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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In This Issue

Sequence neuro conditions correctly or risk reimbursement

Beware of assigning a Neuro 1 diagnosis, such as Amyotrophic lateral sclerosis (ALS) (335.20) in M1020 for a patient who is only being seen for monthly catheter changes, as this constitutes upcoding, and could put your agency at risk for claims denials and auditor scrutiny.

Instead, code the specific reason for the visit, in this case V53.6 (Fitting and adjustment of other device, urinary devices) for catheter changes, says Trish Twombly, HCS-D, senior direction for DecisionHealth in Gaithersburg, Md.

(*see **Neuro conditions**, p. 5*)

Code ostomies correctly to protect reimbursement, prevent ADRs

Don't assign V53.6 (Fitting and adjustment of other device, urinary devices) to capture the care of a suprapubic catheter, or you'll cost your agency valuable case-mix points.

Rather, code the care of a suprapubic catheter with V55.5 (Attention to cystostomy), says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas. A suprapubic catheter is a cystostomy, a surgically created artificial opening into the bladder, rather than a device that is inserted directly into the urethra.

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

Get critical hospice code training

Oct. 1 will be here before you know it, and with it will come a whole new world for hospice coders. If you're still coding the vague diagnoses debility and failure to thrive in the primary slot, or if you're misusing manifestation codes on your hospice claims, be prepared to have them returned without payment. Hospice coding expert Judy Adams details the impact of the hospice changes that take effect on Oct. 1. For more information and to purchase the CD recording, go to *https://store.decisionhealth.com/Product.aspx?ProductCode=TA2532CD*

CB Coding Basics

Learn to code stasis ulcers in ICD-10

The way you'll code stasis ulcers in ICD-10 is similar to how you code them now as your code choice will depend on the specific cause of the ulcer, either varicose veins or venous insufficiency. However, the ICD-10 environment will demand an enhanced level of detail, including identifying laterality, location and severity of the ulcer.

ICD-10 codes for stasis ulcers are found in two chapters: Chapter 9 (Diseases of the circulatory system) and in Chapter 12 (Diseases of the Skin and Subcutaneous Tissue). In a change from ICD-9, all stasis ulcers, regardless of etiology, will require two separate codes in ICD-10, one for the disease causing the ulcer (found in Chapter 9) and one for the ulcer's severity (found in Chapter 12).

A basic understanding of what stasis is and what it does is vital for accurate code assignment. Stasis refers to the stoppage or slowdown in the flow of blood, and stasis ulcers, which can also be called venous or varicose ulcers, develop in an area where the circulation is sluggish and the return of venous blood toward the heart is poor.

These ulcers develop because venous valves, usually in the legs, don't function properly. The body tries to compensate and fluid leaks from the veins into the surrounding soft tissue, leading to ulceration. Stasis ulcers are usually shallow in depth, have irregular margins and produce moderate to heavy exudate. They may have a ruddy red base and may also present with yellow slough or with granulation tissue.

Codes come down to etiology

As with any diagnosis, you must have physician confirmation that the patient's wound is a stasis ulcer, and the confirmation must further specify whether the ulcer was caused by varicose veins or venous insufficiency. This specific information is crucial because stasis ulcers with different etiologies are coded differently. Additionally, determining the ulcer's specific etiology will impact home health interventions and goals. Here are your options:

- ***If the etiology is varicose veins***, begin your search in the Alphabetic Index under the term "Varix" and then follow it to "leg" and then "ulcer." Then, in the Tabular you'll code from options for ulcers of various parts of the leg, such as I83.002 for the calf. Additional code choices are available if the patient has ulcers with inflammation, such as I83.202 for an ulcer of the calf with inflammation.

In a change from ICD-9, where only one code is required for a stasis ulcer caused by varicose veins, an additional code from category L97 (Non-pressure chronic ulcer of lower limb, not elsewhere classified) is required

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to denote the severity of the ulcer. For example, L97.213 (Non-pressure chronic ulcer of right calf with necrosis of muscle).

- ***If the etiology is venous insufficiency,*** look in the Alphabetic Index under the term "Stasis," then to "ulcer" and then to "without varicose veins" and you'll find code I87.2 (Venous insufficiency (chronic) (peripheral)).

