# 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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## Clear up the COPD coding confusion, answer your toughest questions

Conquer the confusion that surrounds the coding of common pulmonary conditions, including chronic obstructive pulmonary disease (COPD), and avoid charges of upcoding, or even worse, losing rightful reimbursement.

The conditions that fall under the umbrella of COPD are sources of tremendous confusion for coders. There are more than 25 unique codes available in the Chronic obstructive pulmonary disease and allied conditions category (code ranges 490 to 496) in Chapter 8 (Diseases of the Respiratory System).

(*see* ***COPD FAQ***, *p. 6*)

***Transition to ICD-10***

## Learn when to properly assign A vs. B infectious organism codes in ICD-10

Never assign A49.02 (Methicillin resistant Staphylococcus aureus infection, unspecified site) to capture a MRSA organism that's caused acute bronchitis in a COPD patient, or you could be putting your claims at risk.

Instead, assign B95.62 (Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere) directly following the code for the lung condition, J44.0 (Chronic obstructive pulmonary disease with acute lower respiratory

(*see* ***Infectious organisms***, *p. 8*)

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## Make sense of sepsis in ICD-9 & ICD-10

Whether it's making sense of the different terminology used to describe these conditions, figuring out vague documentation or choosing the right code and sequencing it properly, coding bacteremia, septicemia, SIRS, sepsis and severe sepsis is extremely confusing. Adding to the confusion, the rules will change when ICD-10 arrives. Join home health coding expert Brandi Whitemyer on **Thurs., Feb. 19 at 1 p.m. E.T.,** to learn how to accurately capture these conditions ***in both code sets***. For more information and to register, go to *http://www.decisionhealth.com/conferences/A2569.*

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**Tool of the Month: Quick Guide to Coding COPD in ICD-9 and ICD-10** Extra

## Avoid palpitations when coding heart failure in ICD-10

You won't have to worry anymore over whether to assign one code or two for a patient with diagnoses of acute-on-chronic diastolic heart failure and congestive heart failure, once ICD-10 arrives. One combination code, I50.33 (Acute on chronic diastolic (congestive) heart failure), is all you'll need.

Currently in ICD-9, two codes are required for a patient who has both the aforementioned conditions: 428.33 (Acute on chronic diastolic heart failure) and 428.0 (Congestive heart failure NOS).

The change in ICD-10 results from the fact that the word "congestive" has been included as a non-essential modifier on all except one — I50.1, Left ventricular failure — of the heart failure codes.

A non-essential modifier is a term encased in parentheses on a particular code, but the patient doesn't have to have the condition in the parentheses in order to assign the code, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

This means that when you assign I50.33, it covers a patient who has acute on chronic diastolic heart failure ***and*** congestive heart failure (CHF), but I50.33 is ***also*** appropriate for a patient with acute on chronic diastolic heart failure when the documentation doesn't also state CHF, Twombly says.

Neglecting to assign both codes in ICD-9 when appropriate is one of the most common mistakes coders make when coding heart failure, but the way ICD-10 has set up heart failure codes, this mistake will be prevented, says Michelle Mantel, HCS-D, quality assurance manager of the southeast region for Gentiva Health Services in Atlanta.

### Dive into ICD-10 heart failure coding rules

The ICD-10 codes that capture heart failure are found in Chapter 9 (Diseases of the circulatory system), and from there within the I50.- category (Heart failure).

Similar to ICD-9, there are options to capture left ventricular failure (I50.1), systolic heart failure (I50.2-), diastolic heart failure (I50.3-), combined systolic and diastolic heart failure (I50.4-) and unspecified heart failure (I50.9). The ICD-9 equivalents are found in the 428 series (Heart failure).

Also similar to ICD-9, the codes for systolic, diastolic and combined systolic and diastolic heart failure include fifth digits that specify whether the condition is acute (for example, I50.21, Acute systolic (congestive) heart failure), chronic (I50.32, Chronic diastolic (congestive) heart failure) or acute on chronic (I50.33).

