

Get coding & OASIS-C1 training in 4 different cities

Whether your staff needs to take ICD-9 coding to the next level, prepare for the new OASIS-C1 items while reinforcing core competencies, or kick off their ICD-10 education, you can get it all 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 www.decisionhealth.com/ultimatetraining

In This Issue

Warning: 17 dementia codes now invalid as primary hospice diagnoses 2

Coding Basics: Learn how surgical aftercare coding will change in ICD-10 4

ICD-10 news: 7th character use clarified, revisions proposed 10

News brief: CMS releases complete OASIS-C1/ICD-9 guidance manual 10

Tool of the Month: Diabetic ulcer decision tree Extra

Correctly capture stroke residuals to avoid upcoding charges

Don't assign a code from the 438 series (Late effects of cerebrovascular disease) for a patient who suffered a stroke but has **no** documented residual deficits, such as hemiplegia or dysphagia, or you'll put the chart at risk for upcoding charges.

In these cases, the proper code to capture a stroke that didn't leave any lingering conditions is V12.54 (Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits), according to official coding guidelines [*I.C.7.d.3*].

(see *CVA residuals*, p. 5)

Transition to ICD-10

ICD-10 brings changes to diabetic manifestations

You can't assume a connection between diabetes and osteomyelitis once ICD-10 goes into effect. Rather, whether a patient's osteomyelitis is a manifestation of his diabetes must be physician-confirmed before it can be coded.

ICD-10 will bring about some changes in how you code three common manifestations of diabetes: osteomyelitis, ulcers, and gangrene and peripheral angiopathy. For example, long-held assumptions between diabetes and osteomyelitis and diabetes and gangrene in the absence of other stated etiologies, will **not** be valid

(see *Diabetes in ICD-10*, p. 8)

Save the date: Avoid hospice denials, payment delays

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

Warning: 17 dementia codes now invalid as primary hospice diagnoses

Look beyond a dementia diagnosis to the resulting problems caused by the dementia, such as loss of appetite (783.0) or dysphagia (787.20), and code that as the primary terminal diagnosis, or your hospice claims will now be returned.

Hospice coders are scrambling to find suitable alternatives for unspecified dementia diagnoses after CMS made invalid as primary hospice diagnoses almost every dementia code, including the often-assigned, 290.0 (Senile dementia, uncomplicated) and 294.2x (Dementia, unspecified), per Transmittal 3032/Change Request 8877 released Aug. 22 (CPH, 10/14).

And while these dementia codes are still acceptable as secondary diagnoses, it's not unheard of for a patient to come to hospice with a terminal diagnosis stated simply as "dementia" with no further detail about the diagnosis or its etiology, hospice coders say.

It is going to be difficult to no longer be able to use these codes in the primary position on hospice claims, particularly in cases with patients who don't otherwise meet eligibility criteria for other conditions, says Lisa Byrum, HCS-D, quality assurance coordinator for Cedar Home Health and Hospice in West Bend, Wis.

"I think we're going to struggle," Byrum says.

Is dementia really the terminal diagnosis?

Treat dementia the same way you've been treating debility (799.3) and adult failure to thrive (783.7), which are also now invalid as primary hospice diagnoses, and ask yourself what conditions, **because of the dementia**, are going to cause the patient's death within six months, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

For example, consider a primary diagnosis of malnutrition (like 262, Other severe protein-calorie malnutrition) for a hospice patient who has dementia for which a specific etiology cannot be obtained, and that has caused her to forget to eat, says Adams. Then, assign the dementia as the secondary diagnosis.

While official coding guidelines call for the use of specific diagnosis codes over symptom codes whenever possible, you're left with little else besides a symptom code for the condition that is most contributing to a hospice patient's terminal status in the absence of a physician-confirmed etiology for dementia, she says.

