still have problems.

Answer: Sure, here are some things to keep in mind:

- If the patient's Type and level of control is not stated by the physician as controlled or uncontrolled, the default code for the 5th digit is "0."
- If you use a 4th digit of 4-8, you must follow the diabetes code with a manifestation code. Exception: diabetic hypoglycemia is 250.8x/249.8x.
- Do not assume that an ulcer in a diabetic patient is a diabetic ulcer. The physician must state that the ulcer is due to diabetes or one of its manifestations.
- Pressure ulcers and venous stasis ulcers are not diabetic manifestations.
- Always confirm a diagnosis with the physician. Confirmation may be made in writing or by phone. Make sure you document any conversation in the patient's record.

Q My diabetic patient has chronic osteomyelitis. We are managing the patient's IV antibiotic therapy. Should I code V58.81 (Fitting/Adjustment of vascular catheter) or the osteomyelitis as the primary?

Answer: Code the acute condition (diabetic osteomyelitis) for which care is being provided as the primary diagnosis if it is unresolved.

Since the patient is diabetic and has chronic osteomyelitis of the foot, you may assume that the osteomyelitis is due to the patient's diabetes. It takes three codes to code diabetic osteomyelitis.

The appropriate sequencing for this case is as follows:

- 250.80, Diabetes with other specified manifestation
- 731.8, Other bone involvement in diseases classified elsewhere
- 730.17, Chronic osteomyelitis, foot
- V58.81, Fitting and adjustment of vascular catheter
- V58.62, Long term use of antibiotics

Note: The 5th digit use in 730.17 indicates the location of the osteomyelitis.

Anemia

Q When can you code anemia as primary?

Answer: If anemia is your focus of care, it should be coded as the primary diagnosis in M1020. There are specific Official Coding Guideline that deal with the issue of anemia with malignancy.

According to the guidelines:

"When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy."

Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy. Note Antineoplastic chemotherapy induced anemia (285.3) and anemia in neoplastic disease (285.22) may be coded together.

When using a code from Category 285, the condition causing the anemia should always be coded. Sequencing depends on the focus of care (anemia or the condition causing the anemia).

Reference: I.C.2.c. and I.C.4.a .

Low Vision

Q My supervisor wants me to include a 369.xx code for all of our older patients because so many older patients have reduced vision. Are there any rules that I need to follow to use these codes or can I use them anytime I have a patient who does not see as well as he/she used to?

Answer: The 369.xx codes are case-mix codes in the Blindness and Low Vision category, but they require the following three main conditions to be met to justify their use:

- Reporting a 369.xx code must be based on a physician's diagnosis of blindness or low vision on the referral, in the medical record, or verification from the physician that the patients has severe visual loss, decreased visual acuity or decreased visual fields. There must also be a diagnosis defining the etiology causing the visual loss, such as glaucoma, retinopathy, macular edema or macular degeneration. It is not appropriate to list a 369.xx diagnosis for common refractive errors only, such as nearsightedness, presbyopia or astigmatism. While the response to OASIS M1200 (Vision) may provide a clue that the patient has low vision, a 369.xx diagnosis cannot be assigned purely on the basis of the response to M1200.
- The documentation in the medical record also should show how the patient's visual impairment will impact the plan of care. What is the patient unable to do related to his/her plan of care? Many patients who are blind or have low vision are independent and do not require any intervention related to their reduced vision, and therefore these codes would not be justified to list as diagnoses.
- Finally, the clinician must define what intervention(s) will be needed within the plan of care to address the visual impairment. Because 369.xx codes are case-mix codes, they do receive additional scrutiny to determine if the code is being used just to increase payment or if the impaired vision is actually impacting the plan of care and being addressed.

Pain

Q Is there a difference between chronic pain and central pain syndrome?

Answer: Yes. Central Pain Syndrome (338.4) is not the same as chronic pain. Central pain syndrome is a neurological condition caused by damage to or dysfunction of the central nervous system (CNS), which includes the brain, brainstem and spinal cord. This syndrome can be caused by stroke, multiple sclerosis, tumors, epilepsy, brain or spinal cord trauma, or Parkinson's disease. The syndrome must be documented by the physician.

Do not assign codes from subcategories 338.1 (Acute pain) and 338.2 (Chronic pain) if the underlying diagnosis is known or unless the addition of the pain code adds information (i.e., post-surgical, or post traumatic acuity level) about the case.

For example:

Patient admitted for aftercare following abdominal surgery is also experiencing documented problems with pain control and is requiring additional management to achieve pain control.

Code the aftercare first followed by 338.18, Acute postoperative pain.

Patient admitted for aftercare following abdominal surgery is also on analgesic medication for pain control.

Code the aftercare code only. Patient is experiencing pain associated with the surgery.

The pain category includes:

- 338.1x: Acute pain
- 338.2x: Chronic pain
- 338.3: Neoplasm related pain
- 338.4: Central Pain Syndrome

Chronic pain (338.2x) should not be coded unless the physician documents pain as chronic. If the physician does not specify acute or chronic – code the pain as acute (338.1x).

338.3 (Neoplasm related pain) includes acute or chronic pain. If neoplasm pain is the focus of care, code the pain first and the malignancy second. If the malignancy is the focus of care and the patient also has pain related to the neoplasm, code the malignancy first followed by 338.3

Neuropathy

Q There are a couple of codes that deal with neuropathy. How do we know when to use them?

Answer: Neuropathy is a problem with the nerves that carry information to and from the brain and spinal cord to the rest of the body. There are multiple causes for neuropathy – diabetes, malignancy, as a side effect of drugs, renal disease, etc. This can produce pain, loss of sensation, and/or an inability to control muscles or regulate bodily functions.

Polyneuropathy (peripheral neuropathy) is characterized by pain, numbness or tingling in the hands and feet. Patients may also be insensitive to temperature, have gait changes or loss of balance, and other symptoms.

If the cause of polyneuropathy is known, code the cause first followed by a code for polyneuropathy as a manifestation. For example:

Polyneuropathy in diabetes:

- 250.6x + 357.2

Polyneuropathy due to rheumatoid arthritis:

- 714.0 + 357.1

Polyneuropathy in diabetes is coded to 357.2 (a manifestation only code) and is also called "stocking/glove" numbness because patients have numbness and tingling of their hands and/or feet.

