Diagnosis CODING PRO for Home Health

ICD-9 coding and training answers for accurate OASIS, 485 and UB-04 completion to ensure full reimbursement

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PPS final rule:

Prepare for more case-mix losses to common codes, OASIS items

You'll no longer get case-mix points for 201 codes in the pulmonary, psych 1, psych 2 and blindness/low vision diagnosis categories as well as two OASIS items starting Jan. 1 — and CMS says the responsibility rests solely with the home health industry.

With the exception of a few areas that saw minor changes, CMS has finalized its proposal to overhaul the four equation model, which is used to determine the clinical and functional points of an episode, and ultimately generates the agency's payment, according to the final PPS rule released Oct. 30. [*See final case-mix table online at http://codingcenter.decisionhealth.com/Library/GetFile.ashx?FileId=101524*]

(*see* ***PPS final rule****, p. 5*)

Pay attention to sequencing to ensure proper payment, keep claims compliant

Coding a diabetic ulcer with osteomyelitis can be a tricky task, requiring multiple codes, and how you sequence those codes can mean the difference in gaining or losing crucial supply dollars.

In this scenario, when the ulcer is the focus of care, you would first assign the diabetes code (250.8x, Diabetes with other specified manifestations) immediately followed by the ulcer code, such as 707.15 (Ulcer of toe). Then, assign the codes for diabetic bone changes (731.8) and osteomyelitis (730.xx) immediately after.

(*see* ***Sequencing****, p. 8*)

4 options for ICD-10 & OASIS-C1 training

Kick off your ICD-10 education, take ICD-9 coding to the next level, and prepare for the new OASIS-C1 items at *DecisionHealth's* **2015 Ultimate Coding & OASIS Training Series**. The series offers three intensive boot camps, led by the leading home health experts in the nation, at four different locations across the country. For more information and to register, go to *http://www.decisionhealth.com/ultimatetraining/*.

In This Issue

Avoid hospice denials & payment delays

The world of hospice coding has changed. You can no longer assign debility (799.3) and adult failure to thrive (783.7), or any unspecified or manifestation dementia diagnosis as primary. Join hospice coding expert Judy Adams on **Wed., Dec. 17 at 1 p.m. E.T.**, as she details the code edits CMS has put in place and get strategies for getting the information you need to correctly code and adequately support your hospice records. For more information and to register, go to *http://www.decisionhealth.com/conferences/A2552/*.

CB Coding Basics

ICD-10: Understand ostomies to avoid upcoding

By Kammie Beversdorf, RN, HCS-D, HCS-D

Assigning the correct code to capture a patient's ostomy will be a critical component of ensuring your records are accurate and compliant in ICD-10. And just like now, the key to capturing these conditions is the ability to differentiate the kind of ostomy a patient has and the type of care it requires.

To do that, you'll need to acquire knowledge of three vital pieces of information:

- The type of opening, whether it's a colostomy (an artificial opening into the patient's colon, or large intestine), ileostomy (an artificial opening into a patient's ileum, or part of the small intestine), tracheostomy (an artificial opening into a patient's trachea or windpipe), or other;
- Whether the agency will be providing care to the ostomy; and
- Whether there is any type of complication.

Based on the information gleaned from each of the areas above, you will assign a "status" code, an "attention to" code or a complication code. And fortunately, though the ICD-10 codes you'll use look different from the codes you're used to assigning in ICD-9, the principles you'll apply are largely the same.

To develop the necessary understanding of the basics, let's look individually at the proper application of each code type.

Status codes indicate presence, but not care

The ICD-10 codes that capture ostomy "status" codes are found in the Z93 category (Artificial opening status) in Chapter 21 (Factors influencing health status and contact with health services). Here you'll find codes to capture the presence of various ostomy types including tracheostomy (Z93.0), gastrostomy (Z93.1), ileostomy (Z93.2), colostomy (Z93.3) and cystostomy (Z93.5-).

The ICD-9 equivalents are found in the V44.xx series (Artificial opening status), with choices such as V44.0 (Artificial opening status, tracheostomy), V44.1 (Artificial opening status, gastrostomy), and V44.50 (Artificial opening status, cystostomy, unspecified).

Just like in ICD-9, these ostomy status codes are to be assigned when a patient has an ostomy for which the agency is ***not*** directly providing care. Consider a patient who has had a colostomy for many years and cares for it without assistance. The status code Z93.3 (Colostomy status) is appropriate in this scenario.