Tip: Make use of the hospice interdisciplinary group (IDG) when struggling to find an appropriate terminal diagnosis. The purpose of the IDG is to discuss these diagnosis issues and to determine the most accurate reason why the patient meets the eligibility requirements for hospice care, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

Subscriber Services

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice President: Corinne Denlinger
1-301-287-2363
cdenlinger@decisionhealth.com

Product Manager: Maria Tsigas
1-301-287-2305
mstsigas@decisionhealth.com

Editorial:

Editor: Megan Gustafson, 1-612-834-6896
mgustafson@decisionhealth.com

Technical Editor: Tricia A. Twombly
BSN, RN, HSC-D, CHCE, COS-C
ttwombly@decisionhealth.com

DISTRIBUTION RIGHTS AND COPYRIGHT

All content is copyrighted and may not be excerpted or copied in part, nor do such rights provide for re-sale or competitive use of editorial. To request permission to make photocopy reprints of *Diagnosis Coding Pro for Home Health* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number. Copyright violations will be prosecuted. *Diagnosis Coding Pro* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations, contact: Steve McVearry at 1-301-287-2266 or email him at smcvearry@ucg.com.

CEUs

Each issue of *Diagnosis Coding Pro for Home Health* is approved for 1.0 HCS-D CEU from the Board of Medical Specialty Coding (BMSC). To earn your newsletter CEUs, you must take a short online quiz at ceus.coursewebs.com/courses/DiagnosisCodingPro/includes/register.asp.

Diagnosis Coding Pro is published monthly by **DecisionHealth**, Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878-7364. Price: \$447/year. Copyright 2014.

THE DECISIONHEALTH PLEDGE OF INDEPENDENCE

At DecisionHealth, the only person we work for is you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry.

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status to 1-855-225-5341 (toll-free), or email customer@decisionhealth.com.

FREE INTERNET FORUM

To join our free subscriber email exchange, register at <http://listserv.ucg.com/cgi-bin/listserv/listserv.pl/homecarecoding-1>.

CONFERENCES

Diagnosis Coding Pro holds seminars to help you meet your diagnosis coding challenges. For program schedules, email conference@decisionhealth.com or go to www.decisionhealth.com.



Association of
**Home Care Coding
& Compliance**



Board of
**Medical Specialty
Coding & Compliance**

Look for evidence of other etiologies

Dig through patients' medical records for any indication that their dementia may have been given a specific etiology. Chances are, by the time the patient arrives in hospice, the diagnosis will be several months to years old and somewhere along the line its cause was identified, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

For example, Byrum found a CT scan from 2009 in the records of a patient who came to hospice with a diagnosis of "dementia." The scan showed that the dementia was due to cerebral degeneration and she was able to code that condition (331.9) with dementia (294.1x) as a secondary diagnosis, she says.

Dementia can also be a late effect of a cerebrovascular accident (CVA) or stroke. If there's evidence of this etiology, capture it first with 438.89 (Other late effects of cerebrovascular disease) followed by the code for the specific type of dementia, such as 290.4x (Vascular dementia), Adams says.

Additionally, it's important to understand that dementia, from a pathophysiological standpoint, *always* has an etiology, says Whitemyer.

Dementia describes a cluster of specific symptoms that can be tied to a variety of causes, which can include cardiovascular or cerebrovascular illness, a disease of the nervous system such as Parkinson's disease or an organic brain disorder, she says.

Tip: Go to your hospice medical director to obtain an etiology for a patient's unspecified dementia if the patient's primary care physician (PCP) is unwilling to commit to a specific diagnosis. Often it's PCPs who don't like to settle on a specific condition but hospices have the added advantage of the presence of a medical director who's familiar with Medicare hospice eligibility requirements and should be able to specify a qualifying diagnosis, says Whitemyer.

Tip: Do *not* assume that a patient's dementia was caused by Alzheimer's disease simply because it is a common cause of dementia, and then code it without a physician's confirmed diagnosis, Twombly says. If you do this, you'll be in violation of official coding guidelines, which can lead to claims denials and even more serious consequences.

Tips to correctly code dementia in hospice

Here are three more tips to aid your hospice coding:

- **Ask for a copy of the neurologist's history and physical (H&P) report** for a hospice patient with vague diagnosis of dementia, Twombly says. Getting the information you need may come down to asking the right people the right questions.

- **Don't assign 307.1 (Anorexia nervosa) for a patient with dementia who isn't eating without further confirmation**, Adams says. This is a psychiatric diagnosis that implies intentional starvation and requires a physician's diagnosis. The symptom code 783.0 (Anorexia/loss of appetite) more accurately describes the condition in this context.

