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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2015 Coders' productivity survey

Coders complete up to 20 charts daily, but revenue at risk without back-ups

Home health agencies are at risk, and potentially costing themselves thousands of dollars in incomplete or improperly coded records by not having a back-up plan when their coder is out of the office sick or on vacation, according to the results of *Diagnosis Coding Pro*'s 2015 Home Health Coders' Productivity Survey of 230 coders.

The sole coder at a South Carolina agency, who reported coding between 16 and 20 records daily, says that the coding just isn't done when she's out of the office and she simply has to catch up when she returns.

(*see* ***Productivity****, p. 4*)

Watch arthritis assumptions to ensure rightful reimbursement, avoid upcoding

Don't assign a code from the 715 (Osteoarthritis and allied disorders) series for a patient whose diagnosis was written only as "arthritis." By making an unallowable assumption about a diagnosis, you've violated coding guidelines and could potentially be upcoding.

Instead, assign a code from the 716.9x (Arthropathy, unspecified) series for patient with a diagnosis of arthritis for which you have no further detail, according to tabular instruction.

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

Master wound coding, secure proper payment

Wound coding is a constant source of confusion — and mistakes are costly. Now's the time to master the fundamentals you'll need to accurately assign wound codes in ICD-9 and ICD-10. Join home health coding expert Brandi Whitemyer on **Tues., March 24 from 1 to 2:30 ET,** to walk through the coding of common home health wounds in both code sets. Bonus: Get the 2015 Wound Coding & OASIS Field Guide at 50% when you register for the webinar. For more information, go to *http://www.decisionhealth.com/conferences/A2572.*

ICD-10 & OASIS-C1 training: Secure your spot

Hurry — seats are filling up! Selecting the most appropriate codes and most accurate OASIS responses are the keys to ensuring proper reimbursement and avoiding auditor scrutiny. Train your staff to do just that at the **2015 Ultimate Coding & OASIS Training Series.** Choose from three intensive boot camps in a city near you. For more information and to register, go to *http://www.decisionhealth.com/ultimatetraining.*

In This Issue

CB Coding Basics

ICD-10 offers greater detail for coding CVA late effects

By Maurice Frear, HCS-D

ICD-10 offers you six subcategories, versus one category in ICD-9, to choose from when you're coding sequelae (late effects) of a cerebrovascular disease.

The codes are found in the I69.- category (Sequelae of cerebrovascular disease) in Chapter 9 (Diseases of the circulatory system) and they identify the sequela (or late effects) of conditions that are defined by the codes found in categories I60.- (Nontraumatic subarachnoid hemorrhage) to I67.- (Other cerebrovascular diseases).

The fourth character of the code will define the specific type of ***underlying cause*** of the sequela condition such as a cerebrovascular accident (CVA) or stroke. The fifth character identifies the ***condition itself***, such as hemiplegia. The sixth character provides information on the ***side of the body affected*** and if it is ***dominant or non-dominant***. For example, I69.351 corresponds to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.

By contrast, the one category of codes for CVA late effects in ICD-9 is the 438 series (Late effects of cerebrovascular disease) which is found in Chapter 7 (Diseases of the circulatory system), and the available codes offer far less specificity. Take a diagnosis of hemiplegia, for example.

The fifth digit, such as in 438.22 (Hemiplegia affecting nondominant side as late effect of cerebrovascular disease), indicates whether the side affected is dominant, non-dominant, or unspecified, but not whether the side affected is left or right. The detail provided by the ICD-10 codes will require greater specificity in your documentation so you'll be able to identify and select the correct codes for your patients.

But, besides enhanced specificity and the need for more detail, the way you'll code these conditions in ICD-10 won't be all that different from how you code them now. Just as in ICD-9, many of the ICD-10 codes are combination codes that include both the residual condition plus the specific cause of the sequela, such as I69.354 (Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side).

And it will still be important to read all of your notes, including the Excludes 1 and Excludes 2 notes, to ensure that you select the correct codes for your patient.