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Association of Home Care Coding & Compliance

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Even though the agency isn't directly caring for the colostomy in this scenario, assigning the status code is necessary because any kind of ostomy has the potential to impact a patient's home health plan of care, and thus its presence should always be coded.

Scenario: Pressure ulcer, quadriplegia, tracheostomy

A patient is admitted to home health for wound care to a stage 3 pressure ulcer on his sacrum. He is a quadriplegic and has had a tracheostomy for many years, which his mother is competent in caring for.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Pressure ulcer of sacral region, stage 3	L89.153		
M1023: Quadriplegia, unspecified	G82.50		
M1023: Tracheostomy status	Z93.0		

Rationale:

- Because the patient's mother independently cares for the tracheostomy, the appropriate code for it in the scenario is the status code Z93.0. It is still important to code the tracheostomy as it has the potential to affect the plan of care and therefore requires continued monitoring.
- The pressure ulcer is focus of care so this is coded as primary. Note that the ICD-10 codes for pressure ulcers are combination codes that include both the location and the stage.
- With no further information available about the quadriplegia it must be coded as unspecified. However, it would be prudent to ascertain the cause and specific type of quadriplegia as the use of non-specific codes in ICD-10 may affect the agency's reimbursement.

Justify use of ostomy "attention to" codes

Assign a code from the Z43.- category (Encounter for attention to artificial openings) if your agency is going to be ***directly providing care*** for a patient's ostomy, such as by teaching, cleansing or feeding. This category is the ICD-9 equivalent of the V55.x series (Attention to artificial openings).

To understand the proper use of these codes, consider a patient who recently underwent the placement of a tracheostomy due to throat cancer. The patient and her daughter had some instruction on care of the tracheostomy during the hospitalization, but they both have a great deal of trepidation regarding its care.

Thus skilled nursing has been ordered to continue teaching on the care of the tracheostomy to the patient and her caregiver. In this scenario, the patient's artificial opening would be captured with a Z43.0 (Encounter for attention to tracheostomy).

Additionally, it's important to note that Z43.0 is one of the three codes in Chapter 21 that is set to carry case-mix points, according to the ICD-10 Final Translation List. The other two are Z43.5 (Encounter for attention to cystostomy) and Z43.6 (Encounter for attention to other artificial openings of urinary tract).

These codes correspond directly with the only V codes that carry case-mix points in ICD-9, which are V55.0 (Attention to tracheostomy), V55.5 (Attention to cystostomy) and V55.6 (Attention to other artificial opening of urinary tract).

Tip: Be aware that because three codes in the Z43.- category can earn case-mix points, you risk upcoding charges if you and your agency are not providing direct care to the ostomy. Instead, assign a code from the Z93.- category (Artificial opening status) if your agency isn't providing care to the ostomy.

Tip: Do ***not*** assign a code from the Z93.- category on the same claim as a code from the Z43.- category. Also,

Mark your calendar for live chats with Trish Twombly!

Save the following dates for the upcoming monthly, live Q&A sessions, during which subscribers to *Diagnosis Coding Pro* will be able to ask all their coding questions in an online forum, and coding expert Trish Twombly will provide answers. You can find links to the chats at *http://codingcenter.decisionhealth.com/Articles/Detail.aspx?tab=1&id=518894*. Take note of upcoming chats:

- Fri, Dec. 5, 12 – 12:45 p.m. E.T.
- Fri, Jan. 9, 12 – 12:45 p.m. E.T.
- Fri, Feb. 6, 12 – 12:45 p.m. E.T.
- Fri, Mar. 6, 12 – 12:45 p.m. E.T.
- Fri, Apr. 10, 12 – 12:45 p.m. E.T.
- Fri, May 8, 12 – 12:45 p.m. E.T.
- Fri, June 12, 12 – 12:45 p.m. E.T.

do not assign a code from either of these categories if the ostomy is complicated.

Scenario: New ileostomy, diabetes

A patient is admitted to home health with a newly created ileostomy. He lives alone and currently is unable to independently care for the ostomy. He has a history of prostate cancer, now resolved, and is being treated for diabetes, which is diet-controlled.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Encounter for attention to ileostomy	Z43.2		
M1023: Type 2 diabetes mellitus without complications	E11.9		
M1023: Personal history of malignant neoplasm of prostate	Z85.46		

Rationale:

- In this scenario, a code from "encounter for attention to" (Z43.2) is used because the agency will be providing hands-on care and teaching for this patient who needs assistance with his new ileostomy.