Just like with stasis ulcers caused by varicose veins, you'll also need to assign an additional code from L97 for the severity of the ulcer, such as L97.222 (Non-pressure chronic ulcer of left calf with fat layer exposed).

Note, however, that the pathway to this code choice is not, as of yet, abundantly clear. First the index listing, though it offers code I87.2, it also directs you to 'varix, leg, with, ulcer, without varicose veins,' a listing which doesn't actually exist if you try to find it.

Additionally, there is no note at I87.2 that instructs the coder to include an additional code for the ulcer. The directive to assign an ulcer code following the venous insufficiency mirrors current ICD-9 guidance and is best practice until this confusion is clarified.

Note that ICD-10 will require more detailed documentation about the ulcer. To choose the right code, you'll need to know:

- Location (thigh, calf, ankle, heel, etc.; specified by the fourth digit)
- Laterality (right, left, bilateral; specified by the fifth digit)
- Severity of the ulcer in regards to the tissue damage involved (limited to breakdown of the skin, fat layer exposed, necrosis of the muscle and necrosis of bone; specified by the sixth digit)

Tips for coding stasis ulcers

Here are six more tips to guide your coding of stasis ulcers in ICD-10:

- Review anatomy and physiology of skin and subcutaneous tissue to become familiar with the terminology and level of detail that you'll need to use in ICD-10.
- Remember that the diagnosis must be documented by the physician, but the code for the severity of the ulcer can be obtained from the assessing clinician's documentation.
- Do not stage stasis ulcers. Only pressure ulcers are staged.
- Do not document that a wound is a diabetic venous stasis ulcer. A stasis ulcer is not a manifestation of diabetes mellitus.
- Avoid upcoding by assigning the correct codes that represent the specific origin of the stasis ulcer.
- Never assume the etiology of an ulcer although it may appear obvious.

Scenario: Venous stasis ulcer

A patient is admitted to home care for teaching and training for wound care to a stasis ulcer of his left ankle with fat layer exposed. The stasis ulcer was caused by venous sufficiency.

Code the scenario in ICD-9:

Primary and Secondary Diagnoses			M1024 Case Mix 3	4
M1020a	Venous (peripheral) insufficiency, unspecified	459.81		
M1022b	Ulcer of ankle	707.13		

Rationale:

- The stasis ulcer caused by venous insufficiency is captured first with the code for underlying disease (459.81) followed by the code for the location of the ulcer (707.13).

Code the scenario in ICD-10:

Primary and Secondary Diagnoses			M1025 Additional Diagnoses	
M1021	Venous insufficiency (chronic) (peripheral)	I87.2		
M1023	Non-pressure chronic ulcer of left ankle with fat layer exposed	L97.322		

Rationale:

- Similar to scenario coded in ICD-9, this scenario requires a code for the etiology of the ulcer (the venous insufficiency) and the location of the ulcer. Note that the ICD-10 ulcer code offers a much greater level of detail including the depth of tissue the ulcer has affected.

Scenario: Non-healing stasis ulcer with varicose veins

A patient is admitted to home care with a diagnosis of a non-healing stasis ulcer on his right lower leg with skin breakdown. The physician specified that the stasis ulcer resulted from varicose veins. Skilled nursing has been ordered to provide wound care.

Code the scenario in ICD-9:

Primary and Secondary Diagnoses		M1024 Case Mix 3	M1024 Case Mix 4
M1020a Varicose veins of lower extremities with ulcer	454.0		

Rationale:

- The stasis ulcer is the result of varicose veins and is captured with 454.0. No code from 707.1x is required as the 454 series is excluded from the 707.1x series, and the ulcer is included in the 454.0 code title.

Code the scenario in ICD-10:

Primary and Secondary Diagnoses		M1025 Additional Diagnoses	
M1021 Varicose veins of right lower extremity with ulcer other part of lower leg	I83.018		
M1023 Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin	L97.811		

Rationale:

- Since the ulcer was caused by varicose veins, the I83.0- category is the appropriate place to begin, and I83.018 specifies the location of the ulcer.

- Unlike in ICD-9, a separate code is needed to identify the severity of the ulcer, L97.811 in this case to indicate that the wound is limited to the skin.