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Association of Home Care Coding & Compliance

Board of Medical Specialty Coding & Compliance

Scenario: Hemiplegia following stroke

A 63-year-old male admitted to home care for physical and occupational therapy to address right-sided hemiplegia due to a recent stroke. The patient also has hypertension, coronary artery disease and diabetes and continues to smoke a pack of cigarettes per day.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side	I69.351		
M1023: Essential (primary) hypertension	I10		
M1023: Type 2 diabetes without complications	E11.9		
M1023: Atherosclerosis of native coronary artery without angina pectoris	I25.10		
M1023: Current tobacco use	Z72.0		

Rationale:

- In ICD-10 there are no equivalent therapy-only codes. Your primary diagnosis would be the reason the therapy has been ordered. In this case, it is the right-sided hemiplegia.
- Follow the coding rules below to determine whether to code dominant or non-dominant in a patient whose side of paralysis (left or right) is noted but not specified as dominant or non-dominant.
  - For ambidextrous patients, the default is dominant.
  - For right-side affected, the default is dominant.
  - For left-side affected, the default is non-dominant.

Scenario: PEG tube, dysphagia

A 77-year-old patient is referred to home care for skilled nursing to teach the patient and family PEG tube care. The PEG was inserted due to worsening of the patient's oral dysphagia since suffering a stroke two years ago. Nursing will also be assessing and monitoring the care of a stage three decubitus ulcer on the patient's right buttock. His co-morbidities include COPD and a history of pneumonia.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Encounter for attention to gastrostomy	Z43.1		
M1023: Dysphagia following cerebral infarction	I69.391		
M1023: Dysphagia, oral phase	R13.11		
M1023: Pressure ulcer, right buttock, stage 3	L89.313		
M1023: Personal history of pneumonia (recurrent)	Z87.01		

Rationale:

- In this scenario the focus of the care is the PEG tube and therefore it is the primary diagnosis. Coding guidelines require that an additional code be used to identify the type of dysphagia. ICD-10 pressure ulcer codes are combination codes that list the site, laterality and stage of the pressure ulcer in one code, such as L89.313 (Pressure ulcer, right buttock, stage 3).

Hospice scenario: Intracerebral hemorrhage, comatose

A 68-year-old male has been admitted to hospice following a massive non-traumatic intracerebral hemorrhage. The patient is currently comatose with minimal response to painful stimuli. The family has requested comfort care only. His co-morbidities include hypertension with stage 4 chronic kidney disease, congestive heart failure and atrial fibrillation.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Other sequela of nontraumatic intracerebral hemorrhage	I69.198		
M1023: Other coma, without documented Glasgow coma scale score, or with partial score reported	R40.244		
M1023: Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease	I12.9		
M1023: Chronic kidney disease, stage 4	N18.4		
M1023: Heart failure, unspecified	I50.9		
M1023: Atrial fibrillation, unspecified	I48.91		

Additional diagnoses: Encounter for palliative care (Z51.5)

Rationale:

- Regardless of setting, whether hospice or home health, you are required to follow the official coding guidelines.

About the author: *Maurice Frear, HCS-D, has been the coder for Bon Secours of Virginia Home Health and Hospice since 2005. Prior to that, he served in the United States Navy for 30 years as an Independent Duty Hospital Corpsman.*

Ask the Expert

Code impingement, amputation

Question: *How do I code a femoral acetabular impingement?*

Answer: The correct code is 355.1 (Meralgia paresthetica). To get there, it's important to know that 'impingement' also means 'entrapment,' and a search under "entrapment" in the alpha index directs you to 355.9 (Mononeuritis of unspecified site).

However, notice that the 355 series gives several options for the location of the impingement/neuropathy, including 355.1 (Meralgia paresthetica), which includes compression of the femoral nerve of the thigh. Because it's more specific to the condition you've described, 355.1 is the correct code choice over 355.9.

Question: *How do you code in ICD-10 an amputation that includes the entire leg and even part of the pelvis?*

Answer: You'll assign Z89.62 (Acquired absence of hip) with a sixth digit of either 1 or 2, depending on whether the left or right side was amputated. To get there, first look under 'Absence (of organ or part) (complete, partial)' in the alpha index.

Follow this list to 'hip (following explantation of hip joint prosthesis) (joint) (with or without presence of antibiotic-impregnated cement spacer),' which will lead you to code Z89.62-. This code requires a sixth character to identify laterality.