- **Code the symptom the physician has specified is leading to the patient's terminal status**, Adams says. Some may diagnose "underweight" (783.22) or "abnormal weight loss," (783.21) while others will offer "malnutrition" (262). Only the physician can decide.

Scenario: Nutritional deficiency, dementia

A 92-year-old female patient has recently lost a significant amount of weight and is experiencing increased confusion due to a UTI and her dementia. She also fell recently, fracturing her left hip. Her family has decided not to put her through surgery to repair the hip, but instead to keep the hip immobilized in bed and seek comfort care through hospice due to her worsening dementia. No etiology for the dementia can be obtained. The IDG determined that her terminal diagnosis is nutritional deficiency due to her weight loss and lack of interest in eating.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
Primary Other nutritional deficiency	269.9		
Other Dementia, unspecified, without behavioral disturbance	294.20		
Other Aftercare for healing traumatic fracture of hip	V54.13		
Other Urinary tract infection	599.0		
Other Loss of appetite	783.0		
Other Debility	799.3		

Rationale:

- The IDG determined that nutritional deficiency was the diagnosis most contributing to her terminal status, so that is coded as the primary hospice diagnosis, with 269.9.
- Because her dementia is contributing to her decline, it is also coded. The unspecified dementia code, 294.20, is acceptable as a secondary diagnosis.
- The hip fracture, urinary tract infection, loss of appetite and debility are all contributing to her terminal status and thus are included as related diagnoses.

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

The scenario was adapted from one supplied by Adams.

CB Coding Basics**Learn how surgical aftercare coding will change in ICD-10**

By Lesia Hulme, RN, BSN, HCS-D, COS-C, BCHH-C

You'll no longer be able to rely upon the "conditions classifiable to" ranges that presently exist in ICD-9 when choosing surgical aftercare codes in ICD-10. These ranges help guide coders to the right aftercare code based on the condition that necessitated the surgery, but they do not currently exist in ICD-10.

For example, currently if a patient has surgery to treat acute cholecystitis (575.0), the correct surgical aftercare code would be V58.75 (Aftercare following surgery of the teeth, oral cavity and digestive system, NEC) because 575.0 falls into the conditions classifiable range (which is 520 to 579) on that aftercare code.

Without an equivalent in ICD-10, let the ICD-9 ranges guide your choice of an ICD-10 aftercare code. For example, Z48.812 (Encounter for surgical aftercare following surgery on the circulatory system) is the best choice for a patient who had surgery to treat an abdominal aortic aneurysm (AAA).

This is because the diagnosis codes to 441.4 in ICD-9, which falls into the conditions classifiable range (390 to 459) for the ICD-9 code V58.73. The ICD-10 equivalent to V58.73 is Z48.812.

Another key difference in the coding of surgical aftercare from ICD-9 to ICD-10 will be the absence of a unique code for aftercare following surgery to the musculoskeletal system, which is coded to V58.78

(Aftercare following surgery of the musculoskeletal system, NEC) in ICD-9.

A good ICD-10 strategy for this should involve looking for an alternative code in the Z47.- category (Orthopedic aftercare) to capture surgical aftercare for musculoskeletal conditions. For example, assign Z47.89 (Encounter for other orthopedic aftercare) to capture aftercare for a patient who underwent surgery for a ruptured lumbar disc, which would be captured by V58.78 in ICD-9.

Other than this, coding surgical aftercare in ICD-10 won't be all that different from how you currently code these cases in ICD-9. The codes may look a little different, but the logic behind it will remain mostly unchanged.

Understand surgical aftercare in ICD-10

Surgical aftercare codes are found in Chapter 21 (Factors influencing health status and contact with health services) in ICD-10. You'll select your surgical aftercare code from among those at categories Z47.- (Orthopedic aftercare) and Z48.- (Encounter for other postprocedural aftercare).

Notice that this chapter bears a strong resemblance to the ICD-9 V code chapter (Factors influencing health status and contact with health services), where surgical aftercare codes are found primarily in category V58.7x (Aftercare following surgery to specified body systems, not elsewhere classified).

The general logic of finding your code is the same: Look for the main term and then narrow down to the most specific term in the alpha index. So in ICD-10, first search under "Aftercare," and then go immediately to "following surgery (for) (on)." For example, "Aftercare, following surgery (for)(on), digestive system" takes you to Z48.815.