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***Tip:*** Assign the non-specific I50.9 (Heart failure, unspecified) for a diagnostic statement of "congestive heart failure" with no further detail, Twombly says. This is the ICD-10 equivalent of 428.0 (CHF NOS). Note that "Congestive heart failure NOS" is an inclusion term under this code.

## Understand pathophysiology to select the right code

Do not assign I50.1 (Left ventricular failure) on the same claim with I50.9 (Heart failure, unspecified). This is because I50.1 refers to heart failure that is on the left side of the heart only, whereas the I50.9 code captures right-side heart failure ***that has been caused by*** left-side heart failure, Twombly says.

Developing a keen understanding of the pathophysiology behind the different kinds of heart failure — left ventricular, congestive, systolic, diastolic — can help you make sense of the available code choices, both now and in ICD-10, she says.

For example, the reason that you'd never assign I50.1 with I50.9 is because a person with CHF already has left-side heart failure, Twombly says. Thus, the assignment of both codes would be redundant.

On the other hand, including the I50.9 code for a patient who only has left-side failure amounts to giving a person a record of a condition he or she doesn't have. "If you have left-side heart failure only, the right is not involved," Twombly says.

Note that this guidance is a direct carry-over from ICD-9, where coders also may not assign 428.1 (Left heart failure) together with 428.0 (Congestive heart failure NOS), Mantel says.

Furthermore, understand that systolic and diastolic heart failure are ***specific areas of failure of the left ventricle*** of the heart, Twombly says. In systolic failure, the heart can't pump enough blood out. In diastolic failure, the heart cannot properly relax enough between beats to adequately fill up again.

Patients can have both types at the same time, which is captured by the I50.4- category (Combined systolic (congestive) and diastolic (congestive) heart failure).

Diagnostic statements of "left heart failure" or "left ventricular failure" are rare in home health, though. Generally, heart failure is specified as either being systolic or diastolic or as simply congestive, Twombly says.

***Tip:*** Never make an assumption about whether a patient's heart failure is acute or chronic, Twombly says. "The physician has to diagnose the failure as chronic," she says. While it's possible to be treated for acute heart failure in the home health setting, it's worth a call to the physician to determine whether chronic is the more appropriate diagnosis.

## Scenario: Acute systolic heart failure, CHF

An 87-year-old woman was hospitalized for an acute exacerbation of systolic heart failure. She also has congestive heart failure and atrial fibrillation. She recently started taking a new anticoagulant and antihypertensive medication for her severe hypertension, and will receive skilled nursing as well as physical and occupational therapy for her severe shortness of breath. A call to her cardiologist reveals that the appropriate heart failure diagnosis is acute on chronic systolic heart failure.

***Code the scenario in ICD-9:***

| Primary and Secondary Diagnoses | | M1024 Case Mix 3 | 4 |
|---|---|---|---|
| **M1020a** Systolic heart failure, acute on chronic | 428.23 | | |
| **M1022b** Congestive heart failure, unspecified | 428.0 | | |
| **M1022c** Atrial fibrillation | 427.31 | | |
| **M1022d** Essential hypertension, unspecified | 401.9 | | |
| **M1022e** Long-term use of anticoagulants | V58.61 | | |

***Rationale***:

- The physician specified the diagnosis as acute on chronic systolic heart failure and thus 428.23 is the most appropriate code for M1020.
- A second code, 428.0, must be added to capture that she also has a diagnosis of congestive heart failure.
- The physician did not state that the patient's hypertension caused the heart failure. Thus, it is appropriately captured with the 401 series (Essential hypertension) and not the 402 series (Hypertensive heart disease).
- Her long-term use of anticoagulant medication is captured with V58.61.
- Though her shortness of breath is a major component of her care, it is considered integral to a diagnosis of heart failure and is therefore not coded separately.