Never use Z codes for complications

Do not capture the care of a complicated ostomy with any code from the Z93.- or the Z43.- categories. Rather, look to the specific body system with which the ostomy is associated to find the appropriate code corresponding to the specific type of complication. For example, you'll find the code for an infected cystostomy in Chapter 14 (Diseases of the genitourinary system).

Consider a patient with a suprapubic catheter, or cystostomy, which was recently diagnosed as infected. The appropriate code to capture this is N99.511 (Cystostomy infection). If you know the specific type of infection, such as cellulitis (L03.314, Cellulitis of groin), sequence that code immediately following N99.511.

Understand that you can never assume that an ostomy is complicated. There must be documentation from the physician that there is a cause-and-effect relationship between the care provided (i.e. to the ostomy) and the condition (such as an infection or mechanical complication), and an indication in the documentation that it is a complication. If documentation is unclear or you're not sure, query the physician.

Scenario: Infected gastrostomy, chronic obstructive asthma

A patient is admitted to home health with abdominal wall cellulitis stemming from his infected gastrostomy tube. He also is being treated for chronic obstructive asthma. The patient has no history of tobacco use, but his wife is a smoker.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Gastrostomy infection	K94.22		
M1023: Cellulitis of abdominal wall	L03.311		
M1023: Chronic obstructive pulmonary disease, unspecified	J44.9		
M1023: Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)	Z77.22		

Rationale:

- In this scenario, because the gastrostomy is complicated by infection, neither of the Z code categories that capture ostomies are appropriate. Rather, the code for the infected site K94.22 (Gastrostomy infection) is the correct code choice.
- There is a "use additional code" note on K94.22 to specify the type of infection, which is cellulitis. Thus, L03.311 is assigned immediately following.
- As a comorbidity that could impact his plan of care, the chronic obstructive asthma should be coded and J44.9 is the most appropriate code in the absence of more information about the diagnosis.
- ICD-10 requires the additional coding, if known, of any exposure to tobacco smoke for, among other conditions, respiratory diseases such as chronic obstructive asthma. So, Z77.22 is assigned to indicate that the patient is exposed to tobacco due to wife's smoking.

About the author: *Kammie Beversdorf, RN, HCS-D, HCS-D, has more than 18 years of experience in the home health industry. As a documentation review specialist at BlackTree Healthcare Consulting, she performs clinical coding and OASIS reviews and on-site agency consultations. She can be reached at kammiebeversdorf@blacktreehealthcare.com*

Editor's note: *The ICD-10 Final Translation List can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1450-F.html.*

? Ask the Expert

Code peristomal hernia, ICD-10 G-tube complications & more

Question: *A patient was hospitalized for peristomal hernia and had mesh repair. She now has a localized infection of the midline abdominal wound. How do I code this?*

Answer: Capture the infected post-operative wound with 998.59 (Other postoperative infection) if it is localized to the operative wound itself and does not involve the ostomy opening. If the ostomy itself is also infected, you'd capture that with 569.69 (Colostomy or enterostomy complication, other). Since the peristomal hernia was repaired with surgery, that condition would not be coded in M1020/M1022. You should also include a code for any cellulitis as well as a code for the infecting organism, if known.

Question: *We have a patient who had a G-tube recently removed as a fistula was found at the site of the G-tube along with a yeast infection. How do I capture the fistula and the yeast infection in ICD-10?*

Answer: Code both of these conditions as complications of the G-tube. To code the fistula, begin your search in the alpha index under 'Complication, gastrostomy' which will lead you to the K94.2- category (Gastrostomy complications). These codes are found in chapter 11 (Diseases of the digestive system). From there, assign K94.29 (Other complications of gastrostomy) for the G-tube fistula.

The infection at the G-tube site requires a separate code, which would be K94.22 (Gastrostomy infection). To capture that the infection was caused by yeast, search the alpha index under 'Infection, yeast (see also candidiasis),' which will lead you to B37.9 (Candidiasis, unspecified). However, B37.9 captures an unspecified yeast infection. Since the infection in this scenario is of the skin, the more specific B37.2 (Candidiasis of skin and nail) should be assign instead.