This differs slightly from ICD-9, where you'd first look under "Aftercare," then go to "following surgery." From there your options would further drill down into "for" (if you're looking for particular type of surgery, such as for organ transplant, V58.44), "joint" (if you're dealing with joint replacement surgery, V54.81) or "of" (for surgery of a specific body system, like circulatory, V58.73).

Just like you do now, you'll **always** need to verify the code you find in the alpha Index at its tabular

listing, where you may find further specification and further instruction. This rule stays the same from ICD-9 to ICD-10.

Consider a search for the aftercare code following a right total hip arthroplasty. You'd find Z47.1 (Aftercare following joint replacement surgery) from "Aftercare, following surgery, joint replacement."

When you verify the code in the tabular, you'll find an instructional note to use an additional code from the Z96.6- category (Presence of orthopedic joint implants) to identify the specific joint and laterality. The specific code for the replaced hip joint would be Z96.641 (Presence of right artificial hip joint).

Coding surgical complications in ICD-10

Just like you do in ICD-9, you will **not** code surgical aftercare when there is a complication resulting from the procedure in ICD-10. Aftercare Z codes should not be used if treatment is directed at a current, acute disease. Instead, in these cases, you'd code the condition itself, such as a dehiscence surgical incision, according to ICD-10 official coding guidelines [I.C.21.c.7].

Understand that treatment directed at dehiscence surgical incisions, post-operative wound infections and non-healing surgical wounds is by definition "treatment directed at a current, acute disease" and thus the surgical aftercare code is no longer appropriate in these situations [I.C.21.c.7].

Consider a patient who has surgery for appendicitis and who later experiences external dehiscence of the surgical incision. When that patient comes to home health, code Z48.815 (Encounter for surgical aftercare following surgery on the digestive system) would not be the appropriate code choice.

Rather, you'd assign T81.31xD (Disruption of external operation (surgical) wound, not elsewhere classified, subsequent episode) for the care of the surgical wound.

Aftercare following coronary artery bypass graft

A 69-year-old woman is admitted after being hospitalized for coronary artery bypass graft (CABG) surgery to treat coronary artery disease (CAD). She also has severe hypertension and ulcerative colitis.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Encounter for surgical aftercare following surgery on the circulatory system	Z48.812		
M1023: Atherosclerotic heart disease of native coronary artery without angina pectoris	I25.10		
M1023: Essential (primary) hypertension	I10		
M1023: Ulcerative colitis, unspecified, without complications	K51.90		

Rationale:

- The correct surgical aftercare code is Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, because it is the ICD-10 equivalent of V58.73 (Aftercare following surgery of the circulatory system, NEC). The condition necessitating the surgery, CAD, codes to 414.00 in ICD-9, which falls within the "conditions classifiable to" ranges on V58.73.

- The CABG surgery does not resolve the CAD, so it is still coded as a relevant comorbidity. Additionally, the hypertension and ulcerative colitis are coded as relevant comorbidities.

- The CAD and hypertension are not coded as connected diseases, as hypertensive heart disease, because the physician didn't connect them and there is no allowable assumption.

About the author: Lesia Hulme, RN, BSN, HCS-D, COS-C, BCHH-C, has worked in home health for more than 20 years, with much of her time spent in management and quality. She has many years of experience in coding, OASIS review, documentation and quality improvement. She works as an independent coder and OASIS reviewer.

Editor's note: See the online version of this story for additional scenarios.

CVA residuals

(continued from p. 1)

One of the biggest mistakes made when coding stroke conditions is the reluctance to assign V12.54 for stroke patients without residuals, and so instead coders will assign 438.9 (Unspecified late effects of cerebrovascular

disease), says Michelle Mantel, HCS-D, quality assurance manager for Gentiva Home Health in Atlanta, Ga.

This is not only upcoding (438 series codes earn case-mix points as Neuro 3 diagnoses, while V12.54 earns no points), but the use of 438.9 will raise a red flag because it is so vague that it's essentially saying to Medicare that your agency doesn't know what it's treating but it would nevertheless like to be paid for it, Mantel says.

Correctly sequence stroke residuals to guard against scrutiny

Avoid the temptation to code only one CVA residual in the top six diagnosis slots and then move codes for other stroke residuals further down on the claim for the purpose of leaving room for other comorbid diagnoses in the positions that generate points. Otherwise, you'll be giving reviewers a reason to think you're coding for payment.