Autonomic neuropathy is a nerve disorder that affects involuntary body functions, including heart rate, blood pressure, perspiration and digestion. Autonomic neuropathy commonly manifests itself in diabetic patients as gastroparesis and orthostatic hypotension. Diabetic gastroparesis is coded as: 250.6x + 563.3 If your patient has bouts of varying heart rate, orthostatic hypotension or blood sugar fluctuations, you should ask about autonomic neuropathy.

Hypertension

Q Two hypertension codes, 401.9, essential hypertension unspecified and 401.1, benign essential hypertension, were removed from the list of case-mix diagnosis codes effective Jan. 1, 2012. My agency administrator has told me I can no longer use these codes, but we have a lot of patients that have one of these diagnoses. What should I do?

Answer: While it is true that 401.9 and 401.1 were removed from the list of case-mix diagnoses, these are still valid and important codes and should be used whenever they impact the plan of care. The only thing that has changed is that these two codes no longer provide the agency with case-mix points toward the Home Health Resource Group payment for the episode.

Hypertension almost always impacts home health plans of care and needs to be monitored on an ongoing basis. Hypertension can impact or be impacted by a number of medical conditions and treatments or services provided to the patient, such as the presence of pain, anxiety, medications, increased activity seen with therapy services, etc.

The important thing to remember is that ICD-9-CM requires coders to include all of the codes that impact a patient's plan of care and that require direct treatment or monitoring and evaluation on an ongoing basis. This rule does not refer to whether the diagnosis includes case mix points or not.

Secondly, this change has added emphasis to the responsibility of the coder to select the correct diagnosis for each patient. While the majority of patients have essential hypertension, which means the underlying reason for the hypertension is unknown, some patients have a specific type of hypertension that is linked to chronic kidney disease, heart failure or both. It is vitally important to remember that any patient that has chronic kidney disease and hypertension should be coded to the 403 codes and there is no requirement for the physician to state the connection. On the other hand, use of 402 codes for hypertensive heart disease do require the physician to state the two conditions are linked.

In addition, all of the other hypertension codes in the 401, 402, 403 and 404 categories, other than 401.9 and 401.1 are still case-mix codes.

Q How do you know which hypertension to code?

Answer: There are many ways to code hypertension and numerous guidelines governing hypertension (HTN). The coder must first determine if the cause of the patient's HTN is known. If a cause is not documented, use Category 401 (Essential hypertension or primary hypertension).

The 4th digit of hypertension codes indicates whether the HTN is malignant, benign, or unspecified. Malignant HTN is severe, accelerated, or uncontrolled. It is a medical emergency and is rarely, if ever, treated in home health. Both benign and malignant HTN require specific physician documentation.

Hypertension unspecified (401.9) is used when no cause of the HTN has been identified. Having a patient with high blood pressure does not mean that there is hypertension. Hypertension must be documented.

Benign hypertension (401.1) progresses slowly and may progress to the same endpoint as malignant hypertension, but at a slower rate. It must be documented by the physician.

Extra!

Benign or malignant hypertension must be documented by the physician as such in order to code them.

Important!

In the 2012 PPS Rule, CMS removed both unspecified hypertension (401.9) and benign hypertension (401.1) from the list of case-mix codes. However, hypertensive heart disease (402), hypertensive chronic kidney disease (403) and combined hypertensive heart and chronic kidney disease (404) codes remain case-mix codes.

Because hypertension nearly always has an impact on the plan of care, it continues to be important for coders to code the appropriate hypertension code regardless of whether it is a case-mix code or not.

Q What diseases are assumed to be related to hypertension?

Answer: Although the 402-404 categories all deal with hypertension and its relationship with other diseases, coders need to be careful about assumptions.

- **Category 402 (Hypertensive Heart Disease):** There is no assumed cause-and-effect relationship between hypertension and heart failure. The doctor must document that heart failure is a result of the hypertension.
- **Category 403 (Hypertensive Chronic Kidney Disease):** There is an assumed relationship between hypertension and chronic kidney disease. Remember to code the stage of chronic kidney disease.

- **Category 404 (Hypertensive Heart and Chronic Kidney Disease):** A physician must document heart failure due to hypertension, however, the hypertensive kidney disease and CKD can still follow the assumption rule as long as both hypertension and CKD are diagnoses for the patient.

With all of these categories, watch ICD-9-CM rules regarding additional codes and mandatory coding. It is crucial to read the notes in the Tabular List.

Coronary artery disease (CAD)

Q Is 414.00 used for coronary artery disease in a patient without a bypass? I've seen 414.01 used, but it seems like 414.00 would be right.

Answer: 414.00 (CAD of unspecified type of vessel, native or graft) is a default code for CAD. It should be used when there is no documentation as to the arteries involved.

414.01 is used when there is documented CAD of a native coronary artery. The record should establish that the patient has no history of coronary artery bypass.

Myocardial infarction (MI)

Q What if my patient has cardiac symptoms for more than eight weeks after a myocardial infarction (MI)?

Answer: A myocardial infarction is coded as acute for eight weeks after onset. For home health patients, a fifth digit of "2" indicates care provided in a subsequent (not initial) episode of care.

After eight weeks, if the patient is continuing to have cardiac symptoms related to ischemia, the appropriate code to assign is 414.8, Other specified forms of chronic ischemic heart disease.

Instructions in the Tabular state that 414.8 includes any condition classifiable to 410 specified as chronic, or presenting symptoms after eight weeks from the date of infarction.

Assign code 412, Old myocardial infarction, for healed myocardial infarction or past MI diagnosed on EKG but currently presenting no symptoms.

Heart failure

Q What is heart failure? Is it the same as congestive heart failure?

Answer: Congestive heart failure (CHF) is coded to 428.0. It is one TYPE of heart failure. In general, the codes for other types of heart failure are found in the Category 428.

Heart failure is when the heart is unable to pump the appropriate amount of blood in the circulatory system. This can lead to decreased blood to kidney, water retention and a buildup of fluid in the lungs, abdomen and lower extremities.

Congestive heart failure addresses the congestion, the systemic fluid build-up. The congestion can be a feature of heart failure. Congestive heart failure includes left-sided heart failure. Never code 428.0 and 428.1 together.