Next, turn to the tabular list under Z89.62-, where you will find that this diagnosis includes a patient who has a limb amputated extended into the hip/pelvis area. The necessary sixth character identifies the laterality of the missing limb/hip, whether right, (1), left (2) or unspecified (3). However, you should never code unspecified as the side of the missing limb should be known. An absence status code like Z89.62- should never be listed as a primary diagnosis.

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.*

Productivity

(continued from p. 1)

Nearly ***half*** of coders are in a similar position, with no back-up coder at their agencies to fill in for them while they're out, according to the January survey results.

Of those agencies that do have back-up coders, 43% do not spend the majority of their time solely on coding but rather have other roles within the agency such as field clinicians or billers. Only 17% said their agencies utilize outsource coding services to cover for them while they're away, according to survey results.

Home health agencies often lack good systems for dealing with their coders' absences, and those agencies that rely on just one coder without a back-up are leaving themselves "extremely vulnerable" to coding errors and productivity losses, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

And it's only going to get worse. Whatever time it takes coders now to catch up on work that sits undone while they're out of the office, it'll take at least twice that once ICD-10 arrives, says Michelle Mantel, HCS-D, quality assurance manager for Gentiva Home Health in Atlanta, Ga.

Develop a customized back-up plan

The majority of home health agencies — 89% — have no formal policy for how coding is to be done while the coder is out of the office

Those whose agencies do have processes in place pointed to the presence of back-up coders, some of whom aren't certified or who have other jobs within the agency and fill in only when needed, or of having their work temporarily reassigned to others.

Furthermore, about a third of coders reported having been discouraged from taking sick time or vacation due to its impact on productivity. About 41% said they must

give a minimum of two weeks' notice before taking time off, 17% must give a month and 3% have to give at least six months' notice.

To develop a workable plan to ensure accuracy and productivity during coder absences, avoid looking for a "one-size-fits-all" vacation/sick time policy. Instead, build an individualized plan that fits your agency and accounts for all relevant factors, Adams says.

Such factors may include the cost of paying another coder's salary and benefits, whether there's an adequate supply of trained coders in the agency's geographic area to locate and hire, and the agency's size and average patient census, she says.

There are two basic options for maintaining coding productivity during coders' vacation and sick time — either invest in as-needed outsourcing services or have another adequately trained, up-to-practice, back-up coder on staff, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

However, just having a back-up coder isn't a safe bet if that coder is someone who opens a coding manual three times a year and spends the rest of her time doing another job, Twombly says. The back-up coder must be someone who spends the majority of his or her time coding.

Be prepared, or risk productivity & revenue

While the cost of hiring and/or training another certified coder, or utilizing outsourcing services to provide back-up is a cost about which many administrators are concerned, the cost of productivity losses may be far greater, says Twombly.

Consider that 23% of coders said they code between one and five records per day; 28% code six to 10; 18% code 11 to 15; and 14% code between 16 and 20 records. *(See chart on this page for a more detailed breakdown.)*

And if coding wasn't a full-time job, most coders often have additional duties, too. In fact, in addition to coding, 63% say they are also responsible for educating and training staff, another 63% report performing QA audits, while 44% perform coding management duties. *(See chart on pg. 6 for more details.)*

The outsourced coding company for which Jill Dyer, HCS-D, works for on an as-needed basis expects full-time coders to complete three to four records ***per hour***, which equates to nearly 30 per day. Dyer also owns JID Consulting and Coding in Houston, Texas, and until 2012 was a home health agency owner herself.

How many charts do you code in an average day?

The following represents the average number of charts coded per day, as reported by home health coders.

Number of charts	Percentage of coders
0 to 5	23%
6 to 10	28%
11 to 15	18%
16 to 20	14%
21 to 25	5%
26 to 30	3%
More than 30	9%

Source: 2015 Diagnosis Coding Pro *Home Health Coders' Productivity Survey*

Terry Hatch codes an average of 18 records a day and was her agency's sole coder with no back-up for five years. Prior to the agency providing her with a back-up, she had to work overtime to catch up after being out of the office, which became costly to the agency, says Hatch, HCS-D, who codes for North Kansas City Hospital Home Health in North Kansas City, Mo.