Coders are often tempted to do this in cases of patients who come to home health with multiple stroke residuals, such as dominant-side hemiplegia, vision loss, dysarthria, facial droop and ataxia, because case-mix points from the 438 series are only earned once as they're all in the same category (Neuro 3), says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

For example, consider a patient with all five residuals mentioned above, who also has congestive heart failure (CHF), diabetes and Crohn's disease. If the residuals are the focus of care, with the hemiplegia being the most serious, the appropriate code selections and sequencing will fill all the top six slots.

Even though the CHF, diabetes and Crohn's should still be coded as comorbidities that will impact the patient's recovery, there isn't room to include them in the positions in which they'll earn points. Assuming an early episode, high-therapy case (equation two), there are six points available for the CHF, five points for the diabetes and another six points for the Crohn's disease [see scenario on page 7].

There may be no immediate consequences for moving, for example, the visual defects and ataxia out of the top six in an attempt to get the 17 points from the other comorbidities, but keep in mind that in the event of an audit, a reviewer will notice this and may assume you've upcoded, Twombly says.

Let etiology guide you to the right stroke codes

Do **not** assign a code from the 438 series (Late effect of cerebrovascular disease) for a patient who is being treated for residual deficits from a CVA that resulted from trauma or you could be failing to provide appropriate care as well as forfeiting rightful reimbursement.

Instead, code the specific residual being treated, such as 342.91 (Unspecified hemiplegia and hemiparesis affecting dominant side), and immediately follow it with 907.0 (Late effect of intracranial injury without mention of skull fracture), to indicate that it's the result of a traumatic brain injury, Mantel says.

Most patients coming to home health following a stroke suffered it as result of cerebrovascular disease, caused by conditions such as hypertension, she says. However, there are patients who've had CVAs that resulted not from disease but from external causes like trauma.

Not only is 438.21 (Hemiplegia affecting dominant side as late effect of cerebrovascular disease) the incorrect code, but it could also cost you case-mix points. Consider that the correct 907.0 code in the secondary position can earn up to 10 points when combined with an response of '2' or more on OASIS M1840 (Toileting).

Furthermore, having a clear understanding of the etiology of a patient's CVA is important in the design of his or her treatment plan in communication with the physician to obtain orders, Mantel says.

For example, a patient whose stroke resulted from hypertensive disease may need instruction on diet as part of their treatment plan. But that wouldn't necessarily be a part of the treatment plan for a patient who fell and hit his head, she says.

More tips to keep coding above the fray

Here are five more tips to help you code stroke residuals accurately:

- **Follow the instructions in the tabular that point you to assign an additional code.** Most of the codes that capture stroke residuals (the 438 series) are combination codes, such as 438.21 (Hemiplegia affecting dominant side as late effect of cerebrovascular disease). Some, however, require an additional code to further describe the residual, such as dysphagia (438.82). A "use additional code" note can be found at 438.82 specifying this.

- **Never assume, if it isn't documented, which side is the patient's dominant side** when coding hemiplegia. If it isn't clear, query the assessing clinician or physician, Twombly says. Note that there is an allowable assumption in ICD-10 that, if not documented, a coder can assume right-sided dominance. However, this assumption won't go into effect until ICD-10 does.

- **Do not assign 438.20 (Hemiplegia affecting unspecified side as late effect of cerebrovascular disease)**, Twombly says. This code communicates that your agency is unable to determine which side of the patient is dominant and therefore calls into question the validity of the care it is providing.

- **Use multiple codes from the 438 series instead of coding quadriplegia (344.00)** to capture a stroke patient who has hemiplegia on both sides of the body as the result of multiple strokes, says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice in Virginia Beach, Va. For example, you may assign both 438.21 (Hemiplegia affecting dominant side as late effect of cerebrovascular disease) and 438.22 (Hemiplegia affecting nondominant side as late effect of cerebrovascular disease) if the situation calls for it.

- **Don't ever code an acute stroke code in M1020/M1022**, says Lynn Speckels, HCS-D, vice president of HealthCare ConsultLink in Fort Worth, Texas. Though this may seem like a basic rule, it's still a very common mistake. Consequences include the claim being rejected outright, or being automatically downcoded. Repeated assignment of acute stroke codes in M1020/1022 may lead

to ADRs, she says. Acute stroke codes can only be used acute care settings, such as hospitals.

