

ICD-10-CM for Home Health Outreach Staff Webcast #1



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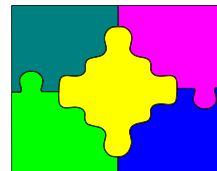
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Referral Data: Impact Overview

- **Lay the Groundwork for Comprehensive Assessment & Care Plan**
 - Accurate Case Mix
 - Appropriate Care Plan
- **Provide Current & Historical Data**
 - All Relevant Medical Data
- **Clear Transmission of Prior Setting(s)**
- **Regulatory Foundation**
 - Communication
 - Referral Needs/Orders
 - Face to Face Encounter



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Objectives



- **Identify expanded medical documentation for Home Health to assign accurate ICD-10-CM diagnosis codes;**
- **Discuss disease specific medical documentation most pertinent to home health providers;**
- **Detail required medical documentation for common home health diagnosis;**
- **Utilize tools and tips to enhance accurate ICD-10-CM diagnosis code selection and sequencing;**
- **Apply ICD-10-CM to common case examples in the home health setting that requires specific documentation.**

Deja Vu

- **Some Ready, Some Not**
 - **28% Home Care Providers have performed ICD-10 Assessments**
 - **68% have budgeted ICD-10 Resources for 2015**
 - **37% System Providers have integrated with System ICD-10 assessments and training**
 - **74% are confident they will meet ICD-10 Deadline of October 1, 2015**
- **CMS on ICD-10 Impact**
 - **Requires a Sense of Urgency**
 - **Failure to Meet this Deadline May be Devastating to Providers (13% Denial Rate: October 1, 2015)**

COUNTDOWN

For Coders.....

- **Know the ICD-10-CM Code Guidelines**
- **Consider All Code Conventions**
 - Convention Trumps Guidelines
- **Know the Default Codes**
 - In all Chapters
- **Scan Medical Documentation and Clinician Assessments to Ensure Consistency**
- **Unspecified Codes**
- **Query Only When Necessary**
- **Feedback to Intake and Clinicians is Critical**
 - Learning Curve



Dual Code Interface

- **Check CMS Memorandum SE1410 for further Revisions**
 - Revised twice to address coding spanning October 1
 - Chart for RAP's; ROC's; Recerts; Final Claims
- **Clarifies Coding for Claims that Span October 1st**
- **Expect Further Updates on this Memo**
 - Considerations
 - MO090 Dates
 - From/Through Dates
 - RAP Dates
 - Final Claim Dates

2015 CM Updates

- **Current CMS ICD-10-CM Case Mix Not Updated**
 - Draft posted case mix diagnoses include non-case mix due to 2015 PPS Updates
- **Access and Download Updates 5/1/15**
 - Cross Reference with Tools for Intake and Staff
- **Current ICD-10-CM Assignment Plan**
 - Recertifications
 - LUPA's; Other
- **Timing of ICD-10-CM**
 - Dual Code Process
 - Testing

The Reality of ICD-10-CM

- **ICD-10-CM (The Next Generation)**
 - Provides specificity & detail not in ICD-9-CM
- **Final Rule: January 16, 2009**
 - HIPAA Transaction Code Sets
 - HITECH: 5010 Electronic Format
 - Access: <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>
- **Replaces ICD-9-CM October 1, 2015**
 - Aligns with worldwide code systems
 - Enhanced accuracy and specificity (granularity)
 - Higher quality healthcare data for research & outcomes
 - Ability to meet HIPAA electronic code set regulations
 - **Requires Greater Specificity with Anatomy & Physiology**

History & Use

- *The International Classification of Diseases, Clinical Modification (ICD-10-CM)*
 - a. Based on WHO (1994)
 - b. Classifies morbidity
- NCHS modified for use in the United States
- ICD-10-CM Committee
 - a. American Hospital Association
 - b. National Institute for Health Statistics
 - c. Centers for Medicare & Medicaid
 - d. American Health Information Management
- WHO Owns and Copyrights ICD-10
 - a. October 1, 2015 in U.S. (ICD-10-CM)
 - b. No delays or grace periods

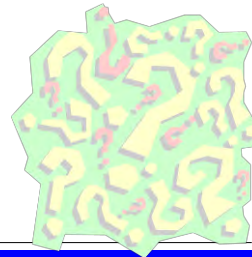


Why is Coding So Important?

- Statistical Data – Track and trend best practice variances; volume; complications; treatment patterns
- Research for Enhanced Outcomes and Treatments
- Reflects Patient Acuity for injury or illness; Plan of Care centers on Codes and Severity Indices
- Medical Necessity Determination
- PPS Payment – HHRG calculation
- Resource Allocation
- Risk Adjustment for Quality Outcomes
- Accurate Reimbursement for All Settings

So What Does CMS Want?

- **Intake Provides Critical Medical Data**
- **Ensure Accurate Current Diagnoses**
- **Greater Precision for Treatment, Communication and Care Planning**
- **Ensures Accurate Payment for Services**
- **Decrease Supporting Documentation Needs with Claims and Audits**
- **Enhances Data Integrity**
 - Evolving Payment Models
 - Incentive Programs



Be a Detective

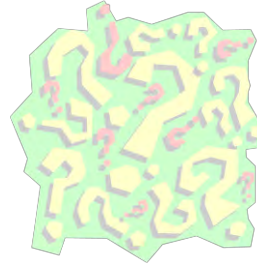
Documentation is Key

- All reported codes **MUST** be supported by physician documentation in the medical record
- Report an updated, accurate picture of patient's health status reflected in OASIS assessments and clinical documentation
- Report diagnoses and conditions which relate to the patient's **CURRENT** plan of care
- Historical and acute care conditions that impact Care Plan Risk Management
- Do **NOT** include conditions that have been resolved or no longer effect patient care needs