With the average amount of a home health claim estimated at roughly $2,500, it's reasonable to conclude that an agency may risk revenue delays in the thousands a day when records aren't being coded and submitted, Mantel says.

In addition, 57% of coders said it takes them between two days to a week to catch up after being sick or on vacation, and almost a quarter said it takes them more than a week, according to survey results.

So, "it could be a slippery slope really fast," Mantel says. If completed records don't leave the agency, revenue doesn't come in and clinicians can't be paid to make visits. Ultimately, the agency's patients could end up being picked up by competing agencies.

The cash flow decreases during her sole coder's absences became obvious to former agency owner Dyer. She was forced to learn the "the hard way" to deal with coding processes ahead of time or find that cash flow will be "a mess," she says.

Besides coding charts, what other responsibilities do you have?

In addition to coding, the following duties are those that coders most often report being responsible for.

Additional duties	Percentage of coders
Education and training of staff	63%
QI / QA work (includes auditing)	63%
Coding management	44%
Clinical management	31%
Administrative / reception work	30%
Intake / referral work	17%
Field nurse / therapist (making patient visits)	11%

Source: 2015 Diagnosis Coding Pro *Home Health Coders' Productivity Survey*

Dyer ultimately invested in as-needed outsourced coding, paying between $250 and $500 upfront and then about $50 per chart after that during the times the coder was away. This allowed her to project what she'd need to spend based on when her coder was expected to be out of the office, Dyer says.

As a result, cash flow decreases stemming from the coder's absences were halted, she says.

Address poor documentation to up coder productivity

Implement processes to help ensure the critical detail needed to accurately and completely code a record is obtained upfront, and you'll see productivity improve.

Consider that the single biggest barrier to coder productivity is incomplete information in the record as well as the time it takes to call providers to clarify diagnoses, according to 82% of respondents to *Diagnosis Coding Pro's* 2015 Home Health Coders' Productivity Survey of 230 coders.

OSF Healthcare in Peoria, Ill., instituted specific processes that have helped remove this barrier, says Margie Fitzgerald, HCS-D, one of the agency's coders. For example, they now send records back to clinicians when they don't contain enough detail to be properly coded.

In the past, they would have coded the record as well as they were able and then send a note to the clinician asking for more detail "next time," she says.

Simply refusing to code the record until more information was given had the effect of slowing down productivity to the point where management noticed and stepped in to help induce change, says Fitzgerald, who codes part-time on a team that includes four full-time coders, plus a supervisor and a manager.

Getting management involved in addressing the hindrance that poor clinician documentation is on coding productivity is imperative, says Judy Adams, HCS-D, presidents of Adams Home Care Consulting in Asheville, N.C.

Also, keep track of relevant data, such as through the "before and after" scenarios mentioned above, to help make the often-difficult argument for the worthiness of investing in more coders, Adams says. "The coder needs to be a data collector," she says.

While administrators don't often have trouble seeing the value in hiring more clinical staff, many of them don't automatically see the close connection between trained and competent coding staff and their bottom lines, says Jill Dyer, HCS-D, owner of JID Coding and Consulting in Houston, Texas. *(See coding and documentation example p. 7.)*

Demonstrate the revenue impact

Use this example to show the notable difference in potential case-mix points and revenue when adequate clinical documentation is obtained, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Original diagnostic statement: Patient has an ulcer of the left heel. The face-to-face and referral documentation says "SN (skilled nursing) for care of ulcer and occupational therapy to improve ADLs." OASIS reports this as a "stage 2 pressure ulcer with 30% slough." Patient is diabetic. This is an early episode, high therapy scenario.

Questions that should be raised:

- Physician has only specified that there's an "ulcer." What is the etiology?
- The nursing assessment is providing conflicting information by indicating that the ulcer is due to pressure and is a stage 2, but that slough is present. A stage 2 pressure ulcer cannot demonstrate slough in the wound bed; slough would indicate that the wound is at least a stage 3 ulcer.

There is no documentation that the etiology of pressure for the ulcer was confirmed with the physician.