***Code the scenario in ICD-10:***

| Primary and Secondary Diagnoses | | | M1025 Additional diagnoses | |
|---|---|---|---|---|
| **M1021** | Acute on chronic systolic (congestive) heart failure | I50.23 | | |
| **M1023** | Unspecified atrial fibrillation | I48.91 | | |
| **M1023** | Essential (primary) hypertension | I10 | | |
| **M1023** | Long term (current) use of anticoagulants | Z79.01 | | |

***Rationale:***

- Only one code, I50.23, is required to capture both the acute on chronic systolic heart failure and the congestive heart failure.
- Note the level of specificity available to capture atrial fibrillation in ICD-10. Where ICD-9 offers only one code for this condition (427.31), the ICD-10 category I48.- (Atrial fibrillation and flutter) offers four different subtypes (paroxysmal, persistent, chronic and unspecified).

*— Megan Gustafson (mgustafson@decisionhealth.com)*

***Editor's note:*** *See more heart failure scenarios online at www.HHCodingCenter.com.*

## CB Coding Basics

# Get specific to accurately code GI conditions in ICD-10

*By Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O*

You need just one code to capture co-occurring gastroesophageal reflux (GERD) and esophagitis in ICD-10: K21.0 (Gastroesophageal reflux with esophagitis). By contrast, in ICD-9 you need two codes — 530.81 for the GERD and 530.11 for the esophagitis.

While the coding of many conditions will be simplified by the presence of combination codes, the coding of gastrointestinal (GI) conditions in ICD-10 will also require greater attention to detail and an enhanced knowledge of anatomy and physiology.

This is because many of the codes that capture gastrointestinal disorders in ICD-10 are combination codes that not only include the diagnosis, but also the symptoms that may manifest from the condition. Because of this, you'll need to know more detail about these diagnoses than is currently required to code them accurately.

ICD-10 codes for GI conditions are found in Chapter 11 (Diseases of the Digestive System) and range from K00.- (Disorders of tooth development and eruption) to K95.- (Complications of bariatric procedures).

Common gastrointestinal disorders that will require enhanced specificity in ICD-10 include GERD, Barrett's esophagus and diverticular disease.

## How to code Barrett's esophagus & diverticular disease

Enhancing your knowledge of the pathology of the disease process for GI conditions will aid you in identifying what level of detail you'll need to know to code these diseases in ICD-10. For example, consider the diagnosis of Barrett's esophagus.

Since patients with this condition often develop dysplasia within the esophagus, if the medical record indicates both esophageal dysplasia and Barrett's esophagus, you will assign a code from the K22.71- category to indicate Barrett's esophagus with dysplasia. The sixth character will specify the level of dysplasia, such as K22.711 (Barrett's esophagus with high grade dysplasia).

In the current system, this condition is captured with 530.85 (Barrett's esophagus), and dysplasia is not included in the code choice. There is no unique ICD-9 code for dysplasia associated with Barrett's esophagus.

***Tip:*** Code only Barrett's esophagus (K22.7-) for a diagnosis specified as an esophageal ulcer with Barrett's esophagus due to the presence of an Excludes 1 note that disallows an esophageal ulcer (K22.1-) from being coded on the same claim as Barrett's esophagus.

Diverticular disease of the intestine is another example of a GI condition for which ICD-10 offers more specific code choices than are currently available. This disease is coded to category K57.- (Diverticular disease of intestine). Codes within this category are not only specific to diverticular disease of the small and large intestine, but also include specific codes for the presence of bleeding and perforation and/or an abscess.

To accurately assign these ICD-10 codes, you'll need to know specifics about the patient's condition and any associated complications. Should a patient have a diagnosis of diverticulitis of the large intestine, for example, you'll need to first identify if the patient had a resulting abscess and/or perforation.


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Imagine a patient with diverticulitis with an abscess or perforation. You'll start with the K57.2- category, but you'll need more information to choose the appropriate fifth character which indicates whether bleeding is present (K57.21) or not (K57.20).

Remember that coding any gastrointestinal condition in ICD-10 will require a closer examination of the clinical record in order to assure that any associated symptoms are coded using the correct combination code when this is an option.

***Tip:*** Be sure to carefully review medical record documentation and the diagnoses provided by the physician. The record will need to support the assignment of any of these combination codes with a confirmed diagnosis by the physician.

