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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Correct your coding, documentation now or expect more case-mix losses down the road

Don't stop assigning the 201 codes that just lost their case-mix status or you'll confirm the validity of CMS' decision to cut payment for those conditions, which include the commonly assigned 491.21 (Obstructive chronic bronchitis with (acute) exacerbation) and 331.0 (Alzheimer's disease).

The changes in case-mix were driven by home health utilization data that indicate a lower level of resource use for the conditions that lost case-mix points. But experts say the data looks the way it does because of poor documentation *(CPH 12/14)*.

*(see **Documentation**, p. 5)*

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*.

Transition to ICD-10

ICD-10 simplifies coding of diabetic renal, ophthalmic & neurologic manifestations

Just ***one*** combination code, E11.311 (Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema), will sufficiently capture diabetic macular edema in ICD-10, whereas, in ICD-9, the condition requires three separate codes: 250.50 for the diabetes, 362.01 for background diabetic retinopathy and 362.07 for the diabetic macular edema.

ICD-10 will simplify the coding of renal, ophthalmic and neurological diabetic manifestations, as most of these conditions, which require a

*(see **Diabetes in ICD-10**, p. 7)*

In This Issue

Bolster coding, avoid more case-mix losses

Starting Jan. 1, you will no longer get case-mix points for more than 200 of your most commonly assigned home health codes as well as two OASIS items — and CMS says current coding and documentation practices have led to the losses. It's important than ever to make sure your coding and documentation can stand up to scrutiny. Join home health coding expert Brandi Whitemyer on **Wed., Jan. 28 at 1 p.m. E.T.**, to learn what you can do to improve your coding to better reflect the care provided and ensure proper reimbursement.

CB Coding Basics

Don't lose your breath coding COPD in ICD-10

By Jan Hayes-Favre, RN, HCS-D, HCS-O

Stop stressing about coding chronic obstructive pulmonary disease (COPD) and all its different forms — ICD-10 will make it easier.

Most forms of COPD will be captured by the J44.- category (Other chronic obstructive pulmonary disease) in ICD-10. By contrast, coders currently must choose between options in three separate code series for COPD: 493.2x (Chronic obstructive asthma), 492.x (Emphysema) and 491.2x (Chronic obstructive bronchitis), in addition to the generic 496 (COPD NOS).

In ICD-10, the J44.- category includes many COPD conditions, including ***chronic obstructive asthma***, ***chronic obstructive bronchitis*** and ***chronic bronchitis with emphysema***. The fourth character will specify whether the condition is unspecified (J44.9), exacerbated (J44.1) or co-occurring with an acute respiratory infection (J44.0).

Basics of coding COPD remain unchanged

Approach the coding of COPD with the same basic rules that you follow in ICD-9. Begin your search for the right code in the alpha index based on the specific term that the physician used to describe the condition. Once you locate the appropriate term, verify the code in the tabular. COPD codes are found in Chapter 10 (Diseases of the respiratory system) in ICD-10.

For example, searching under "Obstructive/ obstructed," then "airway" and then "chronic" leads you to J44.9, which corresponds to 'Chronic obstructive pulmonary disease, unspecified.'

The one form of COPD that is not captured by the J44.- category is emphysema that is not described as with chronic bronchitis, or as chronic bronchitis with emphysema. Emphysema by itself is coded to the J43.- category (Emphysema). This is because it is listed in an Excludes 1 note in the J44.- category, which reflects the fact that emphysema affects a different part of the lungs than either chronic bronchitis or chronic asthma.

Tip: Pay attention to Excludes 1 and 2 notes for further direction. In a clear distinction from ICD-9, ICD-10 contains two different types of Excludes notes. An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note. An Excludes 2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient

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may have both conditions at the same time, according to coding guidelines *[I.A.12]*.

Tip: Assign two codes for a patient who has COPD (any condition that would fall under the J44.-category) and a type of asthma that is coded to the J45.- category (Asthma). There is a "code also" note on the J44.- category instructing the coder to include a code from J45.- if applicable. However, understand that the type of asthma captured by the J45.- category is ***separate from*** the chronic obstructive asthma form of COPD that is included within the J44.- umbrella.