Sequence the fistula (K94.29) first, followed by the infection (K94.22) and then the yeast (B37.2) code.

Question: *One of our patients has had a few falls lately and the nurse wants V15.88 (Personal history of fall) to be the primary code. I want to use muscle weakness (728.87) because as I read through the documentation that seems to be the reason for the falls. What is the correct approach here?*

Answer: V15.88 may be used as a primary diagnosis, but there's likely an underlying reason or diagnosis that is responsible for the patient being at risk for falls and you should question the physician as to what that is. Also, ask yourself whether your plan of care is focusing solely on the patient's fall risk and history of falls, as that's when it would appropriate to assign V15.88 in M1020. It's more likely that there's something more going on, whether it's Parkinson's disease, the late effects of a CVA, neuropathy, recent joint surgery or something similar.

Muscle weakness or deconditioning also may be a primary diagnosis. But, as with history of falls, generally there's an underlying reason for the muscle weakness and that's the diagnosis that should be coded whenever possible.

However, keep in mind that V15.88 will support your agency's fall prevention program.

Editor's note: *The Ask the Expert answers were provided by Jean Bird, RN, HCS-D, clinical coordinator at Gentiva in Fall River, Mass. Submit your questions to mgustafson@decisionhealth.com.*

PPS final rule

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In general, there'll be a reduction of case-mix points for clinical diagnosis and OASIS items, while high-therapy episodes (14 or more visits) will earn the most points. Common home health diagnoses such as COPD (491.21), Alzheimer's disease (331.0) and low vision (369.xx), as well as OASIS items M1200 (Vision) and M2030 (Injectable drug use) will lose their case-mix status altogether *[CPH, 8/14]*.

The majority of industry comments expressed surprise and disappointment that the new case-mix model rewards high-therapy episodes, which creates "financial incentives to increase therapy" and docks payment for clinical conditions that typically don't require a lot of therapy. But CMS holds firm that the changes in the case-mix weights

are driven by home health utilization patterns observed in FY2013 claims data.

"We find a notable shift across all therapy groups away from the use of home health aides and a shift to either more nursing or more therapy care. While some of the low therapy groups did add more skilled nursing visits, most of the therapy groups added more occupational therapy (OT) and speech-language pathology (SLP)," CMS says in the rule.

This may be a sign that some agencies are more effectively case managing their episodes, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

However, she believes the industry as a whole still relies too heavily on home health aide services, and misses opportunities to more effectively manage cases in ways that would better reflect the true cost of care.

Correctly code fracture late effects to steer clear of upcoding

Don't assign V54.13 (Aftercare for healing traumatic fracture of hip) for a patient admitted to home health with leg length discrepancy and abnormal gait resulting from a hip fracture that healed incorrectly, or you could be upcoding.

Rather, recognize that this is a ***late effect of a fracture*** and should be coded like any other late effect — with the residual problem(s) (in this case the leg length discrepancy (736.81) and the abnormal gait (781.2)) followed immediately by the appropriate late effect code, 905.3 (Late effect of fracture of neck of femur), says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

Coders frequently capture what actually are fracture late effects as either standard fracture aftercare, such as with the V54.1x code or with the non-specific V15.51 (Personal history of traumatic fracture), Whitemyer says.

But beware: In the event that the patient also had a qualifying condition that made the fracture eligible for case-mix points (i.e., the patient has a pressure ulcer or receives parenteral or infusion therapy), incorrectly coding fracture aftercare would lead to undeserved reimbursement, she says.

Specific fracture codes assigned in M1024, when paired with an eligible aftercare V code in M1020 or M1022, are the only resolved conditions eligible for case-mix points *[CPH, 12/12]*.

Tips to correctly code fracture late effects

Here are four more tips to help you detect and accurately code fracture late effects:

- **Don't forget the late effect code (such as 905.2, Late effect of fracture of upper extremities)** when coding a case of a fracture that healed with either a malunion (733.81) or nonunion (733.82), Whitemyer says. Assign the malunion or nonunion code first and follow it with the late effect code in accordance with coding guidelines *[I.B.12]*.
- **Query the physician to determine whether a patient's abnormal gait is actually a late effect of an improperly healed fracture** if the chart indicates there's an old fracture (a year ago or more) and the patient is still experiencing problems, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. However, the doctor must confirm any diagnosis of a late effect; you can never assume.
- **Remember that a late effect is a condition that has resulted once the acute phase of the illness or injury is *over [I.B.12]*.** For example, a patient whose ankle fracture still hasn't healed after six months doesn't have a late effect of the fracture. This would be a *complication* because the healing phase hasn't yet completed, Twombly says.
- **Look for words like "residual," "sequelae" or "late effect" in the documentation** to indicate that the patient's condition may be a late effect of an old fracture, says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston.