## Clinician documentation ties it all together

Make sure that the home health clinical record supports coding a more specific diagnosis, in addition to obtaining more specific physician documentation. If the clinical record does not address the specifics of a combination code under consideration, more clear documentation from the assessing clinician will be necessary.

For example, if the physician records provided indicate that the patient has esophageal reflux and reflux esophagitis, clinicians should indicate the esophagitis as well as the reflux in the admission and plan of care.

Obtaining history and physical documents, physician progress notes, and other medical records pertinent to the patient upon admission is critical. Start stressing the importance of obtaining these documents to the staff members responsible for the admission process and begin implementing processes within the agency to secure these records at that time.

Lack of support for diagnoses in the clinical record, as well as unclear or unavailable physician confirmation of a diagnosis, result in a less specific and, ultimately, a poorly supported claim. Coding guidelines require the assignment of the most specific code and it is always in the best interest of the agency to obtain detailed information and reflect this in the plan of care and clinical record. When documentation is not present to support assigned codes, the claim and your agency's reimbursement may be at risk.

## Scenario: Gastroesophageal reflux

A patient is admitted to home health following an exacerbation of gastroesophageal reflux disease with significant reflux that has affected her appetite and caused a weight loss of 35 pounds. Her H&P notes "significant reflux esophagitis."

***Code the scenario in ICD-9:***

| Primary and Secondary Diagnoses | | M1024 Case-mix diagnoses | |
|---|---|---|---|
| **M1020:** Esophageal reflux | 530.81 | | |
| **M1022:** Reflux esophagitis | 530.11 | | |

***Rationale:***

- This condition requires two codes in ICD-9 to indicate both the reflux and the esophagitis.

***Code the scenario in ICD-10:***

| Primary and Secondary Diagnoses | | M1025 Additional diagnoses | |
|---|---|---|---|
| **M1021:** Gastroesophageal reflux disease with esophagitis | K21.0 | | |

***Rationale:***

- The availability of a combination code in ICD-10 enables both conditions to be captured in one single code.

## Scenario: Barrett's esophagus

A patient is admitted to home health for teaching regarding newly diagnosed Barrett's esophagus with low-grade dysplasia.

***Code the scenario in ICD-9:***

| Primary and Secondary Diagnoses | | M1024 Case-mix diagnoses | |
|---|---|---|---|
| **M1020:** Barrett's esophagus | 530.85 | | |

***Rationale:***

- There's no way to indicate that the patient also has low-grade dysplasia along with Barrett's esophagus in ICD-9. Thus, only the Barrett's esophagus is coded.

***Code the scenario in ICD-10:***

| Primary and Secondary Diagnoses | | M1025 Additional diagnoses | |
|---|---|---|---|
| **M1021:** Barrett's esophagus with low grade dysplasia | K22.710 | | |

***Rationale:***

- There are three separate codes for Barrett's esophagus with dysplasia in ICD-10, depending on

the grade of the dysplasia. In this case, K22.710 is the appropriate code choice.

***About the author:*** *Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, is an AHIMA-Approved ICD-10-CM Trainer and the Product Specialist for DecisionHealth in Gaithersburg, Md. She continues to provide quality oversight for Transitions Health and Wellness Solutions, an outsourced coding and QA firm, in Harlingen, TX. She can be reached at bwhitemyer@decisionhealth.com.*

## Ask the Expert

## Code breast cancer & heart transplant

***Question:*** *The patient was admitted for neglected fungating breast cancer. Does the breast cancer code cover the wound or do I need to code it separately?*

**Answer:** Code a fungating ulcer caused by breast cancer with 174.9 (Malignant neoplasm of breast (female), unspecified) for the cancer, and immediately follow it with 707.8 (Chronic ulcer of other specified sites) to capture the ulcer. You may also include V58.30 (Encounter for change or removal of nonsurgical wound dressing) for the wound care.