Number of Diagnosis Codes

- **ICD-9-CM Compare to ICD-10-CM**
- **Diagnoses**
 - ICD-9-CM = 14,315
 - ICD-10-CM = 69,099
- **Procedures**
 - ICD-9-CM = 3,838
 - ICD-10-PCS = 71,957
- **Two Code Manuals**
 - ICD-10-CM Diagnosis Manual (Volumes 1 & 2)
 - ICD-10-PCS Procedure Manual (Volume 3)



Intake Is Critical Here

- **Medical Documentation to Support ALL Pertinent Diagnoses**
- **Diagnosis Documentation Details**
 - Type of Disease or Injury
 - Acuity and Severity (Chronic or Acute)
 - With or without Signs and Symptoms
 - Etiology and/or manifestations of a disease
 - Laterality and anatomical location
 - With or without complications
 - External cause(s) of injury or illness
- **Specificity is Critical with ICD-10-CM**

Surgical Aftercare

■ Documentation Needs

- Reason of Surgery
 - Acute condition or planned
 - Joint Replacement or Revision
- Routine or Complications
- Treatment(s)
- Related Past History



■ Routine Aftercare

- No Complications or Infections
- Home Health Uses Z Codes (Replaces V Codes)
- I-10 Surgical Aftercare Codes are a bit Tricky
 - Reason for Surgery is Essential

Routine Care: Z Diagnosis Codes

Definition: Z Codes are used to identify encounters for reasons other than illness or Injury (Z00-Z99)

Same concept as V codes but expanded content

Rephrased Titles

Encounter Reasons

Exposure to hazardous substances

Inoculations & vaccinations

Status

Artificial openings

History of

Aftercare

Observation

Routine Care

Common Aftercare Diagnoses

- **Z47 Orthopedic Aftercare**
 - **Excludes1** *Aftercare for healing fracture-code to fracture with 7th character D*
 - **Z47.1** Aftercare following joint replacement surgery
Use additional code to identify the joint (Z96.6-)
 - **Z47.2** Encounter for removal of internal fixation device
 - **Z47.81** Encounter for orthopedic aftercare following surgical amputation
Use additional code to identify the limb amputated (Z89.-)
 - **Z47.82** Encounter for orthopedic aftercare following scoliosis surgery
 - **Z47.89** Encounter for other orthopedic aftercare
- **Z48 Encounter for other postprocedural aftercare**

More on Aftercare for Surgery

- **Z48 Encounter for other postprocedural aftercare**
 - **Z48.2 Encounter for Organ Transplant**
 - **Z48.21** Encounter for aftercare following heart transplant
 - **Z48.3 Aftercare for surgery for neoplasm**
Use additional code for the neoplasm
 - **Z48.81 Encounter for surgical aftercare following surgery on specified body systems**
 - **Z48.810** Encounter for surgical aftercare following surgery on the sense organs
 - **Z48.811** Encounter for surgical aftercare following surgery on the nervous system
 - **Z48.813** Encounter for surgical aftercare following surgery on the respiratory system
 - **Z48.814** Encounter for surgical aftercare following surgery on the teeth or oral cavity

Common Case Scenario

- Patient admitted to home health post right hip replacement. SVN for PT/INR & dressing changes. PT for gait training, home safety, muscle strengthening and assistive device. HTN.

ICD-9-CM

~~V54.81 A/C Joint Replacement
781.2 Abnormal gait
401.9 HTN
V58.83 Enctr. Drug monitoring
V58.61 Long term Use of anticoags
V58.31 Dressing Changes
V43.65 Joint Replaced, Hip~~

ICD-10-CM

Z47.1 A/C joint replacement
Z96.641 Right artificial hip joint
I10 HTN
Z51.81 Enctr. therap. drug mn.
Z79.01 LT use anticoags
Z48.01 Surgical dressing chngs.

**Documentation Needs: Reason for Surgery
Which Hip Replaced?**

Another Case Scenario

- Patient admitted post hospitalization for CABG for CAD. HTN; Hyperlipidemia; Monoplegia lower right limb post CVA 2 years ago..

Z48.812 Aftercare following surgery for circulatory system

I25.10 CAD

I69.341 Monoplegia, lower right limb, post CVA

I10 Essential Hypertension

E78.5 Hyperlipidemia

Z95.1 Status post aortocoronary bypass

**Documentation Needs: Reason for Surgery
Other Pertinent Co-morbidities**

Aftercare Diagnosis Diversity

- Aftercare for CABG: Z48.812
- Aftercare Surgery to remove cancerous tumor
Brain Neoplasm: Z48.3
- Aftercare Periprosthetic fracture around internal
prosthetic right hip joint: Z47.3-; Z96.6-
- Aftercare following appendectomy: Z48.815
- Aftercare post amputation left foot: Z47.81; Z89.-
- Aftercare ileostomy: Z43.2
- Aftercare Gastrostomy infection: K94.22

Documentation Needs: Specific Reason for Surgery
Specific Site of Surgery

Diagnoses for Ostomies

- Z43 Encounter for attention to artificial openings
Excludes1: artificial opening status only, without need for care (Z93.-)
complications of external stoma (J95.-, K91.4-, N99.5-)
Excludes2: fitting and adjustment of prosthetic and other devices (Z44-Z46)
 - Z43.0 Encounter for attention to tracheostomy
 - Z43.1 Encounter for attention to gastrostomy
 - Z43.2 Encounter for attention to ileostomy
 - Z43.3 Encounter for attention to colostomy
 - Z43.4 Encounter for attention to other artificial openings of the digestive tract
 - Z43.5 Encounter for attention to cystostomy
 - Z43.6 Encounter for other artificial openings of the urinary tract (nephrostomy, ureterostomy, urethrostomy)