Q Coding heart failure is so confusing. What tips can you give me about coding heart failure?

Answer: When coding heart failure keep the following tips in mind:

- There are several types of heart failure:
  - CHF (includes left-sided heart failure and is a chronic condition)
  - Left-sided heart failure
  - Systolic heart failure
  - Diastolic hear failure
  - Combined systolic and diastolic heart failure
- Code acute heart failure **before** chronic heart failure.
- If there is more than one type of heart failure, code them all.
- If documented by the physician as **due to** hypertension, code the appropriate HTN code first (Category 402 or 404), then code the heart failure.
- Do NOT code integral symptoms!
- Always use the instructions in the Tabular to guide you to the correct coding of heart failure.

For example, the correct code sequence for congestive heart failure due to systolic heart failure due to hypertension is:

- 402.91 – Hypertensive heart disease, unspecified, with heart failure
- 428.20 – Systolic heart failure
- 428.0 – CHF

CVA

Q Late effects of CVA codes are already combination codes. Do they ever need a second code to complete a sequence?

Answer: Yes, sometimes a second code is needed to fully code late effects of CVA. Some of the 438 codes stand alone, but others need a second code to identify the

specific late effect. 438 codes that you should add a second code to include:

- 438.50 – 438.53: Other paralytic syndromes
- 438.6 – Alterations in sensations
- 438.7 – Disturbances of vision
- 438.82 – Dysphagia
- 438.89 – Other late effects of cerebrovascular disease

Follow the instructions in the Tabular List.

Q Can we use 430 – 437 codes in home health?

Answer: Only in rare circumstances. Acute CVA codes (Categories 430 - 437) should not be used in the home health setting. Use Category 438 (Late effects of CVA) in M1020 or M1022.

Categories 430-437 cannot be used to represent the residuals of stroke. They can, however, be used to show a condition of the patient that hasn't had a stroke if that 430-437 is an active disease that qualifies for M1020 or M1022.

As an example, if a patient has carotid stenosis but has not experienced a CVA, the 433.10 code can be placed as a secondary diagnosis in M1022.

Respiratory issues

Q How do we know which respiratory codes to use and when?

Answer: Wading your way through respiratory codes means learning respiratory illnesses, how they interact and what exacerbation means.

Looking at the grouping around COPD, remember that COPD is an umbrella term. The listing below should help clear up some questions surrounding which code works in different situations.

496: COPD NEC is an unspecified code that should not be used in home health when a more definitive diagnosis is available.

- Chronic : Nonspecific lung disease
- Obstructive lung disease
- Obstructive pulmonary disease (COPD) NOS

491.20: Obstructive Chronic Bronchitis /COPD without exacerbation

- Bronchitis:
  - Emphysematous

- Obstructive
- (Chronic) (diffuse)

- Bronchitis with:
  - Chronic airway obstruction
  - Emphysema (without exacerbation)

Extra!

It is incorrect to code 491.20 for COPD without exacerbation unless the term "chronic bronchitis" or "emphysematous bronchitis" is documented.

491.21: Obstructive Chronic Bronchitis/COPD with (acute) exacerbation

- COPD
  - With acute exacerbation
  - Decompensated
  - Decompensated with exacerbation
- Emphysema
  - with bronchitis chronic
  - with (acute) exacerbation

491.22 Obstructive Chronic Bronchitis/COPD

- with acute bronchitis

Note: This is a combination code. When acute bronchitis is documented with COPD, code only 491.22.

- Acute Bronchitis
  - with emphysema

492.8 Emphysema/COPD

- with emphysema NOS
- obstructive

493.2x Chronic Obstructive Asthma

- Asthma
  - Asthma with COPD
  - Chronic Asthmatic bronchitis

***Note:** *Do not assume that an infection such as pneumonia has exacerbated a patient's*

COPD. Code both the pneumonia and the COPD.

Q Where can we get specific information on what to do when respiratory conditions (asthma, emphysema, chronic bronchitis, COPD, etc.) overlap or are combined?

Answer: The Official Coding Guidelines have almost a full page that deals with overlapping conditions in this area. The subjects include:

1. Conditions that comprise COPD and Asthma
2. Acute exacerbation of chronic obstructive bronchitis and asthma
3. Overlapping nature of the conditions that comprise COPD and asthma
4. Acute exacerbation of asthma and status asthmaticus

The guidelines also deal with COPD and bronchitis, as well as acute respiratory failure.

Reference: To see the official guidance, go to I.C.8.a-c.

Kidney disease and dialysis

What kidney disease and dialysis codes can be reported in home health?

Answer: The key to coding in this area is to think about what services the HHA is providing, and also what is a chronic disease that impacts the health of the patient, regardless of symptom control.

Patients who are receiving renal dialysis for treatment of end stage kidney disease (ESRD) are receiving Medicare benefits under the ESRD program. ESRD (585.6) is a co-morbid condition which should always be coded but never as a primary diagnosis in a home health patient receiving dialysis because we are not allowed to provide duplicate services. A status V code (V45.1x) should be added indicating the patient's renal dialysis.

Category 403 deals with hypertension and chronic kidney disease. This is certainly a chronic condition that affects a patient's health and should be coded. The stage of the kidney disease should also be reported.

Acute kidney disease is coded to Category 584. It would rarely be coded in home health because of the seriousness of the condition.

UTI

Q My patient had an indwelling catheter (now discontinued) while he was in the hospital. He now has a UTI. How do I code this?

Answer: In this case, code the UTI (599.0). Although you may be tempted to code 996.64 (Infection due to an indwelling urinary catheter) you may not use the complication code unless the physician specifies that the patient's UTI is due to the indwelling catheter.

Complications must always be documented or confirmed by the physician.

Deep tissue injury (DTI)

Q How do we code deep tissue injury?

Answer: Let's take a look at what a DTI is.

DTI is a type of unstageable pressure ulcer. The National Pressure Ulcer Advisory Panel (NPUAP) defines a ***suspected deep tissue injury*** as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Because you cannot truly see the stage of this injury, if you have a documented DTI not due to trauma, code it as an unstageable pressure ulcer, 707.0x, 707.25.

Diabetic ulcers

Q How are diabetic ulcers coded?

Answer: In general, the proper coding for diabetic ulcers when no other etiology is noted is 250.8x, 707.1x or 249.8x, 707.1x.