Scenario: Stroke residuals

A 77-year-old man comes to home health after suffering a massive stroke that left him with dominant side hemiplegia, visual deficits, dysarthria, a facial droop and ataxia. He's been in rehab for several months and will continue his recovery at home with skilled nursing and therapy. He also has congestive heart failure, diabetes and Crohn's disease.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a	Hemiplegia affecting dominant side as late effect of cerebrovascular disease	438.21	
M1022b	Disturbances of vision as late effect of cerebrovascular disease	438.7	
M1022c	Visual field defect, unspecified	368.40	
M1022d	Dysarthria	438.13	
M1022e	Facial weakness as late effect of cerebrovascular disease	438.83	
M1022f	Ataxia as late effect of cerebrovascular disease	438.84	

Additional diagnoses: 428.0 (Congestive heart failure, unspecified), 250.00 (Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled), 555.9 (Crohn's disease NOS)





Please pass this coupon to a colleague who could benefit from a subscription to *Diagnosis Coding Pro for Home Health*.

YES! I want news and guidance on ICD-9 coding and training answers for accurate OASIS, 485 and UB-04 completion to ensure full reimbursement. Please enter my one year (12 issues) subscription at \$447 for *Diagnosis Coding Pro for Home Health*.

Name: _____
 Org.: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____
 Fax: _____
 Email: _____

Payment enclosed. (Make checks payable to *Diagnosis Coding Pro for Home Health*, TIN 26-3622553)

Bill me. (Initial here: _____)

Charge my:    

Card #: _____ Exp. Date: _____
 Signature: _____

Mail to: *Diagnosis Coding Pro for Home Health*
 Two Washingtonian Center, 9737 Washingtonian Blvd., Ste 200
 Gaithersburg, MD 20878-7364 | 1-855-CALL-DH1

PAS2014

Rationale:

- Because the stroke residuals are the focus of care, they must be sequenced before the patient's other comorbidities.
- While hemiplegia, dysarthria, facial droop and ataxia are combination codes that don't require any additional code, the code for stroke-related visual defects (438.7) requires another code (368.40) to fully describe the condition.

Scenario: Stroke without residuals, hypertension

A 72-year-old woman suffered a stroke and was treated in the hospital. She recovered well and is not experiencing any residual effects from the CVA. Her doctor ordered an episode of home health to monitor her recovery as well as to manage new medications for her severe hypertension. She is an insulin-dependent type 2 diabetic.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits	V12.54		
M1022b Essential hypertension, unspecified	401.9		
M1022c Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00		
M1022d Long-term (current) use of insulin	V58.67		

Rationale:

- The patient had a stroke but is not experiencing any residuals. Therefore, the scenario must be coded with V12.54, versus a code from the 438 series (Late effects of cerebrovascular disease).
- The code for long-term insulin use is assigned because the patient is stated to be insulin-dependent and her diabetes is specified as type 2. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Diabetes in ICD-10

(continued from p. 1)

in ICD-10 because those assumptions are based on ICD-9 Coding Clinic guidance, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

Consider that there *are* clear instances in which a diabetic patient has osteomyelitis but the infection's

etiology is *not* diabetes, which calls into question the viability of an assumed relationship, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas. This is likely part of why a physician's specification is required in ICD-10.

So for example, without a confirmed diagnostic connection, diabetes and osteomyelitis must be coded separately in ICD-10, with a code for the diabetes without a manifestation (such as E11.9, Type 2 diabetes mellitus without complications) and a code for the osteomyelitis (such as M86.672, Other chronic osteomyelitis, left ankle and foot), according to official ICD-10 coding guidelines [*I.B.16*].

ICD-10 diabetes codes 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 (1 or 2) and its cause (such as drug of chemical-induced diabetes, or diabetes resulting from another disease).

The diabetes code category that will be used most often in home health is E11 (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*].

In some cases, such as with diabetic ulcers, the way you'll code these conditions in ICD-10 will generally follow how you code them in ICD-9. Other times, such as the coding of diabetic peripheral angiopathy with and without gangrene, the coding is modified by the presence of a combination code.