Code exacerbated vs. uncomplicated COPD

Be careful to distinguish uncomplicated COPD from a case that is acutely exacerbated. If a diagnosis of COPD is exacerbated, you'll indicate this with a fourth character of "1," as shown in the crosswalk *(see the COPD crosswalk on page 4)*, such as J44.1 (Chronic obstructive pulmonary disease with (acute) exacerbation).

An acute exacerbation is defined as a worsening or decompensation of a chronic condition. Remember that only a physician can specify an exacerbation; you can never assume. While an exacerbation is ***not*** the same thing as an infection (such as pneumonia) that is complicating a chronic condition, an exacerbation may be ***triggered by*** such an event.

If the patient also has an infectious disease on top of exacerbated COPD, assign an additional code for the infectious organism, if known. For example, a patient who experienced an exacerbation of his chronic obstructive bronchitis due to having contracted pneumonia caused streptococcus bacteria would be coded first with J44.0 (Chronic obstructive pulmonary disease with acute lower respiratory infection), followed by J15.4 (Pneumonia due to other streptococci).

Scenario: Exacerbation of chronic obstructive bronchitis

A 78-year-old man was admitted to the hospital with lower lobe methicillin resistant staph aureus pneumonia, which resulted in an acute exacerbation of his chronic obstructive bronchitis. While hospitalized, he received IV antibiotics as well as aggressive respiratory therapy. His co-morbid conditions of hypertension, and generalized osteoarthritis were not affected or treated. He was discharged with a prescription for oral antibiotics. He also has an additional prescription for tapering steroids.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Chronic obstructive pulmonary disease with acute lower respiratory infection	J44.0		
M1023: Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere	B95.62		
M1023: Essential (primary) hypertension	I10		
M1023: Polyosteoarthritis, unspecified	M15.9		

Rationale:

- The patient is continuing antibiotic treatment to help resolve the infection that led to an exacerbation of his chronic bronchitis. Therefore, J44.0 is the most appropriate code to capture his form of COPD.
- As the causative organism, MRSA (B95.62) is coded next.
- As comorbidities that will impact his ability to recover, his hypertension and osteoarthritis are coded as well.

Scenario: Acute exacerbation of chronic obstructive asthma

An 86-year-old woman was admitted to the hospital in respiratory distress and diagnosed with acute exacerbation of chronic obstructive asthma and treated with steroids and antibiotics. While hospitalized, she was started on oxygen therapy that was ordered to be continued at home. Antibiotics were discontinued prior to discharge. Her co-morbidities include benign essential hypertension, gout and GERD.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1		
M1023: Essential (primary) hypertension	I10		
M1023: Gout, unspecified	M10.9		
M1023: Gastro-esophageal reflux disease without esophagitis	K21.9		
M1023: Dependence on supplemental oxygen	Z99.81		

Rationale:

- Documented as acutely exacerbated, the patient's COPD is most appropriately captured with J44.1.

Scenario: Emphysema with chronic obstructive bronchitis

A 92-year-old man was admitted to home health after an emergency room visit for a fractured rib as the result of a coughing fit brought on by his emphysema with chronic obstructive bronchitis. The physician's records indicate that he smoked for 46 years but quit in 1999. His co-morbidities include atrial fibrillation, congestive heart failure, osteoporosis and chronic anticoagulant therapy. Physical and occupational therapy have been ordered at home and the rib fracture is the focus of care.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter	M80.08xD		
M1023: Chronic obstructive pulmonary disease, unspecified	J44.9		
M1023: Unspecified atrial fibrillation	I48.91		
M1023: Heart failure, unspecified	I50.9		
M1023: Long term (current) use of anticoagulants	Z79.01		
M1023: Personal history of nicotine dependence	Z87.891		

Rationale:

- As the focus of care, the rib fracture is coded primary, with the seventh character "D" to denote the subsequent nature of the home health setting.

- The fracture is coded as pathological because the patient has known osteoporosis and the activity that caused the fracture (coughing) not usually cause that injury in people with healthy bones, according to coding guidelines *[I.C.13.d.2]*.

- Since his COPD is not described as exacerbated, J44.9 is the most appropriate code.

- Additional codes are assigned for his atrial fibrillation, congestive heart failure and long-term use of anticoagulants.