Scenario: Malunion of wrist fracture

A 74-year-old woman fractured her wrist 18 months ago and the bone healed incorrectly. Her doctor has diagnosed it as a malunion, and as a result, she has trouble completing her ADLs. While awaiting surgery to correct the malunion, her doctor has ordered home health for physical and occupational therapy. She'll also receive skilled nursing care to manage new medications she was recently prescribed to treat her hypertension.

Code the scenario:

Primary and Secondary Diagnoses			M1024 Case Mix 3	4
M1020a	Malunion of fracture	733.81		
M1022b	Late effect of fracture of upper extremities	905.2		
M1022c	Essential hypertension, unspecified	401.9		

Rationale:

- The patient's fractured has healed, but it healed incorrectly, with the doctor specifically diagnosing it as a malunion. Therefore, it is a late effect of a fracture, and is coded as such. The late effect code (905.2) follows the malunion code (733.81), in compliance with coding guidelines.
- Since she'll be receiving nursing care for medication management for her hypertension, this comorbidity is coded as well. -*Megan Gustafson (mgustafson@decisionhealth.com)*

For example, instead of sending in frequent aide visits to provide patients with ADL assistance, better case management practices may call for an occupational therapy consult to determine if the patient or the patient's caregiver can be taught to manage ADLs on his or her own, Whitemyer says.

In an effort to ensure home health payments continue to accurately reflect resource use, CMS will recalibrate the case-mix weights every year and continue to monitor case-mix growth to consider whether future reductions are necessary, the federal agency says in the rule.

Poor documentation skewing data

Another common argument made by commenters was that case-mix weights appear to decrease payments for third or later episodes of care, which would impact how home health providers treat patients with multiple, chronic conditions. And that there is no longer an emphasis on common home health diagnoses such as diabetes, heart failure, COPD and depression.

Again, CMS' response is that any decreases in the case-mix weights reflect less average resources associated with those episodes according to FY2013 claims data.

The industry's own utilization data is evidence that therapists have been doing a better job than nurses at documenting the time they spend caring for patients, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

Many nurses don't perform documentation of the care they're providing at the time of each visit, preferring to wait until later to do it, and since time spent at each visit is the only time that is counted towards resource use, this is "coming back to bite nursing utilization," says Adams.

"A lot of this just comes down to bad habits," adds Whitemyer.

For example, a home health record that states the patient was short of breath and the nurse notified the doctor and then instructed the patient on the symptoms of COPD, will lead CMS to believe that nursing care for this patient is a quick and easy task that could be done in 15 minutes, Whitemyer says.

In reality, the nurse may have spent 45 minutes instructing the patient on diet, how to read a pulse oximeter, when to report findings, what certain symptoms mean and when to call for emergency assistance. But, if it's not documented, it's not done, she says.

Furthermore, nurses often aren't accustomed to carefully tracking and documenting the amount of time they're spending with patients. However, these tasks are generally more commonplace for therapists, especially because therapists tend to be paid at an hourly rate which further incentivizes careful timekeeping, she says.

More coding updates in the rule

Here's a quick summary of two other notable updates in the final rule:

• **CMS will continue to monitor home health claims that bill solely for insulin injections.** The federal agency expects these claims to include secondary diagnosis codes that support why the patient can't self-inject, according to the rule. The federal agency noted that it did receive suggestions for additional secondary diagnoses that weren't included in the list provided in the proposed rule but it didn't state what those were *[CPH, 9/14]*.

• **The ICD-10 grouper, which will include the list of case-mix codes, will be released by April 1, 2015**, to give the industry more time to prepare for the Oct. 1 implementation date. For those providers who've signed up to be beta site testers, the ICD-10 Grouper will be available on or before Jan. 1, 2015. For more information on how to register as a beta site, go to *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html*
— Megan Gustafson (mgustafson@decisionhealth.com)

Editor's note: To view the FY2015 Final PPS Rule, go to *http://www.ofr.gov/OFRUpload/OFRData/2014-26057_PI.pdf.*

Sequencing

(continued from p. 1)

While coding the osteomyelitis codes ahead of the ulcer wouldn't be wrong, sequencing the ulcer first is a better representation of the focus of the admission, says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston. It can also result in about $100 of increased reimbursement.