Please keep two things in mind as you code:

1. Diabetic ulcers are NOT pressure ulcers and should not be coded as such.
2. An ulcer on a diabetic patient does not default to being a diabetic ulcer. The ulcer must be documented as being caused by the diabetes in order to be coded as such.

There are two other ways to code diabetic ulcers:

- If the physician documents that the diabetic ulcer is the result of a peripheral circulatory disorder, code the ulcer to 250.7x (diabetes with circulatory manifestations), 707.1x or 249.7x, 707.1x.
- If the physician documents that the diabetic ulcer is the result of diabetic neuropathy, code the ulcer to 250.6x (diabetes with neurological manifestations), 707.1x or 249.6x, 707.1x.

Extra!

Non-routine supply points are only earned when the ulcer is coded with 250.8x/249.8x as the etiology.

Pressure ulcers

Q Do a pressure ulcer and its stage need to be sequenced together?

Answer: Yes, they do. The Official Coding Guidelines state:

Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0 (Pressure ulcer) to identify the site of the pressure ulcer and a code from subcategory 707.2 (Pressure ulcer stages).

The codes in subcategory 707.2 are to be used as an additional diagnosis with a code(s) from subcategory 707.0. Codes from 707.2 may not be assigned as a principal or first-listed diagnosis.

The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).

The sequence is:

- 707.0x (ulcer site)
- 707.2x (ulcer stage)

There is no rule that says all pressure ulcers must be coded together. If a patient has three pressure ulcers and a comorbidity that impacts care, the seriousness of the patient's condition dictates the sequence. You may code one pressure ulcer (and its accompanying stage), the comorbidity and then the remaining two ulcers and their stages.

The Official Coding Guidelines are clear on multiple stage and multiple ulcer coding, though. An excerpt from the Guidelines is on the accompanying page.

Guideline information from CMS:

Bilateral pressure ulcers with same stage

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

Bilateral pressure ulcers with different stages

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

Multiple pressure ulcers of different sites and stages

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

Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed.

Guidline reference: Section 1.C.12.a.4)-7)

Q My patient is admitted for management of an ulcer of the calf which has been slow to heal and is now being treated with a wound vac. What V code should I use for the vac therapy?

Answer: There is no V code specific to use for wound vac therapy (a type of wound treatment) even if the wound is complicated. Code this case as follows:

M1020: 707.12, Ulcer of the calf

This leg ulcer is a complicated wound because healing is described as delayed (slow). V codes are never appropriate when there is a complication. Do not use V58.30, Encounter for change or removal of nonsurgical dressings, for this case.

Note that there is no identified cause for the leg ulcer. Instructions in the Tabular instruct the coder to "Code, if applicable, any causal condition first." Since no causal condition is identified it is permissible to code the ulcer alone (without an etiology).

Osteoarthritis

Q How do we know if osteoarthritis is localized or generalized if the documentation doesn't say? This can affect coding, especially after joint replacement surgery.

Answer: Hopefully, documentation will state this. You need to determine from the physician if the osteoarthritis is localized (in one spot) or generalized (affects multiple joints). You should also determine, if possible, if the osteoarthritis is primary (caused by aging) or secondary (caused by trauma or other conditions).

The operative report for a patient who has undergone joint replacement will usually specify that the surgery was done to treat osteoarthritis in a specific joint.

Important note for coding: Bilateral osteoarthritis of the same site is considered localized.

Symptoms

Q How do we know what integral symptoms are to a disease? We know we're not supposed to code them with diseases like heart failure. Is there a list of them?

Answer: There is no master list of integral symptoms for a disease.

Coding Guidelines state that signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Conversely, the Guidelines also state that additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

The best places to find accurate signs and symptom information is a medical-surgical textbook or by looking at the website of a reputable nonprofit organization that deals with the disease. For example, the following symptoms are considered integral to heart failure, per the American Heart Association:

- Shortness of breath or dyspnea
- Persistent cough or wheezing
- Build-up of excess fluids in the body, most often:
  - In the lower extremities (dependent edema)
  - In the lungs (pulmonary edema)
  - In the pleural cavity (pleural effusion)
- Heart palpitations
- Tiredness or fatigue

Important note: These symptoms would not be coded independently of heart failure.

Q When do we code symptoms?

Answer: Symptoms are are coded when they are not integral to a disease process, when the Tabular instructions direct the coder to code them, or when no underlying cause has been confirmed by the physician.

If you believe that a symptom is due to a given condition that is not documented in the record, you will need to query the physician regarding the etiology of the symptom.

Remember that conditions that are documented as "possible," "suspected" or "unable to rule out" may not be coded as if they are confirmed.

Most symptom codes are found in Chapter 16 of ICD-9-CM. However, symptom codes are scattered in throughout other chapters in the manual.

Breast mass or lumps, for example, are found in Chapter 11. Itches are in Chapter 12. Blood in urine is in Chapter 10. This shows how important it is to begin coding with the Alphabetic Index, then verify the code in the Tabular List.

Remember that symptoms integral to a condition are not coded separately of the condition.

Q When is 781.2 appropriate regarding certain types of diseases?

Answer: In general, use 781.2 (Abnormality of gait) when:

1. The physician specifies the patient is to be treated for abnormal gait.
2. The patient has undergone a corrective orthopedic treatment (i.e., surgery).
3. The patient had an amputation.
4. The patient has neurological issues related to a staggering, ataxia, spastic gait and no underlying cause has been identified.
5. The patient is falling for unknown reasons.
6. The abnormal gait is related to a neurologic cause such as Alzheimer's or multiple Sclerosis.

Do **not** use 781.2 when the patient has gait problems related to:

1. Painful joints due to arthritis or other joint disease.
2. Painful gait due to an injury.
3. Hemiplegia as a late effect of a CVA.

Answering "yes" to all four questions below would justify the use of 781.2:

1. **Is skilled gait training the focus of care?** If multiple aspects of care are to be provided in an illness, the underlying cause should be used.
2. **Is the underlying cause (illness) neurological in origin?** 781.2 may be coded in neurological cases if it is the only aspect of the illness being treated.
3. **Is gait abnormality not integral to the condition?**
4. **Is the clinician or therapist providing a single aspect of care of the illness?**

Musculoskeletal

Q Could you offer some tips about coding rotator cuff tears?