COPD ICD-9 to ICD-10 crosswalk		
Condition	**ICD-9 code**	**ICD-10 code**
Obstructive chronic bronchitis with acute exacerbation	491.21	J44.1
Obstructive chronic asthma with acute exacerbation	493.22	J44.1
COPD (unspecified)	496	J44.9
Obstructive chronic asthma	493.20	J44.9
Emphysema, unspecified	492.8	J43.9

About the author: *Jan Hayes-Favre, RN, HCS-D, HCS-O, is an OASIS and Coding Specialist at McBee Associates, Inc. and has more than 30 years of home health industry experience. She can be reached at JanHayes-Favre@McBeeAssociates.com.*

? Ask the Expert

Code joint replacement, Chiari malformation in ICD-10

Question: *How do you code a patient who had a joint replacement due to osteoarthritis of the knee? I was going to assign V54.81 (Orthopedic aftercare following joint replacement), 715.16 (Osteoarthrosis, localized, primary, lower leg) and V43.65 (Organ or tissue replaced by other means, knee joint). Is this correct? I've been told that if the patient has arthritis and had a joint replacement that the surgery does not resolve the arthritis and so it still needs to be coded.*

Answer: You should continue to code osteoarthritis in the knee joint if the condition is specified to be present in *both* knees, but only *one* joint was replaced. But if the arthritis is only in one knee, and that knee is replaced, the arthritis is resolved by the surgery and thus should no longer be coded in M1022.

The knee joint is a hinge that allows the leg to straighten and bend and the surfaces to glide and roll upon each another. The ends of the bone are covered with a layer called articular cartilage which allows the bones to glide smoothly. Arthritis causes a loss of articular cartilage which leads to stiffness and pain in the joint as bone rubs on bone. When the knee joint is surgically replaced, the arthritic surfaces are removed, and the ends of the bone are replaced. As a result, there is no longer any arthritis in that joint so it would be incorrect to code it in M1022.

Question: *How do you code a Chiari malformation in ICD-10?*

Answer: You'll either assign G93.5 (Compression of brain) or Q07.01 (Arnold-Chiari syndrome with spina bifida) depending on the specific etiology of the Chiari malformation. The physician must specify which it is.

A search in the alpha index under 'malformation; Chiari' points to either Type I, which is captured with G93.5 or Type II, captured with Q07.01.

A Type I Chiari malformation is an acquired compression of the brain and is found in Chapter 6, Diseases of the Nervous System. By contrast, a Type II Chiari malformation is a congenital condition and therefore its code is found in Chapter 17, Congenital Malformations, Deformities and Chromosomal Abnormalities.

Question: *Should drug monitoring be coded when a patient is on Coumadin and has his own PT/INR machine and call his own results into the doctor? Also, should drug monitoring be coded when the patient is going to a Coumadin clinic?*

Answer: Assign V58.83 (Encounter for therapeutic drug monitoring) followed by V58.61 (Long-term use of anticoagulants) if your agency is going to be actively monitoring the effects of the Coumadin via lab results. The code doesn't necessarily mean that your agency is the entity that is obtaining the blood work, however.

Here are some questions you should ask that will help guide your code decision: Is the Coumadin a new medication with frequent dose adjustments, or has the patient been taking a regular dose for an extended period of time with no changes? Will your agency be instructing on changes in doses if necessitated by lab work results, or will the physician's office manage that?

If your agency is ***not*** intervening with the monitoring and adjustment of the Coumadin on account of lab work results, ***don't*** code V58.83. However, it would be correct to include V58.61 (Long-term (current) use of anticoagulants) even if your agency isn't providing interventions for monitoring the Coumadin.

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.*

Documentation

(continued from p. 1)

Starting Jan. 1, you will lose case-mix points for several clinical diagnosis and two OASIS items, while high-therapy episodes (14 or more visits) will generally earn the most points. Points for common home health diagnoses such as diabetes (250.xx) and heart failure (428.xx) will be dramatically lowered, and codes in the pulmonary, psych 1, psych 2 and blindness/low vision diagnosis categories will lose their case-mix status altogether, according to the final PPS rule. *(For an example of the impact of the case-mix losses on your coding, see scenario, p. 10.)*

The coming reductions in case-mix points is the pendulum swinging back from changes made in 2008 that de-emphasized the use of therapy and stressed the coding of comorbidities, says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va.