Other Status & History

- Describes the health status of patients
 - Z17 Estrogen receptor site
 - Z46.6 Encounter for fitting & adj. of urinary catheter
 - Z89.411 Acquired absence of right great toe
 - Z66 Do not resuscitate
 - Z79 Long term drug therapy
 - Z74.01 Bed confinement
 - Z93 Artificial opening status
 - Z96.651 Presence of right artificial knee joint
- Personal or family history of illness
 - Z80 Family History of primary malignancy
 - Z85 Personal History of malignant neoplasm

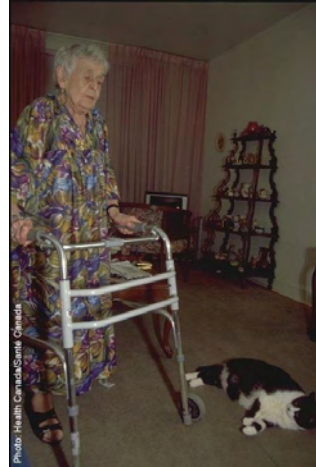
*Secondary
Dx codes*

Other Helpful Data

- History of UTI: Z87.440
- Encounter for therapeutic drug monitoring: Z51.81
- Long term use of anticoagulant: Z79.01
- Below the right knee amputation status: Z89.511
- Supplemental oxygen: Z99.81
- Long term current use of insulin: Z79.4
- History of Falls: Z91.81
- Left knee replacement status: Z96.652
- History of Pneumonia: Z87.01
- Exposure to environmental tobacco smoke: Z77.22

Injuries

- Anatomical Site/Location of Injury
- Specific Type of Injury
- Laterality
- Open *or* Closed
- Displaces or Non-displaced
- Degree of Healing
- Associated Injury
- External Cause(s) of Injury
- *Let's Look at One Example*



Injury Example

- Medical Summary
- Right wrist AP lateral, oblique and 22 degree elevated lateral view, all demonstrate a well-fixed intraarticular distal radius fracture, very comminuted in nature. There is a volar plate and screw fixation noted. Intercarpal distance is without any abnormalities
- Impression: Right intraarticular distal radius fracture, status post open reduction internal fixation 12/19/14. Plan: Cast times 4 weeks with follow-up appt.

Injury Documentation Needs

- **Anatomical site/location:** *Distal Radius*
- **Specific Type/Name of Fracture:** *intraarticular*
- **Laterality:** *right*
- **Open or Closed:** *Comminuted, oblique = closed*
- **Degree of Healing:** *routine*
- **Gustillo Open Fracture Classification:** *N/A*
- **Initial or subsequent episode of care:** *HH is always subsequent (Hospital is always initial)*
- **Associated injury:** *None documented*
- **Cause:** *None Documented*

Open versus Closed

Closed	Open
Comminuted	Compound
Depressed	Infected
Elevated	Missile
Fissured	Puncture
Greenstick	Foreign Body Impact
Impacted	
Linear	
Stress	

Injury Diagnosis Examples

- S01.01 Laceration without foreign body scalp
- S06.2x0 Diffuse traumatic brain injury without loss of consciousness
- S23.0 Traumatic rupture of thoracic vertebrae
- S31.812 Laceration with foreign body of right buttock
- S36.115 Moderate laceration of liver
- S37.021 Major contusion of right kidney
- S40.811 Abrasion of right upper arm
- S43.005 Unspecified dislocation of left shoulder
- S47.2 Crushing injury of left shoulder and upper arm

Traumatic Fractures

- Cause
 - Injury (Sports; Vehicles; Other)
- Code Assignment
 - Anatomic Site
 - Laterality
 - **Fracture Type**
 - Displaced or nondisplaced
 - Open or Closed
 - Episode of Care (7th character)
- Documentation Needs: Open Fracture Long Bones
 - **Gustillo Open Fracture Classification System**
 - Mechanism of Injury; Soft Tissue Damage



Gustillo Classification System

- **Identifies Open Fractures: Soft Tissue Damage**
- **Found in Orthopedic Operative Notes**
 - I Low energy, wound less than 1 cm
 - II Wound greater than 1 cm with moderate soft tissue damage
 - IIIA Adequate soft tissue cover
 - IIIB Inadequate soft tissue cover
 - IIIC Associated with arterial injury
- **Example: Check S52 7th character Guide**
 - Right forearm fracture. Displaced, compound fx of the radial shaft. Type II Open fx
 - S52.351E

Injury & External Cause Extensions

- **Fracture Extensions: 7th Digit**
 - A = Initial encounter for closed fracture
 - B = Initial encounter for open fracture
 - D = Subsequent encounter for fracture with routine healing
 - G = Subsequent encounter for fracture with delayed healing
 - K = Subsequent encounter for fracture with nonunion
 - P = Subsequent encounter for fracture with malunion
 - S = Sequelae
 - **Aftercare codes for fractures no longer used**
 - Acute fracture with the 7th character to show subsequent encounter
 - A fracture not indicated as open or closed should be coded to closed
 - S72.009D Fracture, traumatic hip, NOS

Fracture Diagnoses Specificity

- **S72.0 Fracture of head and neck of femur**

- **S72.00 Fracture of unspecified part of neck of femur**

- Fracture of hip NOS*

- Fracture of neck of femur NOS*

Add 7th character

- **S72.001** Fracture of unspecified part of neck of right femur
 - **S72.002** Fracture of unspecified part of neck of left femur
 - **S72.009** Fracture of unspecified part of neck of unspecified femur
 - *Subcapital fracture of femur*
 - **S72.011** Unspecified intracapsular fracture of right femur
 - **S72.012** Unspecified intracapsular fracture of left femur
 - **S72.019** Unspecified intracapsular fracture of unspecified femur
 - *Transepiphyseal fracture of femur*