Answer: Rotator cuff tears can be caused by trauma or non-trauma. Some are repaired with surgery and some are not. A traumatic rotator cuff repair is coded to 840.4, Rotator cuff (capsule) sprain. If it's allowed to heal with splinting or rest, continue to use the trauma code. If the tear is surgically repaired, code to V58.43, Aftercare following surgery for injury and trauma. Code the focus of care following the aftercare code.

Example: Patient is referred to home health following surgical repair of a rotator cuff tear due to an injury that also resulted in significant muscle strain and damage. The patient has extremely limited shoulder motion because of the damaged muscles. Patient was referred to home health for improved joint motion due to limitation of shoulder motion.

M1020: V58.43, Aftercare following surgery for injury and trauma

M1022: 718.41, Contracture of joint, shoulder region

A non-traumatic rotator cuff tear is coded at 726.13 for a partial tear (partial tear of the tendons) or 727.61 for a complete rupture of the rotator cuff. Surgical repair of either of the non-traumatic rotator cuff tears is coded to V58.78, Aftercare following surgery of the musculoskeletal system, NEC, since both of these codes are included in the conditions classifiable to 710-739. If surgery is not provided, continue to code the actual rotator cuff code.

Example: A patient is referred to home health following a non-traumatic partial rotator cuff tear that the physician has decided to allow to heal on its own.

M1020: 726.13, Partial tear of a rotator cuff (non-traumatic)

Late effects of a rotator cuff tear would be coded with the specific residual deficits followed by 905.8, Late effect of tendon injury.

Fractures

Q When can acute fractures be coded in home health?

Answer: Acute fractures (found in Categories the 800 - 829 and 733 for traumatic and pathologic, respectively) cannot be coded on the home health claim because home health is not an acute setting. Instead, aftercare codes must be used, and the acute codes may be placed in M1024 to earn case-mix points when appropriate. The acute fracture code also can be coded in M1010 (Inpatient diagnosis) and M1016 (Changed patient regimen).

Why can the actual fractures go in M1024? Because this item is strictly for payment purposes, not for claim purposes. So, there is no violation of coding guidelines when these codes are accurately placed in the M1024 optional payment slot.

If your patient is admitted for aftercare for healing of a pathologic fracture of the upper arm, the coding would be:

- M1020: V54.21, Aftercare for healing pathologic fracture of upper arm
- M1024 across from the V code: 733.11, Acute pathologic fracture of the arm

Aftercare for a traumatic fracture of the patella would be

- M1020: V54.16, Aftercare for healing traumatic fracture
- M1024 across from the V code: 822.0, Acute fracture

Wounds

Q I have heard it said that a trauma wound is always a trauma wound, but are there any exceptions to this if the original trauma is resolved by surgery?

Answer: Many trauma wounds are considered "open wounds," which is defined in the coding manual as a wound caused by a cutting or piercing instrument, by firearms, cutting, dissection, incised, laceration, puncture or with hemorrhage, but not internal. All of these wounds have one thing in common – they have a penetration or opening through the skin. These are the wounds that remain a trauma wound even if they are repaired surgically through debridement or suturing.

Example: A patient suffers a laceration of his lower leg from a piece of metal sent flying when run over by the lawn mower while he was cutting grass. Even if this wound was treated surgically with debridement, repair of a tendon laceration and closed with sutures, it remains a trauma wound and would be coded as follows:

M1020: V58.43, Aftercare following surgery for injury and trauma

M1022: 891.2, Open wound of the leg with tendon involvement

In this situation, although the wound is clean following the surgical treatment, it remains a trauma wound.

This type of injury falls under the Skin 1 category in home health and is subject to a special rule to garner the higher points for home health case mix as a first listed diagnosis even though the trauma injury is not fully resolved. When code 891.2 is listed as a current diagnosis in M1022 immediately following V58.43 (aftercare of surgery for a trauma wound), it receives the higher first-listed diagnosis points.

There are also internal injuries that result from trauma such as contusions, crushing injuries, or laceration or rupture of an internal organ without an open wound into the

body cavity. Although these are also trauma wounds and often coded in the 800 series, they do not meet the definition of having an "open wound." Thus, if this type of injury is resolved with surgery, the wound is resolved and no longer listed as a trauma wound.

Example: A patient is involved in an automobile accident that causes a ruptured spleen without an open wound into the body cavity. In this situation, the surgery resolves the injury, and if the wound is clean after the surgery without complications, it is a surgical wound and would be coded as follows:

M1020: V58.43, Aftercare following surgery for injury and trauma

Q Is it true that I should always code a wound with a wound vac as complicated?

Answer: While the initial use and the majority of current wound vac use is related to complicated wounds, that is not an absolute. A wound vac is a treatment approach used to help heal a wound. It is a costly approach, which is why wound vacs are used most often with wounds that are complex or resistant to healing. However, increasingly physicians are choosing to use wound vacs for routine wounds that are not complicated.

For example, a surgeon caring for a very obese patient who required abdominal surgery may elect to leave the wound open to allow it to heal by secondary intention rather than close the wound with sutures and retention sutures. The physician orders a wound vac from the beginning to accelerate the wound healing process and prevent complications such as wound dehiscence that result from the strain on the suture line from the excess muscle and fat in the abdominal wall. In these situations, the wound is not infected or otherwise complicated and the usual aftercare code can be used.

Example: A morbidly obese patient had an exploratory laparotomy and a cholecystectomy due to chronic cholecystitis without mention of gall stones. The wound was left open to heal by secondary intention and the physician placed a wound vac on the wound and referred the patient to home health for post-operative care. Effective Jan. 1, 2013, code 575.11, Chronic cholecystitis without mention of calculus, is now a resolved condition and can no longer be coded in either M1024 or M1022 to earn case-mix points.

M1020: V58.75, Aftercare following surgery of the digestive system

M1022: 278.01, Morbid obesity

M1022: V58.31, Change or removal of surgical wound dressing

Q How do I code a patient who had a failed skin graft?

Answer: There are two codes for rejection or failure of a skin graft. Code 996.52 is used for a rejection of a natural skin graft and 996.55 is used for a dislodgement, displacement, failure, non-adherence, poor incorporation or shearing of an artificial skin graft and decellularized allodermis.