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? Ask the Expert

Get ready for hospice changes

Starting Oct. 1, CMS will start returning to provider (RTP) all hospice claims that have the vague symptom codes debility (799.3) or failure to thrive (783.7), or a unspecified dementia code (such as 290.0, Senile dementia, uncomplicated), in the primary position. *(See the list of dementia codes that are invalid as primary diagnoses on hospice claims on p. 5).*

Additionally, hospice claims that inappropriately use manifestation codes (such as 294.10, Dementia in conditions classified elsewhere without behavioral disturbance) will be RTP'd as well. This month's Ask the Expert address common hospice coding questions.

Question: *What if the hospice patient's chart indicates that the terminal diagnosis is a fracture; what should I code?*

Answer: Look for another reason, such as a bone cancer, as it's highly unusual that a fracture would be a terminal diagnosis, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

Discuss with the physician and the IDG whether there's another condition more appropriate for selection as the terminal diagnosis that may have put the patient at a risk for falls wherein a fracture would be sustained, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C. Investigate what's happened to the patient within the past three to six months that has led to his terminal status.

"It's not the fracture that's causing their demise," says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va., who has included aftercare V codes for fracture care on hospice claims as secondary diagnoses for hospice patients who are not candidates for surgery to repair the broken bone, for example. But the aftercare V code cannot be the primary reason the patient is terminal, as V codes cannot be assigned as primary on hospice claims.

Remember that active fracture codes, such as 820.8 (Hip fracture NOS), cannot be assigned as active diagnoses in post-acute care settings such as hospice and home health, according to coding guidelines.

Question: *What if the patient's terminal diagnosis is listed simply as "dementia" with no stated etiology?*

Answer: Seek to change the patient's terminal diagnosis through discussion with the interdisciplinary group, Adams says.

Look for an underlying condition that may be responsible for the dementia, such as Alzheimer's disease or Parkinson's disease. If there's no known underlying disease code the dementia as 294.20 or 294.21 depending on whether the patient has behavioral disturbance or not. Then, look at other conditions the patient may have that are contributing to his or her terminal status, and choose one of those conditions that is most contributory to the terminal status to list as the principal diagnosis making the unspecified dementia a secondary code, she says.

And, remember that patients with unspecified dementia, adult failure to thrive, debility and other vague diagnoses don't have just one condition that is responsible for their terminal status, but rather a combination of conditions and factors that has led to their being terminal. It's the job of the hospice to identify and code every condition and diagnosis that's contributing to the patient's terminal prognosis, Adams says.

Question: *Can a speech therapist diagnose a patient with dysphagia or must that come from the physician before we can code it?*

Answer: Yes, you can assign the code for dysphagia (787.2x) with documentation from a speech therapist but keep in mind that this only identifies the symptom of difficulty swallowing, not its cause, Whitemyer says. You should make every effort to determine the underlying reason, such as the late effect of a CVA (438.82), and code that in addition to the symptom code but physician must be the one to determine the cause.

Codes invalid for hospice primary diagnoses

The following codes will be invalid as primary diagnoses on hospice claims beginning Oct. 1, according to CMS Transmittal 3032/Change Request 8877 released Aug. 22. View the transmittal at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3032CP.pdf.*

290.0	290.3	290.9	293.89	310.0-2
290.10-13	290.40-43	293.0-1	294.20-21	310.89
290.20-21	290.8	293.81-83	294.8	310.9

Neuro conditions

(*continued from p. 1*)

Your agency's care must be focusing on more than one aspect of the patient's ALS, such as speech therapy for dysphagia, in order to code it in the primary position, Twombly says. In the case of Neuro 1 diagnoses, which earn more case-mix points when coded primary, improperly assigning them in M1020 is blatant upcoding.

You should still code the ALS as a relevant comorbidity, but as a secondary diagnosis in M1022, says Jean Bird, HCS-D, QA manager for Gentiva in Fall River, Mass.

Neuro 1 and Neuro 2 conditions, along with those in categories Neuro 3 and Neuro 4, will undergo some drastic case-mix recalculations if the 2015 proposed PPS rule becomes final. The proposed changes are all over the map for these diagnoses – in some cases they'll earn more points and in others, much less *(CPH, 9/14). (See the scenario comparison on p. 9 for an estimate of the cost of the proposed case-mix changes.)*

While experts remain unable to pinpoint explainable reasons for these proposed changes, they're in agreement that no agency is in a position to put its reimbursement at risk, either through upcoding or leaving dollars on the table, both of which occur via common coding errors involving Neuro 1 (such as brain neoplasms) and Neuro 2 (such as Parkinson's disease) diagnoses.