More Fracture Code Examples

- **S42.01 Fracture of sternal end of clavicle**

- **S42.011-** Anterior displaced fracture of sternal end of right clavicle
 - **S42.012** Anterior displaced fracture of sternal end of left clavicle

- **S42.3 Fracture of shaft of humerus**

- **S42.4 Fracture of lower end of humerus**

- **S42.9 Fracture of shoulder girdle, part unspecified**

- **S42.00x-** Fracture of unspecified shoulder girdle, part unspecified
 - **S42.91x-** Fracture of right shoulder girdle, part unspecified
 - **S42.92x-** Fracture of left shoulder girdle, part unspecified

Pathological Fractures

- **Cause**
 - Weakness of the bone
- **Underlying Etiologies**
 - Osteoporosis
 - Neoplasms
 - Infections
 - Cysts
 - Other Bone disorders
- **Documentation Needs**
 - Site; Laterality; Underlying Condition; Episode of Care (7th character)



Pathologic Fractures

- **Identify the Cause of Pathologic Fractures**
 - Neoplasms; Osteoporosis; Other
- **M84.4 Pathologic fracture, NEC**
 - M84.471 Pathological fracture, right ankle
 - M84.472 Pathological fracture, left ankle
 - M84.474 Pathological fracture, right foot
- **M84.5 Pathologic fracture in neoplasm disease**
 - M84.511 Pathological fracture in neoplastic disease, right shoulder
 - M84.512 Pathological fracture in neoplastic disease, left shoulder
- **M84.6 Pathologic fracture in other disease**

Common Case Scenarios

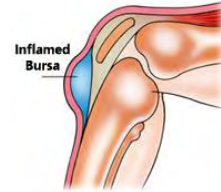
- **Pathological compression fractures of several lumbar vertebrae due to osteoporosis. COPD; HTN.**
 - M80.08xD Age-related osteoporosis with current pathological fracture, vertebrae
 - J44.9 COPD
 - I10 Essential (primary) HTN
- **Pathologic fracture, left shoulder due to osteoporosis. Type 2 DM; UTI.**
 - M80.812D Other osteoporosis with current path fx; left shoulder
 - E11.9 Type 2 Diabetes mellitus; N39.0 Urinary tract infection

Joint Injuries

- **Type of Injury**
 - Sprain: Complete/incomplete tear in 1 or more ligaments surrounding/supporting joint
 - Strain: Ill-defined injury from overuse, twisting or overextension of the muscle or tendons of a joint
 - Dislocation: Traumatic displacement of the bones of an articular joint (Often Shoulder)
 - Subluxation: Partial dislocation (Often Hip)
- **Ligament, Muscles or Tendon Involved**
 - Tibia/fibia; Deltoid;.....
- **Specific Location of Injury**
 - Laterality: Left ankle; Right shoulder

Joint Injuries: Documentation

- **One Example: Rotator Cuff**
 - Partial rotator cuff injury of left shoulder due to overuse
 - Diagnosis Requires: Type of Injury; Complete or Partial Injury; Traumatic or Non-Traumatic; Laterality
- **Another Example: Knee Injuries**
 - **Location & Laterality:** Right or Left Knee
 - **Type of Injury**
 - Subluxation or dislocation of patella
 - Sprain of lateral or medial collateral ligament
 - Sprain of anterior or posterior cruciate ligament, etc.
 - **Tear of Meniscus**
 - Bucket handle, peripheral, complex, other
 - Lateral or medial meniscus



Common Injury Causes

- Fall from motorized scooter: W05.2xxD
- Fall from bed: W06.xxxD
- Fall in bathroom shower: W18.2xxD
- Fall due to ice and snow: W00.0xxD (See Options)
- Fall from toilet: W18.1- (See Options)
- Unspecified fall, subsequent encounter: W19.xxxD
- Burn from heating pad: X16.xxxD
- Burn from hot coffee: X10.0xxD

One Scenario

- 81 year old female admitted to home health after having a skin graft onto her upper right thigh following a third degree burn that occurred when she accidentally spilled hot oil on herself while cooking. Daily dressing changes.
- M1020: T24.311D Burn of third degree of right thigh
- M1022b: Z48.01 Encounter for change or removal of surgical wound dressing
- M1022c: X10.2xxD Contact with fats and cooking oils

Documentation Needs: Laterality

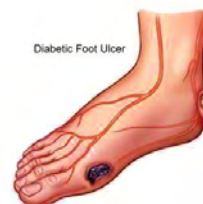
- Bilateral sites, the final character of the codes
- Unspecified site is also provided
- If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side
- C50.512 Malignant neoplasm of lower-outer quadrant of left female breast
- H16.013 Central corneal ulcer, bilateral
- L89.012 Pressure ulcer of left elbow, Stage 2
- S82.311 Torus fracture of lower end of right tibia

Pressure Ulcer Diagnoses Examples

- L89.012 Pressure ulcer of right elbow, stage 2
- L89.021 Pressure ulcer of left elbow, stage 1
- L89.151 Pressure ulcer of sacral region, stage 1
- L89.152 Pressure ulcer of sacral region, stage 2
- L89.210 Pressure ulcer of right hip, unstageable
- L89.214 Pressure ulcer of right hip, stage 4
- L89.223 Pressure ulcer of left hip, stage 3
- L89.311 Pressure ulcer of right buttock, stage 1
- L89.513 Pressure ulcer of right ankle, stage 3
- L89.604 Pressure ulcer of unspecified heel, stage 4

Non-Pressure Ulcers: Etiology

- Non Pressure chronic ulcers of lower limb, NEC
 - Chronic ulcer of skin
 - Non-healing ulcer of skin
 - Non-infected sinus of skin
 - Trophic ulcer NOS
 - Ulcer of skin NOS
- Code first any associated underlying condition
 - Diabetes
 - Varicose ulcers
 - Atherosclerosis
 - Postphlebotic and/or postthrombotic syndromes