The reimbursement difference comes from the fact that when a code from the 707.1x category directly follows a diabetes code with fourth digit of '8,' it triggers the Grouper to award non-routine supply (NRS) points.

This is just one example of the importance of proper and thoughtful sequencing. Read on to learn more about which specific scenarios and diseases most often confuse coders and how to properly sequence them.

Navigate through conflicting guidelines

Assign the code from the 403 series (Hypertensive chronic kidney disease) directly following 250.4x (Diabetes with renal manifestations) and before the code from the 585 series (Chronic kidney disease) for a patient with diabetic kidney disease who also has hypertension, according to Coding Clinic guidance from Sept.–Oct. 1987.

This is the type of scenario that can confuse coders because it involves two sequencing rules that conflict with each other, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

Consider that, on the one hand, "diabetic kidney disease" implies that the kidney disease is a manifestation of diabetes, necessitating the sequencing of the kidney disease code directly after the diabetes code, in accordance with the etiology-manifestation convention *[I.A.6]*.

However, there's ***also*** an assumed relationship between hypertension and chronic kidney disease when both diagnoses are present regardless of whether the physician has stated a connection, with the guideline specifying that hypertension must be coded before chronic kidney disease *[I.C.7.a.3]*.

Find your way out of the this conundrum by following the longstanding Coding Clinic guidance referenced above that directs you to code the diabetes first, then the hypertension code and finally the chronic kidney disease code, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

Tip: Never assign a code from the 401 series (Essential hypertension) on the same record as a code from the 585 series (Chronis kidney disease) because hypertension and chronic kidney disease are ***always*** assumed to be connected, meaning the hypertension should be captured by the 403 series (Hypertensive chronic kidney disease), Blevins says. Furthermore, this mistake could cost you: While case-mix points have been removed from most hypertension codes, 403 series codes still garner them.

Heed all coding instructions or risk costly errors

Be sure to verify the code in the tabular once you find what you're looking for in the alphabetic index. Neglecting this step may lead you to miss important instructions, including sequencing information that could cost you, or put the record at risk, if not followed.

For example, consider the diagnosis of pseudobulbar affect, says Blevins. The index listing leads you to code 310.81 (Pseudobulbar affect) and if you were to only assign that code and move on you'd miss the note in the tabular that instructs you to code first, if applicable, the

underlying cause of the condition, such as a late effect of a traumatic brain injury (907.0).

Neglecting to assign 907.0 before 310.81, when pseudobulbar affect is the residual of a brain injury, will cost you the rare opportunity to earn Neuro 1 primary points if the diagnosis is the focus of the home health admission, she says.

Due to the coding guideline that stipulates that the residual is always coded before the late effect unless otherwise instructed, 907.0 is almost never a primary home health diagnosis, says Blevins. But because the tabular ***has*** instructed otherwise in this case, 907.0 would go first. *[See box on pg. 6 for more information on late effect coding]*

As a Neuro 1 code it will earn up to eight points in M1020. Additionally, note that Neuro 1 codes earn more points when coded primary.

Glossing over tabular notes can also lead to the appearance of upcoding, such as when liver cirrhosis (571.5) occurs with hepatitis (070.x), says Linda Phillips, HCS-D, QA reviewer for McBee Associates in Wayne, Pa.

There's a note at 571.5 that says to code hepatitis first if it's applicable, but Phillips says she almost never sees the hepatitis code included and/or sequenced correctly in these cases.

Beware, though, that this mistake could look like upcoding. Because hepatitis codes don't garner points, if you've left it off the record, or coded it but sequenced it incorrectly outside of the top six, it may appear as though you've done so to make room for other comorbidities that earn more points, she says.

Tip: Read up to the top of the tabular category and down to the subcategory and individual code, to make sure you're not missing any detail or instruction, Blevins says. Consider a question she recently fielded about a search for the code for osteitis deformans as a result of bone cancer. The index leads to 170.9 (Malignant neoplasm of bone and articular cartilage, site unspecified) for the cancer and 731.1 (Osteitis deformans in diseases classified elsewhere) for the osteitis deformans manifestation.