Decipher Parkinson's, related diagnoses to protect payment

Understand that Parkinson's disease (332.0), which can cause dementia, and Parkinsonism (331.82), which is also known as dementia with lewy bodies, are ***two separate conditions*** that should be coded differently, says Twombly. Note that code 332.0 carries an Excludes note that specifically excludes 331.82.

Deciphering between Parkinson's disease with dementia and Parkinsonism or dementia with lewy bodies is one of the biggest challenges coders face when capturing these conditions, says Linda Phillips, HCS-D, QA reviewer for McBee Associates in Destin, Fla.

And if the PPS changes become final, making the wrong choice could cost you because 331.82 falls under the Psych 2 category, which may no longer earn case-mix points. Parkinson's disease, as a Neuro 2 diagnosis, will still earn points.

Parkinsonism represents clusters of Parkinson's-like traits, but it is distinct from Parkinson's disease and impacts a different area of the brain. Additionally, the two conditions do not typically respond to the same treatments, says Brandi Whitemyer, HCS-D, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

Assign 332.0 (Parkinson's disease NOS) followed by a code from the 294.1x series (Dementia in conditions classified elsewhere) for a diagnosis described as Parkinson's disease with dementia, Phillips says. As a manifestation code, 294.1x specifies that the dementia is a manifestation of the Parkinson's disease, and it must be sequenced directly following it, according to coding conventions *(I.A.6)*.

If the patient has both conditions (Parkinson's disease and dementia) but they're not specifically linked by the physician, code them separately with 332.0 and a code from the 294.2x series (Dementia, unspecified) unless the type of dementia is further specified (such as senile dementia, 290.0), she says.

Assign 331.82, followed by a code from 294.1x, for a patient with a confirmed diagnosis of Parkinsonism or dementia with lewy bodies. Tabular instructions call for the additional assignment of the dementia manifestation code.

Tip: Don't ever assume a connection between Parkinson's disease and dementia just because a patient has both diagnoses, Phillips says. Make sure you have physician confirmation of the connection before you code it.

Avoid forfeiting points on brain neoplasms

If you don't sequence a brain neoplasm, provided it's still an active diagnosis, directly following the surgical aftercare code (such as a V58.42, Aftercare following surgery for neoplasm), you're leaving points on the table, Twombly says.

Coders often forget that brain neoplasm codes, such as 191.9 (Malignant neoplasm of brain, unspecified) and 225.0 (Benign neoplasm of brain) fall into the Neuro 1 category, and not the neoplasm category, she says.

Note that Neuro 1 diagnoses earn more points when coded primary, and under the M1024 rules that took effect on Jan. 1, 2013, codes in the case-mix loss groups (Neuro 1, Skin 1 and Diabetes) will still receive primary points when coded in M1022b immediately following a V code *(CPH, 8/12)*.

But coders are apt to assign less-important V codes for dressing changes (such as V58.31, Encounter for change or removal of surgical wound dressing) or some other comorbidity immediately following V58.42 for patients in these scenarios, and in doing so, they forfeit deserved reimbursement for their agencies, Twombly says. Note that eight case-mix points are available for a Neuro 1 "primary" diagnosis. *(See the Tool of the Month for a quick guide to choosing Neuro codes.)*

HHAs to lose case-mix points for their most commonly assigned diagnoses

You will lose case-mix points for your most common diagnoses if the proposed PPS rule becomes final, according to 348 home health agencies responding to *DecisionHealth*'s proposed PPS rule survey.

For example, agencies report that 56% of their current patient cases have a hypertension/heart disease diagnosis. Hypertension/heart disease diagnoses currently garner a maximum of seven case-mix points, but in the reworked proposed case-mix system, they would only garner one point. Also, in the proposed case-mix table, high-therapy episodes (14 or more visits) would garner the most case-mix points, which would not really benefit home health agencies, as they report that most of their patients (75%) do not receive enough therapy visits to meet that threshold, according to the survey data.

What percentage of your current patient cases have the following diagnoses:

Diagnosis category	Percentage
Hypertension/Heart disease	56%
Diabetes	44%
Pulmonary (i.e. COPD)	39%
Psych (i.e. dementia)	26%
Low vision	20%

Which of the statements below describes the majority of your patient cases?