Documentation Needs

- Identify Etiology of Wound

- Varicosities
- Stasis
- Diabetic
- Traumatic
- Lacerations



- Identify Location

- Laterality (right; left; bilateral)
- Specificity (proximal; distal)

- Identify Cause(s)

- Burn; Fall; MVI; Gunshot; Other

Wound Severity

- All Ulcers will Require a Severity Rating by the Assessing Clinician

- Limited to Breakdown of Skin
- Fat Layer Exposed
- Necrosis of Muscle
- Necrosis of Bone



- Coders will Assign the Diagnosis Wound Severity Based on the Clinician Assessment

- Similar to Pressure Ulcer Staging
- Software Wound Rating Changes

One Scenario

- Patient has insulin dependent Type II diabetes, legally blind due to diabetic retinopathy, CHF. Skilled nursing care to include wound care to a diabetic ulcer of the great toe on the left foot, diabetic care and teaching, and monitoring med regimen.
- E11.621 Type 2 diabetes mellitus with foot ulcer
- L97.521 Non-pressure chronic ulcer of other part of **left foot limited to breakdown of skin**
- I50.9 Congestive Heart Failure NOS
- E11.319 Type 2 Diabetes with unspecified diabetic retinopathy without macular edema
- H54.8 Legal Blindness as defined in USA
- Z79.4 Long term (current) use of insulin

More Common Case Scenarios

- **Stasis ulcer left calf, fat layer exposed. COPD.**
 - I87.2 Venous insufficiency (chronic) (peripheral)
 - L97.222 Non-pressure chronic ulcer of **left calf with fat layer exposed**
 - J44.9 COPD
- **Infected stasis ulcer right ankle due to varicose veins.**
 - I83.213 Varicose vein of right lower extremity with both ulcer and inflammation
 - L97.313 Non-pressure chronic ulcer of **right ankle with necrosis of muscle**

Traumatic Wounds

- **Cause**
 - Injury (Sports; Vehicles; Other)
- **Code Assignment**
 - Anatomic Site
 - Mechanism of Injury
 - If Foreign Bodies are Involved
 - Specific Injury
 - Laceration
 - Puncture Wound
 - Open Bite
 - Avulsion
 - Episode of Care (7th character)



One Case Scenario

- Patient admitted with an infected wound post cat bite on her left hand. IV antibiotics. PICC line became infected. MRSA. DM; CHF; CAD; Implanted cardiac defibrillator.
- S61.452D Open bite of left hand, subsequent encounter
- T80.218D Other infection due to central venous catheter
- B95.62 MRSA infection as the cause of diseases classified elsewhere
- E11.9 Type 2 Diabetes mellitus without complications
- I50.9 Congestive heart failure NOS
- I10 Essential (primary) HTN
- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
- Z95.810 Presence of implantable cardiac defibrillator

CAUTION



- Ostomy Infections
- Surgical Wound Complications
- Surgical Wound Infections
- Surgical Amputations
- Documentation Needs: Complication; Infection; Manifestation; Late Effect; Cause & Effect

Complicated Wounds

- Injury, Poisoning, & Certain Other Consequences of External Causes (S00-T88)
 - Injuries Grouped by Site (Injury to head; In
 - Injury to Head
 - Injury to neck
 - Injury to thorax
 - S=Injuries to Single Body regions
 - T=Injuries to Unspecified Body Regions
 - Poisonings; Surgical Complications
- Specific Type of Complication(s)
 - Residuals
- Specific Type of Infection

Common Surgical Complications

- **Disruption of Surgically Repaired Trauma Wound T81.33XD**
- **Dehiscence of Amputation Stump T87.81**
- **Dehiscence through skin closure T81.31XD**
- **Disruption of internal surgical wound T81.32XD**

Documentation Needs: Specific Complication; Infection; Infectious Agent; Cause; Other

One Case Scenario

- **Patient admitted with a surgical wound infection post removal of appendix. Staphylococcus aureus. Cellulitis around wound as well. Diabetes; HTN.**
- **T81.4xxD Infection following a procedure, subsequent encounter**
- **L03.311 Other cellulitis and abscess**
- **A49.01 Staphylococcus aureus, NOS**
- **E11.9 Type 2 Diabetes without complications**
- **I10 Essential (primary) HTN**

Infections

- Patient admitted with cellulitis of the right lower extremity. Culture indicates streptococcus B, documented as cause of cellulitis. Heart Failure; Osteoarthritis.

L03.115 Cellulitis of right lower limb
B95.1 Streptococcus B, as the cause of diseases classified elsewhere

I50.9 Heart Failure, Unspecified

M15.9 Osteoarthritis, generalized



Sepsis

- Replaces the term Septicemia
 - What is the Cause of the Underlying Infection?
 - If type of infection not specific
 - Assign A41.9 Sepsis, unspecified
- Severe Sepsis
 - Assign Severe Sepsis: R65.2 only if documentation indicates severe sepsis and associated acute organ dysfunction or multiple organ dysfunction
 - What is the underlying infection?; then R65.2-
- If severe sepsis and localized infection
 - Code first underlying infection then localized infection
 - Follow Code Guidelines & Instructions Closely

More on Sepsis

- **Sepsis Due to Postprocedural Infection**
 - Based on physician documentation
 - **Obstetric Surgical Wound Instructions**
 - Code first Sepsis due to
 - Followed by Infection
 - If Severe Sepsis: R65.2 with additional codes for any acute organ dysfunction
- **Sepsis and Severe Sepsis with Non-Infectious Process**
 - Code first non-infectious condition that caused Sepsis (burn; trauma)
 - R65.2- if non-infectious condition leads to infection
 - R65.1- SIRS is NOT assigned with R65.2