However, the cancer was specified as affecting the femur and a scan of the 170 category in the tabular indicated that a more specific code for that cancer, 170.7 (Malignant neoplasm of femur), was available. Because you must always code to the highest level of specificity, 170.7 is the correct choice. The index will direct you to the right place, but you still need to investigate it in the tabular, she says.

Scenario: Diabetic chronic kidney disease with hypertension

A 76-year-old man is admitted to home care with type 2 diabetes complicated with chronic kidney disease, stage 4, as well as hypertension. He has a history of peripheral vascular disease (PVD) and coronary artery disease (CAD) with a previous coronary artery bypass graft (CABG). Both of these conditions are stable. The focus of his home health admission is monitoring his diabetes since he was recently started on insulin during a hospitalization.

Code the scenario:

Primary and Secondary Diagnoses			M1024 Case Mix 3	4
M1020a	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled	250.40		
M1022b	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified	403.90		
M1022c	Chronic kidney disease, Stage IV (severe)	585.4		
M1022d	Coronary atherosclerosis of unspecified type of vessel, native or graft	414.00		
M1022e	Peripheral vascular disease, unspecified	443.9		
M1022f	Long-term (current) use of insulin	V58.67		

Rationale:

- The chronic kidney disease was linked to his diabetes, and thus can be coded as a diabetic manifestation. Additionally, it can be assumed to be related to hypertension per coding guidelines.
- As the focus of care, the diabetic kidney disease is coded first. In accordance with Coding Clinic guidance, the hypertensive kidney disease is coded immediately after the diabetes code, followed by the chronic kidney disease code.
- Insulin use is coded because the patient is dependent on it and is not a type 1 diabetic.

Scenario: Cirrhosis, viral hepatitis

A 71-year-old woman is referred to home health with a primary diagnosis of cirrhosis of the liver that is not the result of alcoholism. She also has chronic viral hepatitis C, hypertension, coronary artery disease (CAD), dominant-side hemiplegia resulting from a cerebrovascular accident (CVA), diabetes with peripheral neuropathy, for which she uses insulin, and stage 2 chronic kidney disease.

Code the scenario:

Primary and Secondary Diagnoses			M1024 Case Mix 3	4
M1020a	Chronic hepatitis C without mention of hepatic coma	070.54		
M1022b	Cirrhosis of liver without mention of alcohol	571.5		
M1022c	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled	250.60		
M1022d	Polyneuropathy in diabetes	357.2		
M1022e	Hemiplegia affecting dominant side as late effect of cerebrovascular disease	438.21		
M1022f	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified	403.90		

Additional diagnoses: *585.2 (Chronic kidney disease, Stage II (mild)), 414.00 (Coronary atherosclerosis of unspecified type of vessel, native or graft), V58.67 (Long-term (current) use of insulin)*

Rationale:

- The hepatitis is coded before the cirrhosis, which is the focus of care, in accordance with tabular instructions which say to code hepatitis first, if applicable.
- The patient's additional diagnoses are coded because they have potential to impact her plan of care.

Both scenarios were adapted from ones provided by Phillips. — Megan Gustafson (mgustafson@decisionhealth.com)

News briefs

- **Don't assign a manifestation code, such as 294.11** (Dementia in conditions classified elsewhere without behavioral disturbance) without first coding an appropriate etiology (like Alzheimer's disease, 331.0), or you'll see your claims caught in an edit come Jan. 1, 2015, according to the latest version of the Grouper, released by CMS Nov. 10. The updated payment logic, which will be compatible with the OASIS-C1/ICD-9 assessment, also reflects the sweeping case-mix losses in the 2015 Final Rule. To download the Grouper, go to *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.*
- **Correction:** The Ask the Expert question on heart failure in the February 2014 issue should have included 428.0 (Congestive heart failure NOS) in addition to 428.23 (Systolic heart failure, acute on chronic) to capture the diagnosis of acute-over-chronic systolic congestive heart failure.

When will you start your ICD-10 training for coders?

The following data, from DecisionHealth's ICD-10 Readiness Survey of 248 agencies, reflects when home health agencies are planning to restart training their coders for ICD-10

Source: *DecisionHealth ICD-10 Readiness Survey*