Without further clarification, the scenario would be coded:

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Pressure ulcer, heel	707.07		
M1022: Pressure ulcer, stage 2	707.22		
M1022: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00		

Note: As a secondary diagnosis, diabetes will earn no case-mix points in an early episode, high therapy scenario. The pressure ulcer will earn 19 points when reported in M1324. The scenario will earn a total of 19 case-mix points.

If the nurse confirms that the ulcer is diabetic in origin, the scenario will be coded:

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled	250.80		
M1022: Ulcer of heel and midfoot	707.14		

Note: With the ulcer being confirmed as diabetic in origin, diabetes will be primary due to the etiology/manifestation convention. The primary diabetes diagnosis will earn eight case-mix points in an early episode, high therapy scenario. The diabetic ulcer (707.14) will earn 17 case-mix points as a skin 2 diagnosis. The scenario will earn 25 case-mix points, and even more importantly, the patient's condition is coded correctly.

Scenario 1: Estimated reimbursement	Scenario 2: Estimated reimbursement
Case-mix points from diagnoses = 0	**Case-mix points from diagnoses = 8**
Diabetes = 0	Diabetes = 8
C Score = 0 (C1)	**C Score = 8 (C3)**
M1200 (1) = 0	M1200 (1) = 0
M1242 (1) = 0	M1242 (1) = 0
M1400 (0) = 0	M1400 (0) = 0
M1620 (1) = 0	M1620 (1) = 0
F Score = 0 (F1) (as marked by the therapist)	**F Score = 0 (F1) (as marked by the therapist)**
M1810/20 (2) = 0	M1810/20 (2) = 0
M1830 (2) = 3	M1830 (2) = 3
M1840 (2) = 3	M1840 (2) = 3
M1850 (2) = 4	M1850 (2) = 4
M1860 (2) = 0	M1860 (2) = 0
S Score (Therapy) = S3 (14 visits)	**Score (Therapy) = S3 (14 visits)**
C1F1S3 (0.8499) = $2,516.88	**C3F1S3 (1.0131) =$3,000.17**
	Variance = (+$483.29)

— Megan Gustafson (mgustafson@decisionhealth.com)

Arthritis

(*continued from p. 1*)

There are numerous forms of arthritis, such as osteoarthritis (OA), traumatic arthritis and rheumatoid arthritis, and even more codes that capture them. Deciphering the detail about a patient's joint pain or arthritis diagnosis and assigning the right code isn't happening as often as it should, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

As a result, agencies are both leaving behind reimbursement to which they're entitled and making their records vulnerable to upcoding charges. Home health clinicians and coders make wrongful, and potentially costly, assumptions about patient's joint pain and arthritis diagnoses all the time, Whitemyer says.

"Every coding audit I've ever done, there is some number of charts that have this problem," she says.

Beware of domino effect when making assumptions

Don't code localized primary OA of the knee (715.16) solely on the basis that there's a diagnosis of arthritis in the patient's record and the clinician's documentation indicates that the patient is experiencing knee pain.

This scenario begins when the assessing clinician sees the diagnosis of "arthritis," hears from the patient that her knees hurt and writes "OA" for osteoarthritis on the record. The wrong assumptions begin to domino when the coder takes it one step further and assumes ***osteoarthritis***, and then that it's a ***primary form*** of the condition, and finally that it is ***localized*** to the knee, resulting in 715.16 being coded, Whitemyer says.

But, ***none*** of these conditions can be coded without a physician specifically diagnosing primary localized OA of the knee, she says. The patient could have rheumatoid arthritis (714.0), traumatic arthritis (716.1x) resulting from an injury, or secondary arthritis (715.2x) caused by something like obesity.

Or the patient may not have arthritis in her knees at all; the arthritis may be somewhere else and she may have an entirely separate injury or condition that's causing the knee pain, she says.

"Until the doctor says OA, it's joint pain," Whitemyer says. Code joint pain with a code from the 719.4x series (Pain in joint).

More alarmingly, because there are four potential case-mix points available for the 715 series codes when the disease is impacting the hips and knees, if you code knee osteoarthritis when all you know is "arthritis," you could be upcoding, says Whitemyer, who's seen records get denied for over these kinds of mistakes.