Some Sepsis Examples

- **Sepsis due to Streptococcus, Group A**
A40.0
- **Severe sepsis with acute kidney and pneumonia due to MRSA**
A41.02; R65.20; N17.9; J15.212
- **Septic shock due to staphylococcus resulting in respiratory failure**
A41.2; R65.21; N17.9; J96.00
- **SIRS due to acute pancreatitis**
K85.9; R65.10

Complications: Quick Scan

- Post Operative Wound Infection: T81.4xxD
- Acute cystitis due to foley catheter: T83.51xD; N30.00
- Post surgical amputation abscess: T87.81
- Dehiscence of traumatic injury wound repair: T81.33xD
- Obstruction of vascular dialysis catheter: T82.49xD
- Infected right hip prosthesis: T84.51xD
- Local infection due to PICC line: T80.212D
- Mechanical Obstruction of Cystostomy: T83.090D
- Superficial dehiscence surgical wound: T81.31xD

Sequela More Common

- I69.3- Sequela of CVA
 - May require additional code
- S44.01xS Sequela of Injury to ulnar nerve of upper arm level, right arm
 - Code residual first
- G09 Sequela of inflammatory diseases of the central nervous system
 - Code residual first
- S14.104S Sequela , Unspecified injury at C4 level of cervical spinal cord (List residual first)
- S06.-----S Sequela of Intracranial Injury (Code residual first)

Sequela

- **Documentation Needs**
- *Current Symptom Thought to be Late Effect*
- **Late Effect = Sequela**
 - Documentation indicates “due to”; “because of”; “manifested from”
- **Associated Injury Details**
 - Type and anatomical location of initial injury
- **Affects of Treatment/Therapy for**
 - Work-related
 - Post Trauma
 - Accidents

Late Effect Examples

Intake Locates Documentation for the Residual Conditions

- TBI Post MVA
- Headaches due to Old Neck Injury
- Scar Tissue due to Old Burn
- Arthropathy due to Old Football Injury
- Contracture due to a burn
- Seizures due to TBI
- Head Injuries
 - Type of Injury
 - Loss of Consciousness
 - Other injuries or complications

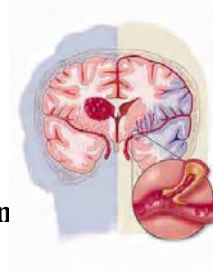


Sequela Examples

- **Spastic hemiplegia of right side as a result of head injury**
 - G81.11 Spastic hemiplegia affecting right dominant side
 - S09.90xS Head Injury NOS, Sequela
- **Abnormal gait as sequela of hip fracture**
 - R26.9 (Abnormal Gait); S72.009S (Hip Fracture, NOS)
- **Malunion of a left wrist fracture**
 - S62.102P Fracture of left wrists NOS, subsequent encounter with malunion
- **Osteopathy as a sequela of polio**
 - M89.60 Osteopathy after poliomyelitis, unspecified site
 - B91 Sequela of poliomyelitis

Sequelae of CVA

- **Late Effects of CVA: Sequelae**
- **No Time Limits on Sequelae**
- **Sequelae Specify the Residual of the CVA**
- **Documentation Needs**
 - Type of Stroke (Hemorrhagic; Embolic; Stenosis; Occlusion)
 - Location of Stroke (Specific artery)
 - Residual
 - Laterality
- **Expanded Instructional Notes**
 - Report Multiple Codes for One Condition
- **Two Diagnoses are Often Required**



Common CVA Codes

- **I69.3 Sequelae of cerebral infarction**

Sequelae of stroke NOS

I69.30 Unspecified sequelae of cerebral infarction

I69.31 Cognitive deficits following cerebral infarction

I69.32 Speech and language deficits following cerebral infarction

I69.320 Aphasia following cerebral infarction

I69.321 Dysphasia following cerebral infarction

I69.322 Dysarthria following cerebral infarction

I69.323 Fluency disorder following cerebral infarction

I69.328 Other speech and language deficits following cerebral infarction

More on CVA Codes

- **I69.3 Sequelae of cerebral infarction**

Sequelae of stroke NOS

I69.34 Monoplegia of lower limb following cerebral infarction

I69.341 Monoplegia of lower limb following cerebral infarction affecting **right dominant side**

I69.342 Monoplegia of lower limb following cerebral infarction affecting **left dominant side**

I69.343 Monoplegia of lower limb following cerebral infarction affecting **right non- dominant side**

I69.344 Monoplegia of lower limb following cerebral infarction affecting **left non- dominant side**

I69.349 Monoplegia of lower limb following cerebral infarction affecting unspecified side

Bottom Line on I-10-CM Diagnoses

- **Physician Documentation is Critical**
 - Etiology
 - Complications
 - Manifestations
 - Treatments
- **Pain**
 - Site specific
 - Cause (Neoplasm; Trauma; Chronic; Other)
- **Dementia**
 - Identify cause if known (Alzheimer's; Parkinson's...)
 - If cause is not known
 - Identify behavior Issues (wandering; irritation; combative...)