***Question:*** *What codes should I be including for a heart transplant? I assigned V58.73 (Aftercare following surgery of the circulatory system, NEC) and V42.1 (Heart replaced by transplant). Should V58.73 be primary? The patient's only other diagnosis is diabetes, which is stable.*

**Answer:** Don't assign V58.73 (Aftercare following surgery of the circulatory system, NEC) for aftercare following a heart transplant because there is a specific code for aftercare following organ transplant, V58.44 (Aftercare following organ transplant).

Secondly, there is a use additional code note on V58.44 to identify the transplanted organ with a code from V42.x (Organ or tissue replaced by transplant). For this scenario, you'd assign the code you already noted, V42.1 (Heart replaced by transplant).

You would then code 250.00 (Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled) for the diabetes. You could also include V58.31 (Encounter for change or removal of surgical wound dressing) if your agency is providing care to the surgical wound and V58.67 (Long-term (current) use of insulin) if the patient uses insulin.

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

## COPD FAQ

*(continued from p. 1)*

Confusion is further compounded by the different ways that physicians describe the condition. Some will just record "COPD" while others specify multiple forms that are co-occurring, leaving coders to grapple with what code — or codes — to assign.

To help you see through the COPD fog, *Diagnosis Coding Pro for Home Health* compiled some of the most frequently asked questions about these diseases and sought expert answers to aid you in coding these cases accurately and defensibly.

***Q: Where should I start to try to make sense of all these COPD codes?***

**A:** Begin by developing an understanding of what COPD refers to. COPD is a non-specific term that describes a set of irreversible, obstructive diseases of the lungs. These diseases fall into three separate components depending on the area of the lungs and type of cells affected: chronic obstructive bronchitis, emphysema and chronic obstructive asthma, says Trish Twombly, HCS-D, senior director for DecisionHealth in HCS-D.

The ICD-9 code set offers separate codes for each of these components. The 491 series captures chronic bronchitis while the 492 series captures emphysema and the 493 series captures asthma. There's also a non-specific code (496) that can be assigned when the diagnosis given is just "COPD."

Finding the correct code requires that you determine, based on the physician's documentation, which aspect of the disease the patient has or if the patient has multiple aspects of the disease simultaneously, which aspect is the most troublesome, Twombly says.

***Q: How do I find the right COPD code?***

**A:** Start in the alphabetic index; don't jump directly to the tabular. Search under 'disease, lung, obstructive' and then scroll down to the specific diagnosis, says Jean Bird, HCS-D, QA manager for Gentiva Home Health in Fall River, Mass.

For example, if the diagnosis is "COPD with asthma," the index search described above will lead to the

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493.2x category (Chronic obstructive asthma), where you'll choose the code based on whether the condition is occurring with acute exacerbation (493.22), status asthmaticus (493.21) or is unspecified (493.20).

Mistakes are often made when coders don't use the coding manual correctly and jump to the tabular before first searching the index, she says.

***Q: I have a patient with a diagnosis of decompensated COPD. How do I code this?***

**A:** Code decompensated COPD as acutely exacerbated obstructive chronic bronchitis with 491.21 (Obstructive chronic bronchitis with (acute) exacerbation), according to Q3 2002 Coding Clinic guidance. "Decompensated COPD is an exacerbation of COPD," according to the Coding Clinic.

***Q: If the doctor's diagnosis is "end-stage COPD" can I code that as exacerbated COPD with 491.21 (Obstructive chronic bronchitis with (acute) exacerbation)?***

**A:** Yes. End-stage COPD is COPD that is decompensating which is captured with 491.21, Bird says.

However, it's advisable in cases like these to seek confirmation from the physician, and to document that communication in the record, Twombly says.

***Q: How do I code a diagnosis described as "emphysema with COPD"?***

**A:** Code this diagnosis with 492.8 (Other emphysema), Twombly says.

This diagnostic statement indicates that the patient has been diagnosed with COPD, and that the type of COPD has been specified as emphysema. It's thus captured with the 492 series, she adds.