Therapy utilization level	Percentage
Our patients receive 1 to 13 therapy visits	75%
Our patients receive 14 or more therapy visits	25%
Our patients do not receive therapy	Less than 1%

More tips for properly coding Neuro diagnoses

Here are two more tips to help guide your coding of these conditions:

- **Never assign the code for a late effect of a traumatic brain injury (907.0) before the code for its residual**, such as seizures (780.39). As a Neuro 1 diagnosis, 907.0 would earn primary points if sequenced first, but to do so would be a violation of coding guidelines which stipulate the assignment of the residual before the late effect code. This would be upcoding, Twombly says.
- **Code the condition that's the focus of care, such as a pressure ulcer, in the primary position** for a patient whose neuro condition is likely the cause of the issue, says Bird. For example, codes for the pressure ulcer's location (such as 707.05, Pressure ulcer, buttock) and stage (such as 707.24, Pressure ulcer, stage 4) should be assigned before a patient's quadriplegia (344.00), even though the quadriplegia will have a significant impact on the patient's recovery. To code the quadriplegia, a Neuro1 diagnosis, in the primary position in this case would also constitute upcoding.

Scenario: Malignant neoplasm of the brain, hypertension, diabetes

A 65-year-old man comes to home health following surgery to remove a cancerous tumor in his brain. He is currently undergoing chemotherapy. Home health will provide surgical aftercare as well as medication monitoring, as his meds for hypertension were recently adjusted. He's also a type 2 diabetic.

Code the scenario:

Primary and Secondary Diagnosis			M1024 Case Mix 3	4
M1020a	Aftercare following surgery for neoplasm	V58.42		
M1022b	Malignant neoplasm of brain, unspecified	191.9		
M1022c	Essential hypertension, unspecified	401.9		
M1022d	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00		

Rationale:

- The brain neoplasm is an active diagnosis because the patient is still undergoing treatment and thus it should be coded as it will have a huge impact on the patient's recovery and care. It is sequenced directly following the aftercare V code so it will earn the primary points for being a Neuro 1 diagnosis.
- The patient's hypertension and diabetes are coded as relevant comorbidities that will require monitoring.

Scenario: Pressure ulcers, quadriplegia

A 42-year-old man is a quadriplegic as a result of a diving accident five years ago in which he severed his spinal cord. He was recently hospitalized after his caregiver found a stage 4 pressure ulcer on his lower back. Home health will

provide wound care as well as therapy to aid his caregivers in pressure-relieving techniques to avoid the development of future pressure ulcers. The patient is wheelchair bound and has a cystostomy, the care of which his caregiver is able to manage.

Code the scenario:

Primary and Secondary Diagnoses			M1024 Case Mix 3	4
M1020a	Pressure ulcer lower back	707.03		
M1022b	Pressure ulcer, stage 4	707.24		
M1022c	Quadriplegia, unspecified	344.00		
M1022d	Late effect of spinal cord injury	907.2		
M1022e	Artificial opening status, cystostomy, unspecified	V44.50		

Rationale:

- The pressure ulcer is the focus of care and therefore must be coded primary, with the code for the stage (707.24) directly following the code for the location (707.03).
- His quadriplegia is sequenced immediately after, as it will have a tremendous impact on his care. As the specific residual that is the late effect of a spinal cord injury, it also must be sequenced before 907.2.
- The patient has a cystostomy but his caregiver is able to manage it independently, and therefore V44.50 is the appropriate code to capture it. —*Megan Gustafson (mgustafson@decisionhealth.com)*

Ostomies

(continued from p. 1)

The improper coding and inconsistent OASIS responses for various types of ostomies common in home health, like cystostomies and colostomies, is an ongoing issue that is costing agencies rightful reimbursement, experts say.

For example, coders frequently see a reference to a urinary catheter or a mention of a "Foley," and automatically assume a urethral catheter. Or "they don't realize (a suprapubic catheter) is an ostomy," Whitemyer says.

Remember that mention of a catheter or a "Foley" only references the ***device***, which can be used in either situation and doesn't automatically mean it's a urethral catheter, says Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas. The correct code will depend on discerning ***where*** and ***how*** the catheter is inserted.