Example: Patient with a natural skin graft to a stage III pressure ulcer of the buttock that has failed.

M1020: 996.52, Skin graft failure or rejection

M1022: 707.05, Pressure ulcer of buttock

M1022: 707.23, Pressure ulcer stage III

Q Are surgical wounds coded from Chapter 17?

Answer: No. Coding surgical wounds and amputations using open wound codes of Chapter 17 is not correct coding because the wound codes in Chapter 17 are trauma wound codes (i.e., those caused by violence or an accident).

Note: A traumatic amputation is an open (trauma) wound, not a surgical wound.

Q What catheter or implant sites are considered surgical wounds in OASIS?

Answer: Here is a listing of some common catheter and implant sites identified by CMS as surgical wounds in OASIS.

Remember that OASIS definitions are not the same as the ICD-9 classification. Always check the CMS Q&As for the most updated guidance regarding lesions that are considered surgical wounds.

- A *port-a-cath or mediport* site is considered a surgical wound for as long as it is present, even when healed.
- *Implanted infusion devices or venous access devices* are surgical wounds.
- *Central venous catheters* are surgical wounds, but care of the venous or arterial line is a fitting and adjustment issue.
- If an incision is made at the site of insertion of a femoral catheter, the site **is** considered a surgical wound. If the entry into the femoral vessel is by puncture, the lesion is **not** considered a surgical wound.

Q Is an open wound a trauma wound?

Answer: Open wounds (coded 870-895) are trauma wounds in ICD-9 coding. Surgical wounds are never open/trauma wounds. Cuts, lacerations, animal bites and punctures due to trauma are all considered traumatic injuries.

Q Is a skin tear a wound?

Answer: Most skin tears are considered superficial injuries and are classified to Categories 910 - 919. Skin tears are classified using the Payne Martin Classification:

Category 1 Skin Tears - exhibit no skin loss and should be coded as superficial wounds. Simple wound care generally is the only treatment required for these wounds.

Category 2 Skin Tears (partial thickness tissue loss) - depending on the amount of tissue lost and underlying problems related to the patient's overall condition, these lesions may be classified as superficial injuries (25% or less of skin flap is lost) or as moderate to large tissue loss (75% or greater loss of skin flap). Documentation in the record should guide the coder to coding as either a trauma wound or a superficial injury.

Category 3 Skin tears — 100% of skin flap (tissue) is lost. These wounds may be coded as trauma wounds since they usually involve more complex wound care.

Coding a skin tear is dependent on the extent of the wound, whether it is complicated or there is an underlying condition that could complicate healing. In those cases, a skin tear may be a trauma wound.

Q My patient's surgical wound appears to be infected. There is purulence and slough at the incision site that has dehisced. The patient is receiving IV antibiotics. M1342 (Status of surgical wound) is Response 3 (Nonhealing). We will be providing wound care. How should I code this case?

Answer: Postoperative infection (998.59) and postoperative dehiscence (998.3x) are both complications and should be confirmed by the physician. Response 3 (not healing) on M1342 (Status of surgical wound) can provide a clue that the patient has a complication, but you are not allowed to assign a complication as a diagnosis without physician agreement.

If the physician confirms the diagnoses of postoperative dehiscence and infection, sequence as follows:

- 998.3x (Disruption or dehiscence of wound)
- 998.59 (Postoperative infection)

Note: Always sequence 998.3x (Dehiscence) before 998.59 (Postoperative infection). Don't forget that since this is a complicated wound, a V code for surgical dressing change may not be used.

Burns

Q Can we code acute burns?

Answer: Yes, nonhealing burns are coded as acute, per Coding Guidelines.

Some guidance:

- You should code by location and severity of the burn, with the worst burn being coded first.

- Category 946, burns of multiple specified sites, should only be used if the locations of the burns are not documented.
- Category 948 deals with the Rule of Nines to help guide you through what percentage of the body has been burned.
- Infected burns take an additional code, 958.3, posttraumatic wound infection.

Extra!

If you're dealing with a scar or joint contracture, you are dealing with late effects of burns. Code the residual condition, followed by a late effect code (906.5 – 906.9).

V code issues

Q Could you explain how to use V54.81 and V54.82 when coding patients who have had a joint replacement?

Answer: V54.81, Aftercare following joint replacement, has been commonly used for patients who have received a joint prosthesis or a repair of a joint prosthesis. V54.81 best reflects the type of care that is required following a joint replacement either because of osteoarthritis or due to a fracture. This code also is used for patients who require repair of a prosthesis that may involve modification or partial repair without removing the entire prosthesis. The Tabular includes the instructional note to add an additional code to identify the joint replacement site from V43.6x, Organ or tissue replaced by other means, joint.

Example: The physician determines a patient with osteoarthritis of his knee needs a joint replacement due to increased pain and limitation in the patient's ability to ambulate and accomplish other activities due to the level of disease in his knee joint. This would be coded as:

V54.81, Aftercare following joint replacement

V43.65, Organ or tissue replaced by other means, knee joint

In 2011, the Coordination and Maintenance Committee determined that a new code was needed for situations in which a prosthesis must be explanted and replaced with a spacer or replaced with another prosthesis in a staged operation because the aftercare for these patients is more complex than following the original joint replacement. Thus, V54.82 was implemented Oct. 1, 2011, for use with patients who are seen for aftercare following explantation of a joint prosthesis. Coding Clinic, an official resource for coding information, offered some limited clarification on the use of this code in the Fourth Quarter 2011 publication (pp. 156-158):

"Code V54.82, Aftercare following explantation of joint prosthesis, has been created to allow the reporting of patient encounters for aftercare following the removal of joint

prosthesis. The aftercare includes encounters for joint replacement insertion surgery where it was necessary to stage the procedure or for joint prosthesis insertion following a prior explantation of the prosthesis. There may be a medical need to remove an existing joint prosthesis (e.g., due to infection or other problem), but it may not be possible to replace the prosthesis at the same encounter, thereby requiring a return encounter to insert a new prosthesis. This code may be used with the appropriate code from subcategory V88.2, Acquired absence of joint, to specifically identify the joint."