***Q: How do you code emphysema with chronic bronchitis? And, how do you code a diagnosis of COPD that indicates the patient has multiple aspects of the disease simultaneously, such as COPD with bronchitis and asthma?***

**A:** Code emphysema with chronic bronchitis with 491.20 (Obstructive chronic bronchitis without exacerbation), Twombly says. Do not assign an additional code for the emphysema because there's an exclusion note on 492.8 (Other emphysema) that excludes "emphysema with chronic bronchitis (491.20-491.22).).

Furthermore, do ***not*** assign more than one code for a patient who's been diagnosed with more than one form of COPD, Twombly says. Rather, code only the aspect of the disease the physician has specified is the greatest concern.

The basis for this comes from the exclusion notes on each of the codes for the various components of COPD that clearly exclude other COPD diagnoses.

For example, don't assign both 491.20 and 493.20 for a patient with obstructive chronic bronchitis and obstructive chronic asthma, she says. Code whichever component of the COPD is the most prominent. So, if that's obstructive chronic asthma, assign 493.20 (Chronic obstructive asthma, unspecified) [*CPH, 11/12*].

***Q: The patient's chart indicates that COPD is the focus of care, but the diagnosis of COPD is all I have. Can I code 496 in the primary position?***

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**A:** Yes, you ***can*** assign 496 (COPD NOS) in the primary position on a home health claim as it is a valid code and if you have no further information beyond "COPD," 496 is your only option, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

However, you should make every effort to find a more specific code because code 496 is a non-specific code that implies that the patient has a chronic lung disease that is stable, which begs the bigger question of why your agency would admit a patient with a stable disease, Bird says.

***Tip:*** Ask your provider referral sources to change how they word their diagnostic statements to make it easier to identify the appropriate code, says Cheryl Andrews, HCS-D, coder for Eastern Maine Homecare in Caribou, Maine. For example, ask providers to use specific words like "exacerbation" and "decompensated."

**Tip:** Look for clues that may indicate a patient's COPD is exacerbated, such as the use of inhalers or a need for oxygen greater than 2 liters per hour, and query the physician about it, Andrews says.

***Q: How do I code a patient with obstructive chronic bronchitis who also has acute bronchitis?***

**A:** Assign the combination code 491.22 (Obstructive chronic bronchitis with acute bronchitis), says Whitemyer. Note that 491.22 includes any acute exacerbation that may also be present, so another code to indicate exacerbated COPD isn't necessary.

***Q: I have a patient who came to home health to be treated for pneumonia who also has COPD. Can I assume, because of the pneumonia, that the patient's COPD is exacerbated and code it with 491.21?***

**A:** No. You cannot assume that COPD is exacerbated simply because the patient has another respiratory issue like pneumonia, Whitemyer says. You also may not assume an exacerbation simply because a patient's medications were changed. The exacerbation must be documented by the physician.

In this scenario, you'd code the pneumonia (486) as your focus of care, and if you're unable to get any further information about the COPD, you must code it with 496 (COPD NOS). It is incorrect to code the COPD with 491.21 (Obstructive chronic bronchitis with (acute) exacerbation) in this case because it would be considered upcoding, she says.

See the below scenario for example of how to code pneumonia and COPD.

### Scenario: Pneumonia, COPD, diabetic ulcer

A 79-year-old man comes to home health to continue recovery from pneumonia, for which he was just hospitalized. He also has COPD, which his physician stated has now decompensated due to the pneumonia. He's a type 1 diabetic and has a small diabetic ulcer on his big toe that will require wound care as well.

***Code the scenario:***

| Primary and Secondary Diagnoses | | M1024 Case Mix 3 | 4 |
|---|---|---|---|
| **M1020a** Pneumonia, organism unspecified | 486 | | |
| **M1022b** Obstructive chronic bronchitis with (acute) exacerbation | 491.21 | | |
| **M1022c** Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled | 250.81 | | |
| **M1022d** Ulcer of toe | 707.15 | | |

— *Megan Gustafson (mgustafson@decisionhealth.com)*

## Infectious organisms

*(continued from p. 1)*

infection), says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

Use codes from the B95.- (Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere), B96.- (Other bacterial agents as the cause of diseases classified elsewhere) or B97.- (Viral agents as the cause of diseases classified elsewhere) categories when a patient has an infection that was caused by a disease that is classified in a chapter ***other than*** Chapter 1 (Certain infectious and parasitic diseases), according to official coding guidelines [*I.C.1.b*].