Many ICD-10 Challenges

- **Documentation Needs**
 - Requires *increased specificity* in the clinical documentation
- **Specific Documentation Needs**
 - *Laterality; Severity; Specific Affected site; Clinical Specificity*
 - **Examples:**
 - Atherosclerotic heart disease heart disease of native coronary artery with unstable angina pectoris (I25.110)
 - Rheumatic aortic valve diseases (I06)
 - STEMI MI involving left anterior descending coronary artery (I21.02)
 - Hemiplegia & hemiparesis following cerebral infarction affecting right dominant side (I69.351)

Clinicians: Increased A & P for 2015 and Beyond

Resource Web Sites

www.cms.hhs.gov
Centers for Medicare & Medicaid Services
PPS Federal Register

www.cdc.gov
Centers for Disease Control
Official ICD-9-CM Code Guidelines

www.ahima.org
AHIMA (American Health Information Management Association)

www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOOASISUSERManual.asp
OASIS User's Manual Revised 12/12

www.medicalspecialtycoding.com
Board of Advanced Medical Coding



Available Education Programs as Webcasts and DVDs

- **Corporate Compliance in the Home Health Setting**
- **HIPAA and What It Means for Home Health Providers**
- **Care of the Geriatric Patient**
- **Abuse and Neglect: Your Care Responsibilities**
- **Advanced Directives**
- **Infection Control for Home Care and Hospice**
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ICD-10-CM SAMPLE CROSSWALK

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
V54.81 Aftercare following Joint replacement	Z47.1 Aftercare following Joint Replacement Therapy	Identical
781.2 Abnormal Gait	R26.0 Ataxic Gait R26.1 Paralytic Gait R26.89 Other Abnormalities of Gait & Mobility R26.9 Unspecified Abnormalities of Gait & Mobility	Approximate
728.87 Generalized Muscle Weakness	M62.81 Muscle Weakness, Generalized	Identical
V15.88 History of Falls	Z91.81 History of Falls	Identical
428.0 Congestive Heart Failure	I50.9 Heart Failure, Unspecified	Approximate
401.9 Essential Hypertension, Unspecified	I10 Essential (Primary) Hypertension	Approximate
427.31 Atrial Fib	I48.0 Atrial Fibrillation	Identical
496 COPD NOS	J44.9 Chronic Obstructive Pulmonary Disease, Unspecified	Approximate
491.21 Obstructive Chronic Bronchitis with Acute Exacerbation	J44.1 Chronic Obstructive Pulmonary Disease with Acute Exacerbation	Approximate
492.8 Emphysema	J43.9 Emphysema, Unspecified	Identical
486 Pneumonia	J18.0 Bronchopneumonia, unspecified organism J18.1 Lobar pneumonia, unspecified organism J18.2 Hypostatic pneumonia, unspecified organism J18.8 Other pneumonia, unspecified organism J18.9 Pneumonia, unspecified organism	Approximate
311 Depression	F32.9 Depression NOS	Approximate
300.00 Anxiety	F41.9 Anxiety Disorder, Unspecified	Identical
331.0 Alzheimer's Disease	G30.9 Alzheimer's Disease, Unspecified	Approximate
332.0 Parkinson's Disease NOS	G20 Parkinson's Disease	Approximate

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
340 MS	G35 Multiple Sclerosis	Identical
290.0 Senile Dementia	F03 Unspecified Dementia	Approximate
294.10 Dementia in diseases classified elsewhere without behavioral changes	F02.80 Dementia in other diseases classified elsewhere without behavioral changes	Identical
294.11 Dementia in diseases classified elsewhere, with behavioral changes	F02.81 Dementia in other diseases classified elsewhere with behavioral changes	Identical
599.0 Urinary Tract Infection, Site Not Specified	N39.0 Urinary Tract Infection, Site Not Specified N30.00 Acute cystitis without hematuria	Identical
596.54 Neurogenic Bladder	N31.9 Neuromuscular dysfunction of bladder, unspecified	Identical
585.9 CKD, Unspecified	N18.9 CKD, Unspecified	Identical
585.6 ESRD	N18.6 End Stage Renal Disease	Z99.2 Additional Code for Dialysis Status
438.21 CVA with dominant Hemiplegia	I69.351 Hemiplegia and Hemiparesis affecting right dominant side I69.352 Hemiplegia and Hemiparesis affecting left dominant side I69.353 Hemiplegia and Hemiparesis affecting right non dominant side I69.354 Hemiplegia and Hemiparesis affecting left non dominant side	Approximate
438.82 CVA with Dysphagia	I69.391 Dysphagia following cerebral infarction	Use additional code for dysphagia R13.1-
787.20 Dysphagia	R13.10 Dysphagia, Unspecified	Approximate
530.81 GERD	K21.0 Gastro-esophageal reflux disease with esophagitis K21.9.....without esophagitis	Identical

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
250.00 Diabetes Mellitus without mention of complication, Type 2 or Unspecified Type, not stated as uncontrolled	E11.9 Type 2 Diabetes Mellitus without Complications	Approximate
440.20 Atherosclerosis	I70.201 Unspecified atherosclerosis of native arteries of extremities, right leg	Approximate
440.23, 707.1x Atherosclerosis with ulceration	I70.23 Atherosclerosis of native arteries of right leg with ulceration I70.24 Atherosclerosis of native arteries of left leg with ulceration	6th character specified exact location on leg 1-thigh 2-calf 3-ankle 4-heel and midfoot 5-other part of foot 8-other part of lower leg 9-unspecified site Use additional code to identify severity of ulcer(I97 with 5th character “1”)
443.9 PVD	I73.9 Peripheral vascular disease, unspecified	Identical
453.42 Acute embolism and thrombosis of deep veins of lower extremity	I82.41 Acute embolism and thrombosis of femoral vein I82.42.....of iliac vein I82.42.....of popliteal vein I82.44.....of tibial vein I82.49.....of other specified deep vein of lower extremity	6th character is used to indicate right, left or bilateral
454.0 Varicose veins of lower extremities with ulcer	I83.00 Varicose veins of unspecified lower extremity with ulcer I83.001.....with ulcer of thigh I83.002.....with ulcer of calf I83.003.....with ulcer of ankle I83.004.....with ulcer of heel and midfoot I83.005.....with ulcer other part of foot I83.008.....with ulcer other part of lower leg	I83.0- codes are combination codes with more detail than ICD-9-CM 454.0. I83.0- codes are differentiated first by right, left or unspecified lower extremity, and then by the ulcer’s location on the leg or foot L97 code is also reported to identify the severity of the ulcer