Understand the types of arthritis to code correctly

Seek out a specific arthritis diagnosis, such as OA of the hip or rheumatoid arthritis, when possible, as doing so could earn your agency case-mix points it would otherwise forfeit, something no agency can afford to turn down in the wake of the 2015 case-mix deletions *[CPH, 12/14]*.

Note that codes that specify OA (primary or secondary, localized or unspecified whether localized or generalized) of the hips and knees (715.15-16, 715.25-26, 715.35-36, 715.95-96) carry case-mix points, as do the codes for rheumatoid arthritis (714.0) and traumatic arthritis (716.1x). Comparatively, the codes you must use when all you know is "arthritis" (716.9, Arthropathy, unspecified), carry none.

So if you suspect that a patient's vague arthritis diagnosis may actually be something more specific, it behooves you to call the doctor and find out, says Lynn Speckels, HCS-D, vice president of Healthcare ConsultLink in Fort Worth, Texas. Not only is this a coding best practice but it'll also ensure that your agency receives all the reimbursement to which it is entitled.

Consider that OA generally results from wear and tear on joints from the aging process, whereas rheumatoid arthritis is an autoimmune disease that causes distinctive joint deformities, Whitemyer says. Primary OA develops on its own while secondary OA results from another disease process.

Traumatic arthritis, as the code title suggests, results from trauma such as a fracture, says Pam Drake, HCS-D, coder for Daymarck in Bismarck, N.D.

Cases of traumatic arthritis are rare in home health, so when they do occur, the physician is likely to specify the diagnosis, Whitemyer says.

More tips to get arthritis coding right

Here are six more tips to help you assign the most accurate arthritis code:

• **Assign a code from the 715.9x series (Osteoarthrosis, unspecified whether generalized or localized)** for a confirmed diagnosis of OA but without further knowledge as to whether the OA is generalized or localized, or primary or secondary, Whitemyer says. The fifth digit will specify the location.

• **Code OA as an active diagnosis *if* a patient receiving aftercare for a joint replacement** is said to have it in both knees, for example, but only one was replaced, says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston. However, don't continue to code the diagnosis as active if the chart is clear that the OA was limited to the joint that was replaced because it is now a resolved condition.

• **Assign separate arthritis codes for each affected site that is specified**, Speckels says. This will keep your coding compliant with official coding guidelines and will also ensure that you receive any case-mix points to which you may be entitled. For example, if the patient has OA in his knees and shoulders and you code 715.89 (Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized) thinking you're covering them both with one code, you are incorrect.

• **Code OA that's specified as affecting two bilateral joints**, such as the both knees, as OA that's localized to the knee, according to Coding Clinic Q2 1995.

• **Understand that degenerative joint disease (DJD)** is the equivalent of OA and you can code it as such, Whitemyer says.

• **Capture traumatic arthritis first with 716.1x**, and then follow with the late effect code of the injury it resulted from, Blevins says. For example, you'd code traumatic arthritis in the ankle resulting from a fracture with 716.17 (Traumatic arthropathy, ankle and foot), followed by 905.4 (Late effect of fracture of lower extremities).

Scenario: Degenerative joint disease

A 77-year-old man is admitted to home health for aftercare following a joint replacement to treat DJD localized to his knees. His chart indicates that he still has DJD in his right knee and will undergo surgery for that at a later date. He will receive nursing care as well as physical therapy. He is also an insulin-dependent diabetic and has hypertension.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix 3	4
M1020a Orthopedic aftercare following joint replacement	V54.81		
M1022b Osteoarthrosis, localized, not specified whether primary or secondary, lower leg	715.36		
M1022c Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00		
M1022d Essential hypertension, unspecified	401.9		
M1022e Organ or tissue replaced by other means, knee joint	V43.65		
M1022f Encounter for aftercare, long-term (current) use of insulin	V58.67		

Rationale:

• As the focus of care, the aftercare following joint replacement is coded primary. Because the DJD was present in both knees and only one was replaced, it is still coded as an active condition and is coded as localized because it was specified as such.

• The status code V43.65 is required to be reported to specify that the patient's knee was replaced.

• Because the patient's diabetes was not specified at Type 1 and he is insulin-dependent, the code for insulin use (V58.67) must be assigned.