Conversely, a MRSA infection caused by a condition that is classified to Chapter 1, like sepsis, would be captured by a code beginning with the letter "A." In this case, it would be A41.02 (Sepsis due to Methicillin resistant Staphylococcus aureus).

Coders frequently struggle over whether they'll need to assign an "A" or a "B" code to capture the organism that is causing a patient's infection in ICD-10, says Brandi

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Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

It's important to learn how to use these codes correctly now, as assigning the wrong infectious organism codes, and/or sequencing them incorrectly, could potentially put your claims at risk as CMS is becoming more stringent about rejecting claims that don't adhere to coding guidelines, Twombly says.

## Draw parallels from ICD-9 to understand ICD-10

Grasp the difference between "A" and "B" infecting organism codes by understanding how their ICD-9 equivalents are currently used.

While the separation into "A" and "B" code choices creates confusion for coders, the ICD-10 guideline that governs the use of the differing infecting organism codes doesn't constitute a change from how these conditions are classified now in ICD-9, Twombly says.

In ICD-9, organisms causing infection in diseases classified ***other than Chapter 1*** (Infectious and Parasitic Diseases) are now captured with the 041 series (Bacterial infection in conditions classified elsewhere and of unspecified site), such as 041.09 (Streptococcus infection, other, in conditions classified elsewhere and of unspecified site), Twombly says.

For example, a 041.xx code would be appropriate to capture a streptococcus organism that is infecting a surgical wound. In ICD-10, these conditions will be captured with "B" codes, she says.

Conversely, the 038 series (Septicemia) now captures infectious organisms causing diseases that are ***classified to Chapter 1***, such as 038.0 (Streptococcal septicemia). These codes refer to ***systemic infections*** rather than infections that cause other conditions classified elsewhere like the surgical wound infection mentioned above, says Whitemyer. These are the ICD-9 equivalents to "A" codes in ICD-10.

Note how "A" codes include the result of the infection, like sepsis, within the code title, while "B" codes always indicate that the infection has caused another disease or condition that's captured with a code found in another chapter, Twombly says.

This means that "A" codes ***can*** stand alone to fully describe a patient's infection, but "B" codes ***always*** require another code to be sequenced before them. For this reason, an "A" code can be sequenced in the primary position if the situation so dictates, but a "B" code cannot, she says.

***Tip:*** Understand that code titles that contain phrases like "in diseases classified elsewhere" are tip-offs that another code, that must be sequenced first, is required to indicate the result of the infection. These codes can never be placed in the primary slot, Twombly says.

***Tip:*** Note the instructions embedded within the Tabular for conditions that often occur with infection, such as cellulitis of the abdominal wall (L03.311), point the coder to assign a code from the B95.-, B96.- or B97.- categories if an infecting organism is present and known.

## Get sequencing right or risk having claims returned

Don't be surprised if CMS institutes an edit with the arrival of ICD-10 that will return to provider (RTP), without payment, claims that contain incorrectly sequenced infecting organism codes, says Twombly.

This would mean that a coding error such as assigning B95.62 (Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere) without first coding the condition resulting from the infection, such as T84.54xD (Infection and inflammatory reaction due to internal left knee prosthesis, subsequent encounter) for an infected left knee replacement, could cause your claim to be RTP'd or put it at an increased risk for an ADR, Twombly says.

Given the scrutiny that has been placed on hospice claims that incorrectly assign manifestation codes without a corresponding etiology, it's not outside the realm of possibility that CMS could begin targeting home health claims with similar sequencing errors, she says [*CPH, 10/14*].

However, regardless of the present or future consequences for sequencing errors, "your first rule of thumb should always be that you're striving to code within the conventions and guidelines," Twombly says. This is your best defense against ADRs and RTP'd claims.