Based on this clarification, use V54.82 following a previous explantation of a prosthesis in two primary situations:

1) The patient has an infection of a prosthetic joint that must be removed and replaced with an antibiotic impregnated spacer or a cement spacer. The infection of the area continues even after the prosthesis is removed. Therefore, these patients frequently also require IV antibiotics to treat the infection.

   a) An infection of a hip joint prosthesis replaced by an antibiotic spacer and referred to home health for IV antibiotics would be coded as follows:

      996.66, Infection due to an internal joint prosthesis

      V88.21, Acquired absence of a hip joint following explantation of joint prosthesis with or without presence of antibiotic-impregnated cement spacer

      V58.81, Fitting and adjustment of vascular catheter

      V58.62, Long-term (current) use of antibiotics – if antibiotics will be administered for an extended time period.

   In this situation, the infection is still present, so a V code for aftercare cannot be used.

   b) Once the infection is resolved, the patient returns to have a new prosthesis inserted. Thus, the full correction of the problem requires two surgeries – one that explants the prosthetic joint and a second one to insert a new prosthesis once the infection is cleared. Aftercare following the second surgery would be coded as follows:

      V54.82, Aftercare following explantation of joint prosthesis

      V43.64, Organ or tissue replaced by other means, hip joint

2) In another situation, a patient is scheduled for surgery to replace a knee joint prosthesis due to a mechanical failure. However, the patient encounters complications during the surgery that requires the surgery to be interrupted after the prosthetic joint is removed, but before a new joint could be inserted.

In this situation the patient will have to return at a later time to have a new prosthesis implanted.

a) The surgical care following the removal of the prosthesis is not complicated, but due to the patient's other medical complications, there must be a delay prior to insertion of another prosthetic knee joint. The patient is referred to home health for physical therapy related to safe transfer, limited range of motion and fall risk prevention and would be coded as follows:

   V57.1, Encounter for physical therapy

   V54.82, Aftercare following explantation of joint prosthesis

   V88.22, Acquired absence of a knee joint following explantation of joint prosthesis with or without presence of antibiotic-impregnated cement spacer

b) Once the patient is stabilized and able to tolerate surgery, a new hip joint prosthesis is inserted. He is again referred to home health for aftercare and the coding would be as follows:

   V54.82, Aftercare for joint prosthesis insertion following prior explantation of joint prosthesis

   V43.64, Organ or tissue replaced by other means, hip joint

Q How do we know when to use a V code?

Answer: CMS has stated multiple times, including in Appendix D, that HHAs will avoid assigning excessive V codes to the OASIS. CMS has urged HHAs to follow V code limitations and consider V code assignment as an ***"assignment of last resort."***

V codes are intended to deal with circumstances other than a disease or injury, or recorded as a diagnosis or problem.

The underlying condition to support the V code should be reported in M1022 after the V code, if appropriate.

Do not use a V code if there is a complication of medical or surgical care, such as an infection or wound complication. Select the code specific to the condition rather than a V code.

Do not use a V code if an acute disease better describes the situation.

V codes may be used as primary or secondary diagnosis unless the ICD-9-CM coding guidelines stipulate otherwise.

V codes are appropriately assigned to M1020 or M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury.

OASIS V code assignment is governed by the ICD-9-CM Official Guidelines for Coding and Reporting. The Guidelines are pages long, so be sure to review the specific areas of V coding.

Q Is V09 always used with infection resistance codes?

Answer: No. With the addition of MRSA and MSSA codes in the FY2009 code set, V09 is not an "automatic" when coding resistance, or lack thereof, to methicillin, because the resistance is built straight into the disease code.

Use V09 when coding multiple resistances or if the infectious organism does not have a combination code that includes resistance.

In those cases, the sequencing is:

- condition
- organism
- V09

Q What is included in an Aftercare code such as aftercare of surgery? Monitoring incisions? Wound care? If so, why do we also use the wound care V58.3 series of codes for non-complicated wounds?

Answer: The Official Coding Guidelines say this about aftercare codes:

"Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury. The diagnosis code is to be used in these cases. ... Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

Certain aftercare V code categories need a secondary diagnosis code to describe the resolving condition or sequelae; for others, the condition is inherent in the code title. Additional V code aftercare category terms include fitting and adjustment, and attention to artificial openings."

"Aftercare" implies a comprehensive approach to the patient and the patient's needs in a specific type of encounter. Surgical aftercare may entail monitoring and observation of the wound, as well as teaching about activity levels, nutrition, etc. Not every patient receiving surgical aftercare requires surgical dressing changes (V58.31). Do not use V58.31 if you are only monitoring the wound, since the code specifies change or removal of dressings.

Surgical aftercare codes may be used whenever we are providing aftercare due to surgery – no matter how many disciplines are involved in the care.

(Reference: 1.C.18.d.7)

Q What should I code if I am performing aftercare for a patient who had surgery for a gunshot wound of the abdomen due to a handgun?

Answer: When providing aftercare following surgery for trauma, use V58.43, Aftercare following surgery for injury or trauma. Trauma wounds do not go away and must still be coded as current (unresolved) conditions.

The code for a gunshot (trauma) wound of the abdomen without mention of complication is 879.2, Open wound of abdomen. Code the trauma wound immediately following V58.43 as the underlying condition. The sequencing is as follows:

- M1020: V58.43, Aftercare following surgery for trauma
- M1022: 879.2, Open wound, abdomen
- M1022: E922.0, Accidental gunshot wound from a handgun (optional)

Note: The use of an E code to further describe the injury is optional.

Q How long is it appropriate to use an aftercare code?

Answer: There is no guideline or benefit policy that could be found by experts that says aftercare should be used only for a specific period of time.

Instead, the way to think of coding an aftercare code is along the same lines as you would when coding a disease.

Is the aftercare of surgery … wound care only? Are there other skilled issues? Is the aftercare of surgery still affecting the patient, or are there other disease or aftercare reasons that the patient is in home health for?

Look at your patient and the patient's conditions to make the decision. Think of whether you're treating a true aftercare issue or another disease issue.

Remember that aftercodes do NOT have to be sequenced primary, unless noted in the ICD-9-CM manual.

Q How can we correctly code history of falls (V15.88)?

Answer: Remember that in the Alphabetic index, you are directed to V15.88 when you look up "history of falls" or "risk of falls." Information at V15.88 in the Tabular also directs you to use V15.88 for "at risk of falls."