Scenario: Traumatic arthritis, breast cancer

A 76-year-old woman comes to home health for physical and occupational therapy to address pain she is experiencing related to traumatic arthritis in her left shoulder, after she dislocated it in a fall five years ago. The plan is to work on strengthening and learning adaptive movement to increase her mobility and completion of ADLs. She is also undergoing treatment for breast cancer, which she receives in her doctor's office.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix 3	4
M1020a Multiple therapies	V57.89		
M1022b Traumatic arthropathy, shoulder region	716.11		
M1022c Late effect of dislocation	905.6		
M1022d Malignant neoplasm of breast (female), unspecified	174.9		
M1022e Late effects of accidental fall	E929.3		

Rationale:

- As a therapy-only case, the V57.89 code must be assigned first.
- The traumatic arthritis in the patient' shoulder is captured first with the 716.11 code, followed by 905.6 to indicate that it is the late effect of a dislocation.
- Though the agency isn't providing the treatment for the breast cancer, it is a relevant comorbidity that will impact her plan of care, and thus it is coded as well.
- The external cause code, E929.3, is added to help paint the picture of how the patient sustained the injury that resulted in the need for therapy.

Scenario: Aftercare, rheumatoid arthritis

A 65-year-old man is admitted to home health for surgical aftercare following an emergency appendectomy. He will also receive physical therapy to treat pain and mobility issues caused by arthritis. Before assigning the code for unspecified arthropathy (716.90), the coder called the physician and found out that that patient's diagnosis is rheumatoid arthritis.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix 3	4
M1020a Aftercare following surgery of the teeth, oral cavity and digestive system, NEC	V58.75		
M1022b Rheumatoid arthritis	714.0		

Rationale:

- As the focus of care following an appendectomy, V58.75 is coded primary.
- With the diagnosis specified as rheumatoid arthritis, the correct code to capture the condition is 714.0. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Expect new wave of diabetes denials

Ensure there is a recent HbA1c test result in patients' charts for whom you're coding diabetes, or prepare to lose money or even face outright claims denials.

A new Local Coverage Determination (LCD) from the Palmetto Medicare Administrative Contractor (MAC) requires current – within 120 days – HbA1c test results be noted in the charts of diabetes patients. The directive applies to services performed on or after Dec. 30, 2014.

"Reasonable and necessary home health plans of care for Medicare beneficiaries with Type II diabetes must therefore include the monitoring and reporting of not only intermittent capillary blood/serum glucose levels but also quarterly (and no less often than 120 days) HbA1c levels," the LCD says.

The directive includes both start of care and recert episodes and if current HbA1c results aren't in the record, the agency cannot bill for the epsiode of care. Furthermore, if no current HbA1c result is on file for a start of care episode that began prior to Dec. 30, 2014, the test result must be obtained before a recert episode beginning on or after Jan. 1, 2015 can be billed, according to a January Ask the Contractor Call with Palmetto.

This requirement is new and it applies whether the claim lists diabetes as a primary or secondary diagnosis, says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston.

Without a current HbA1c test on file, it's possible that the claim could be downcoded by however many points the diabetes diagnosis, when coded secondary, earned. If the claim is based on the diabetes diagnosis as the primary reason for care, the lack of a current HbA1c could result in the claim being completely denied, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Implement best practices going forward

If there is no current test data, agencies should obtain an order to draw the lab, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

Whitemyer recommends that agencies keep logs with current test results and request HbA1c lab draws for diabetes patients as a matter of protocol.

While a diabetes patient may have hyperglycemia for a long time, a single blood sugar reading may not show it, which makes the HbA1c more critical to support use of diabetes with hyperglycemia codes (such as E11.65, Type 2 diabetes mellitus with hyperglycemia) in an ICD-10 environment, she says. Note that "controlled" and "uncontrolled" are no longer part of the diabetes code titles in ICD-10

Additionally, you must assign V58.67 (Long-term (current) use of insulin) for an insulin-dependent type 2 diabetic and documentation must support its use, according to the LCD.

Editor's note: *To view the LCD, go to http://go.cms.gov/1xFyTIL.*