But in the last several years, CMS seems to have realized that while all those comorbidities were costing a lot of money, the documentation wasn't supporting that level of reimbursement, Frear says. For example, how often were there actually documented interventions targeted toward comorbid conditions like chronic obstructive pulmonary disease (COPD) or did agencies just start to code these diseases after they were tied to payment, Frear wonders. Note that COPD is in one of the case-mix categories that was completely stripped of points.

"In a way the industry brought the changes on itself," says Frear, who believes that there'll likely be another change down the line in response to new trends that will form in response to these changes. Note that CMS has removed case-mix points from nearly 400 codes over the last two years, as well as heavily restricted use of the M1024 payment slot.

Detailed documentation must support codes

Documenting "skilled nursing to observe and assess cardiac status as needed" is NOT enough to support a primary diagnosis of 428.0 (Congestive heart failure, unspecified).

This type of documentation will bring about further case-mix cuts as it demonstrates to CMS that these

conditions don't require a lot of resources, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

By contrast, adequate documentation should include specific details about what the nurse is doing in the home and why. For example, instruction on a low sodium diet as part of a CHF plan of care would include items such as setting up a food diary for the patient, going through his cupboards and teaching him how to read labels, says J'non Griffin. HCS-D, senior consultant for Home Health Solutions, LLC in Carbon Hill, Ala.

Though the forte of home health nursing care is in teaching patients about their conditions and how to manage them, which takes considerable time and resources, "nursing isn't taking the time to document what they're teaching," says Cynthia Cooke, HCS-D, clinical coding/OASIS nurse specialist for the Concord Regional Visiting Nurse Association in Concord, N.H.

Furthermore, the ease and convenience of electronic medical records have led to an overreliance on "checkbox documentation" and as a result, "we're losing the ability to report what we've done and how we've done it," she says.

In the past, a nurse would have written out what medication she provided teaching on and what she taught. Now, many nurses simply check the box that says they provided medication teaching, Cooke says.

Look to therapy to better manage cases

Home health should look for opportunities to bring in therapy services for patients who aren't responding to nursing care and teaching, Whitemyer says. Therapy services are not only for "therapy" diagnoses — they can be beneficial for those common home health clinical diagnoses that CMS says lost case-mix status because they didn't require a high level of resources.

There are limits of nursing care, particularly for Alzheimer's and dementia patients who aren't able to retain the knowledge nurses are there to teach them, and there may come a time to call in other disciplines, such as occupational therapy or speech language pathology, who can offer services that aren't focuses of nursing care, Cooke says.

And now that most conditions will earn points only in higher therapy episodes it's imperative that home health be alert to the therapy needs of chronically ill patients that may have gone unnoticed. "Perhaps we need to get these [therapy] resources involved sooner," Cooke says.

An Alzheimer's patient, for example, may be unable to learn the skills she needs from teaching provided by a nurse, but occupational therapy can help her develop routines that maximize her cognitive ability using assistive devices and measures, Whitemyer says.

Another example of a seemingly nursing-oriented case that could benefit from therapy would be a diabetic patient with foot ulcers, Cooke says. Occupational therapy could help the patient be able to reach his feet so he can learn to provide his own wound care.

Tips to ensure coding stands up to auditor scrutiny

- **Assign the codes that best represent the clinical status of the patient and the care** your agency is providing whether they earn case-mix points or not, Whitemyer says. For example, don't simply stop coding low vision (369.xx) just because it no longer earns case-mix points. If it impacts the plan of care and your agency is providing an intervention, code the diagnosis. A noticeable drop-off in the use of these codes will only confirm to CMS that they weren't impacting resource use.

- **Document why you're recertifying a patient with a chronic disease** or prepare to see your claims get denied. It's reasonable to provide observation and assessment care for an exacerbated chronic condition for three weeks, Whitemyer says. If the patient isn't improving after three weeks, it's reasonable to continue service but documentation should be clear about why it's necessary. For example, a patient receiving observation and assessment care following a hypertensive crisis may experience respiratory side effects to new medications prescribed for her blood pressure, which exacerbated her previously stable COPD and then necessitates further care beyond the standard three weeks.