Coding diabetic osteomyelitis simplified in ICD-10

You'll need just two codes to capture diabetic osteomyelitis in ICD-10 versus the three codes it takes now. For example, you'll assign E11.69 (Type 2 diabetes mellitus with other specified complication) followed by M86.672 (Other chronic osteomyelitis, left ankle and foot) for a patient with type 2 diabetes that has been confirmed by the physician to have caused chronic osteomyelitis in the left foot, says Blevins.

In ICD-9, diabetic osteomyelitis requires three codes: 250.8x (Diabetes with other specified manifestations) for the diabetes, 731.8 (Other bone involvement in diseases classified elsewhere) for the bone infection and 730.xx

(Osteomyelitis, periostitis, and other infections involving bone) for the specific type of osteomyelitis.

Notice, however, that there's no specific, unique code in ICD-10 for the diabetic manifestation that causes osteomyelitis, says Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas.

Furthermore, there is no listing of osteomyelitis in relation to diabetes in the ICD-10 alphabetic index. Additions to the ICD-10 alphabetic index have been proposed that would correct this, however [11/13].

But until those proposals are finalized, the choice of E11.69, for example, results from having no other feasible option, Blevins says. The non-specific '.69' in the fourth and fifth character positions, which simply means the patient has some other specified complication, are added to the appropriate diabetes code (E11.-, for example for a type 2 patient, or E10.- if the patient has type 1 diabetes) to capture the diabetic manifestation.

Prepare for greater detail in coding diabetic ulcers

In ICD-9, you can code a wound described only as a diabetic ulcer to the bottom of the foot with 250.80 (Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled) followed by 707.14 (Ulcer of heel and midfoot).

But if this is all you know in an ICD-10 world, you'd have to assign E11.621 (Type 2 diabetes mellitus with foot ulcer) for the diabetes followed by the extremely vague L97.409 (Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity).

While the **basic formula** for coding a diabetic ulcer will remain the same from ICD-9 to ICD-10 — you'll still assign the appropriate diabetes code and follow it with a code for the ulcer itself — the new system will require more detail to code this condition with the appropriate specificity.

Notice that ICD-10 offers more specific codes indicating that a patient's diabetes has caused skin complications, such as with E11.621 (Type 2 diabetes mellitus with foot ulcer). It also gives you code choices for other diabetic skin conditions, such as diabetic dermatitis (for example, E11.620) and diabetic ulcers in other areas besides the feet (for example, E11.622).

Furthermore, consider the level of detail that you'll need to choose the right ulcer code. Lower-limb

non-pressure ulcer codes are found in the L97.- category (Non-pressure chronic ulcer of lower limb, not elsewhere classified). And there you have a vast array of options to describe the location of the wound, what side of the body it's on and how severe it is.

You'll need to know whether the wound is limited to breakdown of the skin, or if it's gone deeper in to the patient's fat layer, muscle or bone. For example, L97.423 corresponds to non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle.

Tip: Save time by first searching the alphabetic index for the term "diabetes," instead of "ulcer," to find the right code, says Blevins. In fact, if you search under "ulcer" first, it will send you to "Diabetes, ulcer" anyway, so looking under "diabetes" first will save you a step. (*See the enclosed Tool of the Month for a diabetic ulcer coding decision tree*)

Combination code simplifies diabetic gangrene

Coding diabetes with gangrene in ICD-10 will be simpler thanks to the availability of combination codes grouped under the headings of diabetes with circulatory conditions and captured with a fourth character of '5.' However, these combination codes mean you'll **also** need to obtain physician confirmation that the peripheral angiopathy is related to the gangrene, Twombly says.

For example, E11.52 corresponds to Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene. Changing the fifth character to '1' would indicate diabetic peripheral angiopathy **without** gangrene. These codes, occurring in combination with peripheral angiopathy, are the **only** codes that capture diabetic gangrene in ICD-10.

The assumption that the presence of gangrene in a diabetic means there's also peripheral angiopathy makes good clinical sense, says Whitemyer. Physiologically, gangrene is a circulatory problem and a patient can't develop it without also having peripheral angiopathy. Nevertheless, you still must obtain physician confirmation of the diagnosis; no allowable assumption has been given.