Fiscal intermediary Cahaba has said that when a claim is submitted with V15.88 that there should be a note in the Remarks field (FISS Page 04) that says whether the services are related to a new injury. If yes, where did the injury take place?

An E code would be appropriate to designate where the injury took place.

Extra!

OASIS-C has a falls risk assessment (M1910), so you can now reference that in your documentation.

Q Can we assign a V code with a complication?

Answer: No. In almost every case, a V code cannot be coded with a complication.

The most notable exception in home health is that if there is an infection of the prosthetic joint (996.66) or a mechanical complication of a prosthetic joint (996.4), the Tabular List says to "Use additional code to identify the prosthetic joint with mechanical complication or infection (V43.60-V43.69)."

Q I'm confused about aftercare of amputation codes. The Index lists aftercare of amputation stump as V54.89, but I see other aftercare codes listed. Is there a rule to follow?

Answer: In coding, you want to code to the highest level of specificity. While V54.89 is listed in Aftercare, amputation stump in the Index, if you look at that code in the Tabular List, it is "Other orthopedic aftercare" an unspecified code.

Other aftercare of surgery codes give more specificity, and there is a status V code that lists amputation status, so many coding experts choose to code the more specific aftercare code and the status code.

For example, an amputation of the right foot due to diabetic PVD could be coded with aftercare of surgery for the circulatory system: V58.73.

The V49.6x and V49.7x codes deal specifically with amputation stump status. V49.73 is the code for amputation stump status of the foot. So, in this coding sequence:

- V58.73, Aftercare of surgery of circulatory system
- 250.70, Diabetes with circulatory manifestations (remember that PVD is still active in the body)
- 443.81, Diabetic PVD
- V49.73, Status: Amputation of foot

For other manifestations, the aftercare of surgery code would change.

Amputation because of a diabetic ulcer would deal with V58.77, aftercare of surgery of the skin.

Osteoporosis resolved by surgery would go to V58.78, aftercare of musculoskeletal system.

The V54.89 code (default for aftercare of amputation) can be used, it's just less specific. Many experts code amputation due to gangrene as V54.89.

Q If we use a V57 code, what do we report to support the code?

Answer: Remember that documentation supports therapy, not a specific symptom or disease code. Coding Guidelines state:

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.

Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter.

Extra!

V57 guidelines are at: Section 1.B.15

E Codes

Q I know that if I have a patient who develops some type of complication as a result of taking a medication as directed, I would code it as an adverse effect. However, sometimes I receive referrals for a patient with drug toxicity that developed as a result of the correct use of a medication, but there are no other complications. How would I code these situations?

Answer: An adverse effect is an undesirable side effect or toxicity caused by the administration of drugs. Coding guidelines in I.C.17.e.1 instruct coders to identify drug toxicity as an adverse effect when the drug was correctly prescribed and properly administered by coding the reaction plus an E code from the E930-E949 series:

> "Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhage, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.
>
> "Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability."

To find the codes related to drug toxicity, start with the Alphabetical Index:

Toxicity

drug

asymptomatic 796.0

symptomatic – *see* Table of Drugs and Chemicals

To find the adverse effect code, you can start by looking in the Alphabetical Index under:

Effect, adverse, NEC

drugs and medicinal,

specified drug – see Table of Drugs and Chemicals

At the Table of Drugs and Chemicals, refer to the code for therapeutic use across from the specific agent.

Note: The default code for "**Effect, adverse, NEC**, drugs and medicinals" and "**Drug**, adverse effect, correct substance properly administered" is 995.20, but the entire 995.2x subcategory is unspecified (other and unspecified adverse effect of drug, medicinal and biological substance). Since one of the cardinal rules of coding is to code to the highest degree of specificity, look to the Table of Drugs and Chemicals for a more specific code related to therapeutic use of a specified drug or drug category.

Examples:

1. Patient is referred to home health due to supratherapeutic INR as a result of correct use of Coumadin that has been taken for many months to treat her atrial fibrillation. The patient is not experiencing any other symptoms at this time.

   M1020: 796.0, Nonspecific abnormal toxicological findings

   M1022: E934.2, Coumadin causing adverse effect in therapeutic use

   M1022: 427.31, Atrial Fibrillation

   The 796.0 is used in this example because the patient has high PT/INR levels with no other symptoms.

2. Patient is referred to home health with blood in her stool associated with a continued abnormally high PT/INR. The patient has been taking prophylactic Coumadin following a DVT several months ago (now resolved). Code this situation as follows:

   M1020: 578.1, Blood in stool

M1022: 796.0, Nonspecific abnormal toxicological findings

M1022: E934.2, Coumadin causing adverse effect in therapeutic use

M1022: V12.51, Personal history of DVT

In this situation, the patient still has two issues presenting as a result of the therapeutic use of Coumadin – the blood in the stool and the blood level that continues to be abnormal.

Q Our agency says to never use E codes. Are there cases where we must use E codes?

Answer: Yes, there is a mandatory use of E codes. While coding the External Causes of Injury and Poisoning chapter is generally considered an "add-on," an E code must be coded in these circumstances:

- Coding guidelines state to assign an E code for the *initial* encounter of an injury, poisoning, or adverse effect due to an external cause. (Section 1.C.19.a.2) Home health may not be the setting of an initial encounter.
- E codes are *required* to identify the causative substance for adverse effects of a drug correctly prescribed and properly administered (E930-949). (Section 1.C.19.c.7)

E codes, which explain how and where an accident, injury, poisoning or adverse effect of drugs occurred, can help explain a trauma to Medicare or other insurance companies, but they are not required except as noted above.

Extra!

Remember that E codes can only be coded in M1022. Never in: M1020, M1024, M1010 or M1016.

Additional Resources

Useful websites

CMS main HHA home page:

www.cms.hhs.gov/center/hha.asp

CDC: Official Coding Guidelines and code updates

www.cdc.gov/nchs/icd.htm

OASIS Information download page, including Q&As

www.qtso.com/hhadownload.html

CMS OASIS-C main page

www.cms.gov/OASIS/01_Overview.asp

Medicare Benefit Manual, Ch. 7, Home Health Services

www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf

Claim Policy Manual, Ch. 10, Medicare Conditions of Participation

www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html