- **Ensure documentation backs your codes.** Whitemyer has seen agencies start to assign codes for hypertensive heart disease (402.xx) or hypertensive chronic kidney disease (403.xx) in place of 401.9 (Essential hypertension, unspecified) after getting ADRs on hypertension recert claims, thinking 401.9 isn't a "valid code" on a recert. Without a physician's diagnosis, this is upcoding as well as a failure to see that the real issue is likely documentation that doesn't support medical necessity for the recert. Defensible documentation

would indicate why a patient continues to need care for hypertension, such as he has a new caregiver, is anxious and is responding poorly to medications. Furthermore, Whitemyer worries that the next trend may be the inappropriate coding of 402.xx and 403.xx because she's seen use of these codes spike since essential hypertension codes lost case-mix points.

• **Ask your agency's marketers to provide more detail with their referrals.** Marketers are in a position to have access to more information about the patient and why they're coming to home health but don't often realize how important that is to coders, Griffin says. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Diabetes in ICD-10

(continued from p. 1)

minimum of two codes in ICD-9, are captured with single combination codes in the new code set. In fact, most of the time, the only additional code required when coding diabetic manifestations is that for insulin use (Z79.4, Long term (current) use of insulin) in patients with the type 2 form of the disease *[I.C.4.a.3]*.

The ICD-10 codes that cover diabetes are found in Chapter 4 (Endocrine, nutritional and metabolic diseases) and range from the E08 (Diabetes mellitus due to underlying condition) to the E13 (Other specified diabetes mellitus) categories, depending on the type of the condition (1 or 2) and its cause (such as drug of chemical-induced diabetes, or diabetes resulting from another disease).

Home health coding will make the most use of codes from the E11.- category (Type 2 diabetes mellitus), says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston. Just like in ICD-9, when the type of diabetes is not specified, type 2 should be coded *[I.C.4.a.2]*.

Renal, ophthalmic and neurological manifestations are indicated in ICD-10 with the use of the fourth character — '2' for renal, '3' for ophthalmic and '4' for neurological. Read on for a specific discussion of each area and how you'll approach it in the new code set.

One code for renal manifestations

With the exception of diabetic chronic kidney disease, you'll only need to assign one code for all other diabetic kidney conditions in ICD-10, a striking change from ICD-9, where two codes are necessary for all renal manifestations of diabetes.

Diabetic renal manifestations are captured with the fourth character '2' in each of the ICD-10 diabetes categories, such as E11.2- (Type 2 diabetes mellitus with renal manifestations). The category further separates into specific manifestations that include diabetic nephropathy (E11.21), diabetic chronic kidney disease (E11.22) and diabetes with renal tubular degeneration (E11.29).

For example, E11.21 will sufficiently capture Type 2 diabetic nephropathy in ICD-10. This is a striking change from ICD-9, where you'd need to first assign 250.40 (Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled) and immediately

follow it with the manifestation code 583.81 (Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere).

The one diabetic renal manifestation exception, diabetic chronic kidney disease, requires ***two*** codes in ICD-10: one for the diabetes (such as E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease) and one for the stage of kidney disease, from the N18.- (Chronic kidney disease) category, according to tabular instructions.

Tip: Note that N18.9 (Chronic kidney disease, unspecified) is not an allowable pairing with a diabetic kidney disease code in ICD-10, according to tabular instructions. The stage of the chronic kidney disease must be specified.

Diabetic ophthalmic codes greatly expanded

You'll have 12 unique codes to choose from when capturing diabetic ophthalmic manifestations in ICD-10, which is twice the number of codes currently available for this condition in ICD-9. All of them describe various kinds and severity levels of diabetic retinopathy.

The fourth character '3' indicates the presence of an ophthalmic manifestation in the ICD-10 diabetes categories, and the codes are further broken down into codes for proliferative and non-proliferative diabetic retinopathy that is diagnosed as mild, moderate or severe, with or without macular edema, such as E11.349 (Type 2 diabetes mellitus with severe non-proliferative diabetic retinopathy without macular edema).

Patients diagnosed with diabetic macular edema ***always also*** have diabetic retinopathy, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness in Harlingen, Texas. This is the reason that coding diabetic macular edema in ICD-9 requires three codes, and that one of them is for diabetic retinopathy. In ICD-10, however, one code will capture all of these conditions, which will prevent coders from inadvertently neglecting to assign a necessary code.