But hasty assignment of V53.6 will cost you because V55.5 carries up to 22 case-mix points depending on therapy usage and episode timing, while V53.6 carries no points. In fact, V55.5 is one of only three V codes (the others being V55.0, Attention to tracheostomy, and V55.6, Attention to other artificial opening of urinary tract) that carry case-mix points.

The extra points available for the care of the cystostomy correspond to the fact that it's more complicated than a urethral catheter – for example, the potential for skin breakdown at the site of the artificial opening must be taken into account during the epsiode, Whitemyer says.

Furthermore, incorrectly marking a suprapubic catheter as a urethral catheter will also lead to a wrong response to M1350 (Skin lesions/open wounds), which should be marked with '1' for 'yes' because that item captures the care of non-bowel ostomies, Whitemyer says.

Physician's documentation key to correct code

Carefully review all documentation when coding a patient's ostomy to avoid assigning an incorrect code. Consider a case recently seen by coder Shirley Kucirek, HCS-D, owner of MBIC in Rochester, Minn. The patient had a colostomy for which the agency would be providing care, and a diagnosis of abdominal cellulitis.

The nurse's documentation listed the two conditions as separate diagnoses, but a review of the physician's documentation indicated that the cellulitis was a complication of the colostomy, Kucirek says.

Had Kucirek coded the case based on the nurse's documentation without a closer review of the record, she would have wrongly assigned V55.3 (Attention to colostomy) instead of the 569.61 (Infection of colostomy and enterostomy). Remember, V codes should never be used if a complication is present, such as cellulitis in this case.

And it would have been a costly mistake: Code 569.61 carries up to six case-mix points as a GI disorder, ***plus*** an additional two points could be earned in conjunction with a response to OASIS item M1630 (Bowel elimination) for the colostomy. By contrast, the V55.3 code earns no case-mix points.

Tip: Code skin irritation around a colostomy site, including a fluid-filled blister, as a complication of the colostomy, and not as contact dermatitis, an ulcer or a superficial skin injury, says Lisa Selman-Holman, HCS-D, principal of Selman-Holman Associates and the coding service CoDR – Coding Done Right in Denton, Texas *(CPH, 3/11)*.

Tip: Ensure that a patient's colostomy is captured on the OASIS in M1630 (Bowel elimination) even if the patient is independently caring for it because the agency is responsible for providing supplies even if it's not providing interventions, Rambusch says. The OASIS response will earn valuable non-routine supply (NRS) points that are necessary to defray the cost of those supplies.

Choose the right V code, avoid ADRs

Be wary of assigning a code from the V55 series, such as V55.5 (Attention to cystostomy), to capture routine care of a patient's ostomy for more than one episode, Whitemyer says.

A V55 series code implies that the agency is providing some kind of ***intervention to the ostomy***, and if that isn't the case, then a V44.x code (Artificial opening status) should be assigned to denote the ***presence*** of the ostomy, she says. Wrongfully assigning an "attention to" code when a status code is the correct choice could constitute upcoding.

Confusion about choosing between the V44.x and V55.x codes is one of the most common mistakes coders make when it comes to capturing ostomies, Kucirek says. For example, many times, they'll look at a chart, see that the patient has a colostomy and go automatically to code V55.3 (Attention to colostomy).

Ostomies receive home health care most often when they're new or complicated and require patient/caregiver teaching. If the ostomy is complicated, a V should ***never*** be used. Remember, V codes are for routine care; a complication is not routine care, Whitemyer says.

Furthermore, most patients with ostomies can be taught to care for them independently within three to seven visits. Medicare generally won't pay your

See how the proposed case-mix changes could cost your agency

Consider the difference in reimbursement using current case-mix calculations vs. the proposed case-mix changes.

Scenario: Hemiplegia as a late effect of a CVA

An 80-year-old female patient is admitted for management of hemiplegia of her dominant side as a late effect of a CVA that occurred six days ago. She also has congestive heart failure and diabetes. Her doctor has ordered 14 therapy visits and the epsiode will fall into early episode, high therapy, equation 2.

Code the scenario:

Primary and Secondary Diagnoses			M1024 Case Mix 3	M1024 Case Mix 4
M1020a	Hemiplegia affecting dominant side as late effect of cerebrovascular disease	438.21		
M1022b	Congestive heart failure, unspecified	428.0		
M1022c	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00		

Rationale:

- The combination code 438.21 captures both that she has a late effect residual from a CVA, and what that residual is, dominant-side hemiplegia.
- As relevant comorbidities that will impact her recovery, her congestive heart failure and diabetes are also coded.