## Tips for coding infectious organisms correctly

Here are four more tips to ensure your coding of infectious organisms stays in compliance:

- **Cross out the codes in the A49.- category (Bacterial infection of unspecified site) to remind yourself never to assign them.** They are too vague to ever have an appropriate use in home health, says Pallavi Sheth, HCS-D, clinical coding coordinator for the VNA of Englewood, N.J.

• **Don't ever assign an infecting organism code based on lab results alone,** says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va. A physician must confirm the diagnosis.

• **Code the condition without the infecting organism if the specific organism isn't specified,** Twombly says. While it's nice to know what the organism is, if it isn't specified you can still code the condition.

• **Use your judgment as a professional coder as to how much effort you'll put in to tracking down a specific infecting organism diagnosis.** If the infection is the focus of care and the patient's receiving IV antibiotics, coding the specific organism may be of value in supporting the claim. If it's not the focus of care, it may not be worth several calls to a physician to find out, Twombly says.

## Scenario: Cellulitis with E. coli

A 73-year-old woman comes to home health with a primary diagnosis of cellulitis on her groin that is infected with E. coli and is being treated with IV antibiotics. She also has diabetes and hypertension.

***Code the scenario:***

| Primary and Secondary Diagnoses | | M1025 Additional diagnoses | |
|---|---|---|---|
| **M1021:** Cellulitis of groin | L03.314 | | |
| **M1023:** Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere | B96.20 | | |
| **M1023:** Type 2 diabetes mellitus without complications | E11.9 | | |
| **M1023:** Essential (primary) hypertension | I10 | | |
| **M1023:** Encounter for adjustment and management of vascular access device | Z45.2 | | |
| **M1023:** Long term (current) use of antibiotics | Z79.2 | | |

***Rationale:***

• The E. coli infection caused cellulitis in the patient's groin, which is classified to Chapter 12 (Diseases of Skin and Subcutaneous Tissue). Therefore, the appropriate code to capture the infecting organism is B96.20.

• Code B96.20 is sequenced after the disease that it is causing, the cellulitis, in accordance with coding guidelines.

• The patient is receiving IV antibiotics and therefore Z45.2 and Z79.2 are coded to capture this.

• As important comorbidities, her diabetes and hypertension are also coded.

## Scenario: Streptococcal sepsis

An 84-year-old man is admitted to home health with a primary diagnosis of streptococcal sepsis, for which he will receive IV antibiotics. He also has a stage 2 pressure ulcer on his left heel and a stage 1 pressure ulcer on his left ear, for which he will receive wound care. He also has congestive heart failure, which will require monitoring as he was just prescribed new medications.

***Code the scenario:***

| Primary and Secondary Diagnoses | | M1025 Additional diagnoses | |
|---|---|---|---|
| **M1021:** Streptococcal sepsis, unspecified | A40.9 | | |
| **M1023:** Pressure ulcer of left heel, stage 2 | L89.622 | | |
| **M1023:** Pressure ulcer of head, stage 1 | L89.811 | | |
| **M1023:** Heart failure, unspecified | I50.9 | | |
| **M1023:** Encounter for adjustment and management of vascular access device | Z45.2 | | |
| **M1023:** Long term (current) use of antibiotics | Z79.2 | | |

***Rationale:***

• The patient's infection is a systemic infection classified to Chapter 1, and is therefore appropriately captured with A40.9. No other code is required.

• Note that ICD-10 pressure ulcer codes include the location of the ulcer as well as the stage in one combination code. — *Megan Gustafson (mgustafson@decisionhealth.com)*

# News briefs

• **Congressmen Fred Upton (R-MI) and Pete Sessions (R-TX) expressed a commitment to ensure ICD-10 implementation is achieved on Oct. 1, 2015,** and are prepared to have a hearing on the issue in 2015, according to a joint statement issued Dec. 10, 2014. They also vowed to work closely with CMS to ensure the Oct. 1, 2015 implementation date is met.

• **Correction:** The hypertension code in the "Type 1 diabetes with CKD, hypertension" scenario on page 9 of the January 2015 issue should have been I12.9 (Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease).

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