Pathophysiology determines diabetic neurologic manifestation code

Do not code E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy) for a patient diagnosed with type 2 diabetes with diabetic neuropathy.

This is because E11.42 corresponds to a specific type of diabetic neuropathy called polyneuropathy, a more specific diagnosis that must be confirmed by a physician before it can be coded, Whitemyer says.

Neurologic manifestations of diabetes are captured with fourth character "4" in the diabetes categories in ICD-10. You'll be able to choose from codes that describe diabetic mononeuropathy (such as E11.41), diabetic polyneuropathy (i.e. E11.42), diabetic autonomic polyneuropathy (i.e. E11.43) and diabetic amyotrophy (i.e. E11.44), in addition to "unspecified" (i.e. E11.40) and "other" (i.e. E11.49) options.

Keen knowledge of the different types of diabetic neuropathy is vital for correct coding in ICD-10. For example, diabetic autonomic neuropathy affects the autonomic nervous system that controls bodily functions such as gastric emptying and genitourinary processes. Therefore, a patient diagnosed with gastroparesis caused by type 2 diabetes has a form of diabetic autonomic neuropathy and the correct ICD-10 code would be E11.43, Whitemyer says.

Use manifestation codes correctly or see your claims returned

The Jan. 1 update to the Grouper payment logic will return to provider (RTP) without payment any claim that incorrectly uses a manifestation code, which could create major cash flow headaches for agencies.

The etiology-manifestation convention requires you to sequence the code for the etiology (the underlying condition, for example, 331.0 for Alzheimer's disease) immediately before you assign the code for the manifestation (the disease caused by the underlying condition, such as 294.11 for Dementia in diseases classified elsewhere with behavioral disturbance) *[I.A.6]*.

The rerouting of money that will happen when a claim is RTP'd often results in an average delay in payment of about six weeks, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. Consider that most home health agencies have only between three and four weeks of cash flow available and this could quickly become a serious issue.

And while this convention may seem like a basic rule to many seasoned coders, improper use of manifestation codes is a frequent error, Twombly says.

While CMS has implemented edits in the Grouper logic before, this is the first time an edit will cause a claim to reject, she says.

Tip: Look up the manifestation condition in the alpha index and it will give you both the manifestation code and its etiology pairing in the correct order. Then just verify the codes in the tabular and you will have coded correctly.

Editor's note: *To view and download the updated Grouper, go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.*

Diabetic amyotrophy affects the peripheral nerves of the lower extremities, primarily those in the buttocks, hips, thighs and legs, and it can lead to muscle wasting, she says. So, a type 2 diabetic who comes to home health for physical therapy to address muscle weakness caused by diabetic amyotrophy would be captured with E11.44.

Tip: Assign E11.40 (Type 2 diabetes mellitus with diabetic neuropathy, unspecified) for a patient with type 2 diabetes with neuropathy for whom you're unable to obtain more specific information about the neuropathy, Whitemyer says.

Tip: Use home health record documentation indicating that a patient with diabetic neuropathy is experiencing numbness, burning and tingling in his arms, hands, legs and feet as a clue that diabetic polyneuropathy is the appropriate, more specific diagnosis, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. If the physician confirms it, you'd assign E11.42 if the diabetes is type 2.

Scenario: Type 1 diabetes with CKD, hypertension

A 55-year-old man comes to home health after being diagnosed with stage 2 chronic kidney disease resulting from his type 1 diabetes. He also has hypertension that isn't well controlled, and for which he requires medication management and close monitoring.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Type 1 diabetes mellitus with diabetic chronic kidney disease	E10.22		
M1023: Chronic kidney disease, stage 2	N18.2		
M1023: Essential (primary) hypertension	I10		

Rationale:

- As the primary reasons for home health, the diabetic chronic kidney disease is coded first, and is immediately followed by the code for the stage of the kidney disease, in accordance with tabular instructions.
- The patient will require medication management for his hypertension and I10 is the appropriate way to capture the condition.
- An additional code for insulin use (Z79.4, Long-term (current) use of insulin) is not required because the patient is a type 1 diabetic, and insulin dependence is integral.