Currently, coders may assume a connection between diabetes and gangrene absent another stated etiology. If that's all you know, you'd assign 250.7x (Diabetes with peripheral circulatory disorders) and the symptom code 785.4 (Gangrene), Blevins says. A connection between diabetes and peripheral angiopathy, however, is not allowed.

Scenario: Acute osteomyelitis, diabetes

A 67-year-old woman is admitted to home health on IV antibiotics to treat an acute case of osteomyelitis in her right foot. She is also diabetic and has hypertension. A call to her physician's office to determine whether the osteomyelitis is related to her diabetes was unreturned.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Other acute osteomyelitis, right ankle and foot	M86.171		
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:

- No confirmation of a connection between the patient's osteomyelitis and the diabetes can be found, so the conditions are coded separately. As the focus of care, the osteomyelitis is coded in M1021.

Scenario: Diabetic gangrene

A 92-year-old woman is admitted to home health with gangrene on her right big toe. A call to her physician reveals that her diagnosis is diabetic peripheral angiopathy and the gangrene is a result of that. The peripheral angiopathy and gangrene are the focus of care. She'll also receive monitoring of her recently changed medications for congestive heart failure.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	E11.52		
M1023: Heart failure, unspecified	I50.9		

Rationale:

- The combination code E11.52 covers the diabetic peripheral angiopathy and the gangrene. Since the type of diabetes wasn't specified, type 2 can be assumed.
- As a comorbidity that will require monitoring, her congestive heart failure is coded as well. — Megan Gustafson (mgustafson@decisionhealth.com)

News brief

- CMS has released the complete OASIS-C1/ ICD-9 guidance manual**, including Appendix D, which states all relevant coding guidance is now contained in Chapter 3 of Section C (Patient History and Diagnosis) of the Manual. To download the guidance manual, go to <http://go.cms.gov/1mJLlhc>.

ICD-10 news: 7th character use clarified, stasis dermatitis revision proposed

CMS issued minor updates to the ICD-10 official coding guidelines when it released the 2015 version on Sept. 26.

One of the updates involved several clarifications on the use of the ICD-10 seventh character, including the directive to match the seventh character on the external cause code to the seventh character on the code for the associated injury or condition that is receiving treatment.

For example, this means you would assign an "S" for sequela on the code capturing the cause of a patient's burn, such as X15 2xxS (Contact with hot plate) if you were caring for a sequela condition of that burn, like a contracture.

Other notable guidelines updates include specific examples of what constitutes sequela and clarification of how to code severe sepsis and septic shock resulting from a postprocedural infection.

More ICD-10 code proposals in the pipeline

A source of potential confusion in finding the correct ICD-10 code for stasis dermatitis could be removed per a proposal made during the ICD-10 Coordination and Maintenance Committee Meeting, held Sept. 23-24.

The proposal called for moving the clarifying term "stasis dermatitis" from I83.1 (Varicose veins of lower extremities with inflammation) to I87.2 (Venous insufficiency (chronic)(peripheral)).

This change would correctly align the index with the tabular in ICD-10, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. Currently, the ICD-10 index listing for stasis dermatitis leads you to I87.2 but the clarifying term isn't there to indicate that you've found the correct code.

The earliest this proposal could take effect is Oct. 1, 2016, when regular updates to the ICD-10 code set resume after the partial code freeze, which has been in place since Oct. 1, 2011, is set to be lifted.

Editor's note: View the 2015 ICD-10 guidelines at <http://www.cms.gov/Medicare/Coding/ICD10/Downloads/icd10cm-guidelines-2015.pdf>.

To view the proposals, go to http://www.cdc.gov/nchs/data/icd/Topic_Packet_09_23_2012.pdf.

Copyright notice

It is illegal to forward this electronic version of **Diagnosis Coding Pro for Home Health** to anyone else. It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute electronically **Diagnosis Coding Pro for Home Health** to others in your office or other sites affiliated with your organization. If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, only the party that forwards a copyrighted email is at risk, not you.

To confidentially report suspected copyright violations, call our copyright attorney Steve McVeary at 1-301-287-2266 or email him at smcveary@ucg.com. Copyright violations will be prosecuted. And **Diagnosis Coding Pro for Home Health** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Diagnosis Coding Pro for Home Health** or photocopying of our newsletter.