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
	183.009.....with ulcer of unspecified site	
457.1 Lymphadema	I89.0 Lymphedema, not elsewhere classified	Approximate
459.81 Venous insufficiency	I87.2 Venous insufficiency (chronic) (peripheral)	Identical
459.81, 707.1x Stasis ulcer of lower extremity	I87.2 Venous insufficiency (chronic) (peripheral) L97 Non pressure chronic ulcer of lower limb, not elsewhere classified	L97 codes are specific for location, including right and left, and severity, E.G. skin, fat layer exposed, necrosis of muscle, necrosis of bone
682.6 Cellulitis/abscess leg	L03.115 Cellulitis of right lower limb L03.116 Cellulitis of left lower leg	Cellulitis and abscesses are coded with different codes
707.03 Pressure ulcer, coccyx	L89.15 Pressure ulcer of sacral region	6th character specified stage 0- unstageable 1- stage 1 2- stage 2 3- stage 3 4- stage 4 9- unspecified
707.04 Pressure ulcer, hip	L89.20 Pressure ulcer of unspecified hip L89.21.....of right hip L89.22.....of left hip L89.4.....Pressure ulcer of contiguous site of back, buttock and hip (5th character indicates stage)	6th character specified stage 0- unstageable 1- stage 1 2- stage 2 3- stage 3 4- stage 4 9- unspecified
707.07 Pressure ulcer heel	L89.60 Pressure ulcer of unspecified heel L89.61.....of right heel L89.62.....of left heel	6th character specified stage 0- unstageable 1- stage 1 2- stage 2 3- stage 3 4- stage 4 9- unspecified

ICD-10-CM WOUND CROSSWALK

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
707.03 Pressure ulcer of Lower Back (Coccyx; Sacrum) 707.20-707.25 Pressure ulcer stages	L89.15 Pressure ulcer of sacral region Coccyx; Tailbone L89.150 Pressure ulcer of sacral region, unstageable L89.151 Pressure ulcer of sacral region, stage 1 L89.152 Pressure ulcer of sacral region, stage 2 L89.153 Pressure ulcer of sacral region, stage 3 L89.154 Pressure ulcer of sacral region, stage 4 L89.159 Pressure ulcer of sacral region, unspecified stage	The final character if L89 identifies the Stage L89 instructs coders to code any gangrene (I96) before the pressure ulcer
707.12 Ulcer of the calf	L97.209 Non-pressure chronic ulcer of unspecified calf with unspecified severity L97.201 Non-pressure chronic ulcer of unspecified calf limited to breakdown of skin L97.202 Non-pressure chronic ulcer of unspecified calf with fat layer exposed L97.203 Non-pressure chronic ulcer of unspecified calf with necrosis of muscle L97.204 Non-pressure chronic ulcer of unspecified calf with necrosis of bone	L97.1 Codes are Combination Codes for laterality (right, left, unspecified) and depth L97 instruct coders to <i>Code First</i> any associated condition
454.0 Varicose veins of lower extremities with ulcer	I83.00 Varicose veins of unspecified lower extremity with ulcer I83.001 Varicose veins of unspecified lower extremity with ulcer of thigh I83.002 Varicose veins of unspecified lower extremity with ulcer of calf I83.003 Varicose veins of unspecified lower extremity with ulcer of ankle I83.004 Varicose veins of unspecified lower extremity with ulcer of heel and midfoot I83.005 Varicose veins of unspecified lower	L97 Category instructs coders to report additional code for wound severity (L97-)

ICD-9-CM Diagnoses	ICD-10-CM Code Equivalent(s)	Additional Information
	extremity with ulcer of other part of foot I83.008 Varicose veins of unspecified lower extremity with ulcer of other part of lower leg I83.009 Varicose veins of unspecified lower extremity with ulcer of unspecified site	
440.23, 707.1x Atherosclerosis with ulceration	I70.23 Atherosclerosis of native arteries of right leg with ulceration I70.24 Atherosclerosis of native arteries of left leg with ulceration	6th character specifies exact location on leg Use additional code to identify severity of ulcer (I97 with 5th character “1”)
454.0 Varicose veins of lower extremities with ulcer	I83.00 Varicose veins of unspecified lower extremity with ulcer I83.001.....with ulcer of thigh I83.002.....with ulcer of calf I83.003.....with ulcer of ankle I83.004.....with ulcer of heel and midfoot I83.005.....with ulcer other part of foot I83.008.....with ulcer other part of lower leg I83.009.....with ulcer of unspecified site	I83.0- codes are combination codes with more detail than ICD-9-CM 454.0. I83.0- codes are differentiated first by right, left or unspecified lower extremity, and then by the ulcer’s location on the leg or foot L97 code is also reported to identify the severity of the ulcer
459.81, 707.1x Stasis ulcer of lower extremity	I87.2 Venous insufficiency (chronic) (peripheral) L97 Non pressure chronic ulcer of lower limb, not elsewhere classified	L97 codes are specific for location, including right and left, and severity, E.G. skin, fat layer exposed, necrosis of muscle, necrosis of bone
682.6 Cellulitis/abscess leg	L03.115 Cellulitis of right lower limb L03.116 Cellulitis of left lower leg	Cellulitis and abscesses are coded with different codes
707.8 Chronic ulcer of other specified sites	L98.41 Non-pressure chronic ulcer of buttock L98.411 Non-pressure chronic ulcer of buttock limited to breakdown of skin L98.412 Non-pressure chronic ulcer of buttock with fat layer exposed L98.413 Non-pressure chronic ulcer of buttock with necrosis of muscle L98.414 Non-pressure chronic ulcer of buttock with necrosis of bone	L98.4 combination codes by site and depth of ulcer No additional code required for severity