— Megan Gustafson (mgustafson@decisionhealth.com)

Scenario: Congestive heart failure, type 2 diabetes with diabetic retinopathy

An 80-year-old woman comes to home health following hospitalization for an exacerbation of her congestive heart failure. She also has type 2 diabetes with moderate non-proliferative diabetic retinopathy, and uses insulin. Her physician has ordered occupational therapy, in addition to skilled nursing, to help her in completing ADLS after experiencing significant deconditioning in the hospital.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Congestive heart failure, unspecified	I50.9		
M1023: Type 2 diabetes mellitus with moderate non-proliferative diabetic retinopathy without macular edema	E11.339		
M1023: Long-term (current) use of insulin	Z79.4		

Rationale:

- Congestive heart failure is coded in the primary slot, because it is the reason for the home health admission. A more specific code for the heart failure cannot be assigned because no further information is given. However, it'll be important in ICD-10 to query the physician as to whether the patient's heart failure has diastolic or systolic components.
- As a significant comorbidity that will impact her recovery, the patient's type 2 diabetes with retinopathy is also coded. No macular edema is mentioned, and thus the code 'without macular edema' is assigned.
- Insulin dependence in a type 2 diabetic requires the addition of Z79.4 and thus that is coded as well.

Scenario: Aftercare following appendectomy, type 2 diabetes, polyneuropathy

A 62-year-old woman is admitted to home health for surgical aftercare after undergoing an appendectomy. She also has type 2 diabetes, for which she requires insulin, and polyneuropathy, which her physician confirmed was caused by her diabetes.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Encounter for surgical aftercare following surgery on the digestive system	Z48.815		
M1023: Type 2 diabetes mellitus with diabetic polyneuropathy	E11.42		
M1023: Long-term (current) use of insulin	Z79.4		

Rationale:

- The patient's aftercare is routine, and is therefore most appropriately captured with Z48.815, which is coded primary as the main reason for the home health admission.
- Because her diabetes has the potential to impact her healing from surgery, it is coded as well.
- The patient's polyneuropathy, which her physician confirmed is related to her diabetes, should be captured with E11.42.
- As a type 2 diabetic who requires insulin, Z79.4 is required to capture this. — *Megan Gustafson (mgustafson@decisionhealth.com)*

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, 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.

See how case-mix losses will impact reimbursement

Your agency could stand to lose more than $200 per episode for common home health diabetes scenarios, like the one below:

Scenario: Uncontrolled diabetes, cancer, depression

A 75-year-old female patient is admitted for management of diabetes which is uncontrolled. Her co-morbid diagnoses are depression and breast cancer for which she is undergoing radiation treatment. She is incontinent of stool daily and her vision is assessed as impaired. The episode is in Equation 1 (early episode, low therapy).

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled	250.02		
M1022: Malignant neoplasm of breast (female), unspecified	174.9		
M1022: Depressive disorder, not elsewhere classified	311		

Rationale:

As the focus of care, the uncontrolled diabetes is coded primary. Her comorbidities of breast cancer and depression are coded as they have the potential to impact her recovery.

Estimated reimbursement in 2014	Estimated reimbursement in 2015
Case-mix points from diagnoses = 12 Diabetes = 5 Neoplasm = 3 Depression = 4	**Case-mix points from diagnoses = 0** Diabetes = 0 Neoplasm = 0 Depression = 0
C Score = 14 (C3) M1200 (1) = 1 M1242 (1) = 0 M1400 (1) = 0 M1620 (4) = 1	**C Score = 0 (C1)** M1200 (1) = 0 M1242 (1) = 0 M1400 (1) = 0 M1620 (4) = 0
F Score = 6 (F2) M1810/20 (2) = 2 M1830 (2) = 3 M1840 (1) = 0 M1850 (1) = 0 M1860 (2) = 1	**F Score = 15 (F2)** M1810/20 (2) = 2 M1830 (2) = 6 M1840 (1) = 0 M1850 (1) = 0 M1860 (2) = 7
S Score (Therapy) = S1 (No visits)	**Score (Therapy) = S1 (No visits)**
C3F2S1 (0.8289) = $2,378.34	**C1F2S1 (0.7277) =$2,155.00** **Variance = (-$223.34)**

Source: Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.