Estimated reimbursement:

Current (2014)	Proposed (2015)
Case-mix points from diagnoses = 16 ▸ CVA late effect = 2 ▸ CVA + M1820 = 3 ▸ CHF = 6 ▸ Diabetes = 5	Case-mix points from diagnoses = 14 ▸ CVA late effect = 10 ▸ CVA + M1820 = 4 ▸ CHF = 0 ▸ Diabetes = 0
C Score = 16 (C3)	C Score = 14 (C3)
F Score = 10 (F3) ▸ M1810/20 (Response 2) = 4 ▸ M1830 (Response 2) = 3 ▸ M1840 (Response 2) = 3 ▸ M1850 (Response 1) = 0 ▸ M1860 (Response 2) = 0	F Score = 6 (F2) ▸ M1810/20 (Response 2) = 0 ▸ M1830 (Response 2) = 3 ▸ M1840 (Response 2) = 3 ▸ M1850 (Response 1) = 0 ▸ M1860 (Response 2) = 0
S Score (Therapy) = S1 (14 visits)	Score (Therapy) = S1 (14 visits)
C3F3S1 (1.6263) = $ 4,666.29	**C3F2S1 (1.5386) = $ 4,496.96** **Difference in payment is a loss of $169.33**

Source: Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Tx.

agency to provide routine ostomy care beyond one episode as it's not considered a skill, Whitemyer says.

"If you're sending in routine care (for ostomies) all the time, you're going to end up with an ADR," she says.

Tip: Look for documentation that indicates the agency is providing some kind of intervention to the ostomy that would support the use of an "attention to" V55.x code, such as assessing the skin around the opening or teaching on the care and management of a new ostomy, Whitemyer says.

Tip: Do not assume that a urinary tract infection (UTI) in a patient with a urinary catheter is a complication of the catheter. The physician must specify the connection between the two, according to the Coding Clinic Q3 2009 *(CPH, 5/10)*.

Tip: Query the physician about the etiology of a UTI in a patient with a suprapubic catheter, Rambusch says. The correct code to capture the UTI will depend on whether it can be attributed to the ***urinary device*** (with 996.64, Infection and inflammatory reaction due to indwelling urinary catheter) or to the ***ostomy opening itself*** (with 596.81, Infection of cystostomy).

Scenario: Urine incontinence, cystostomy

A 78-year-old woman who is incontinent of urine is referred to home health with a urinary tract infection (UTI). She had a suprapubic catheter placed while she was in the hospital in hopes that it would be less likely than a urethral Foley to cause UTIs. Documentation in the chart offers no indication that the UTI is secondary to the indwelling catheter, and calls to the physician's office seeking clarification were not returned. The plan of care will focus on treatment of the UTI, as well as teaching care of the new suprapubic catheter.

Code the scenario:

Primary and Secondary Diagnoses		M1024 Case Mix 3	4
M1020a Urinary tract infection, site not specified	599.0		
M1022b Attention to artificial opening: Cystostomy	V55.5		
M1022c Functional urinary incontinence	788.91		

Rationale:

- As the focus of care, the UTI is coded primary. Because it could not be confirmed to be a complication of the cystostomy, it is coded separately.
- The patient's urinary catheter is described as a suprapubic catheter, which is a cystostomy, and because the agency is providing attention to the ostomy, V55.5 can be coded.

Visit the Home Health Coding Center (codingcenter.decisionhealth.com) to see another ostomy scenario.

News briefs

- **CMS has instructed Medicare Administrative Contractors (MACs) to promote ICD-10 acknowledgement testing** during three specific weeks: Nov. 17–2; March 2–6, 2015 and June 1– 5, 2015, CMS stated in IOM 100-20, Change Request 8858. However, it will allow such testing any time before the Oct. 1, 2015 implementation deadline. ICD-10 acknowledgement testing is done to see whether ICD-10-coded claims can be received by CMS. Learn more at *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1423OTN.pdf*
- **Correction:** The "Heel ulcer, diabetic neuropathy" scenario on p. 9 in the August 2014 issue should have described the patient's diabetic neuropathy as polyneuropathy, instead of peripheral autonomic neuropathy.

