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FY2017 guidelines: Hypertension, heart disease can now be assumed to be connected

In a complete reversal from previous coding guidance, you can now assign I11.0 (Hypertensive heart disease with heart failure) for a patient with diagnoses of hypertension and heart failure, regardless of whether the physician has linked the hypertension to the heart failure.

"The classification presumes a causal relationship between hypertension and heart involvement . . . , as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated," according to the FY2017 official coding guidelines, released Aug. 5, and effective Oct. 1. [I.C.9.a]

(see *FY2017 guidelines*, p. 7)

Use 7th characters correctly to get complication coding right, ensure compliant claims

Assign two separate codes, with two separate seventh characters if necessary, to appropriately capture a patient whose incision site resulting from a repaired fracture becomes infected.

For example, you'd assign code T81.4xxA (Infection following a procedure, initial encounter) along with S82.301D (Unspecified fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing) for a patient whose distal right tibia fracture was repaired with surgery and for whom the surgical

(see *Complications*, p. 8)

Are you ready for thousands of code changes?

After almost five years of no code changes, your agency has been inundated with new codes as of Oct. 1. Make sure you are up to speed on the final code and guideline changes, including how they impact your home health coding. Purchase this webinar once and get FREE On Demand access for you and your coding staff. For more information and to purchase, go to decisionhealth.com/A2684

Get answers to your toughest questions about COPD coding

Conquer the confusion that surrounds the coding of common pulmonary conditions, including chronic obstructive pulmonary disease (COPD), to ensure that your coding is accurate and sufficiently captures the care that your agency is providing.

The conditions that fall under the umbrella of COPD can often be sources of tremendous consternation for coders. By breaking it down into simple steps, however, you can avoid getting short of breath trying to code COPD.

Codes covering COPD conditions are found in Chapter 10 (Diseases of the respiratory system) in the Chronic lower respiratory diseases section, which encompasses codes from categories J40 (Bronchitis, not specified as acute or chronic) to J47 (Bronchiectasis).

Note, however, that not every code in that section covers a COPD condition. Specifically, you will not assign codes from J40, J41 (Simple and mucopurulent chronic bronchitis), J45 (Asthma) and J47 for any types of COPD as these codes cover other types of lower respiratory diseases that are distinct from COPD, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

A major part of the confusion in coding COPD results from the different ways that the disease is described and documented. Some physicians will just record “COPD” while others specify multiple forms that are co-occurring,

such as “COPD with emphysema,” leaving coders to grapple with what code, or codes, to assign.

To help you see through the COPD fog now that ICD-10 has arrived, *Diagnosis Coding Pro for Home Health* compiled some of the most frequently asked questions about the disease and sought answers to aid you in coding these cases accurately.

Q: Where should I start to try to make sense of all the COPD diagnoses and codes?

A: You need to develop an understanding of what COPD is, what each term refers to and what each code represents so that you can make the correct choice.

First things first: Know that the term “COPD” is itself non-specific. On the most basic level, “COPD” refers to a group of irreversible, obstructive diseases of the lungs. These diseases fall into three separate components depending on the area of the lungs and type of cells affected, says Twombly. They are:

- chronic obstructive bronchitis;
- emphysema;
- chronic obstructive asthma.

Finding the correct code requires that you determine, based on the physician’s documentation, which aspect of the disease (i.e. chronic bronchitis or emphysema) the patient has or if the patient has multiple aspects of the disease simultaneously (such as chronic bronchitis with emphysema), Twombly says.

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
mtsigas@decisionhealth.com

Editorial:

Editor: Megan Batty, HCS-D,
1-612-834-6896
mgustafson@decisionhealth.com

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

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Diagnosis Coding Pro is published monthly by **DecisionHealth**, Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 502, Gaithersburg, MD 20878-7364. Price: \$447/year. Copyright 2016.



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Q: How do I find the right COPD code?

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

Notice that this search leads you to J44.9 (Chronic obstructive pulmonary disease, unspecified), which is the default code for COPD. Thus, J44.9 is the code you'll assign when all you know is COPD, according to tabular instruction. However, coders need to make every attempt to get a more specific diagnosis, experts agree.

So from there, if you continue to scroll down in the index to asthma, it also leads you to J44.9. This again illustrates that the J44.- category captures many forms of the disease. Multiple diagnoses under the COPD umbrella, including chronic obstructive asthma and chronic obstructive bronchitis, are coded to J44.9.

However, one form of COPD, emphysema, is not included J44.9, **if it occurs by itself**. If patient's diagnosis is specified simply as "emphysema," you'll assign a code from the J43.- category (Emphysema), with the default code being J43.9 (Emphysema, unspecified), according to the index.

Fourth character options specify whether the emphysema is unilateral (J43.0), panlobular (J43.1), centrilobular (J43.2) or other specified (J43.8).

But, if emphysema is stated by the physician to occur **with** COPD or **with** chronic obstructive asthma or chronic obstructive bronchitis, you will **not** assign a code from J43.-. Codes from J43.- are **only** used when emphysema is the **only** form of COPD the patient has, Twombly says.

This illustrates the importance of following proper procedure when coding COPD. Mistakes are often made when coders don't use the coding manual correctly and jump to the tabular before first searching the index, Bird says.

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

A: Code decompensated COPD as acutely exacerbated COPD with J44.1 (Chronic obstructive pulmonary disease with (acute) exacerbation), according to tabular instruction. "Decompensated COPD" is included as a clarifying term at J44.1.

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

A: Code emphysema with chronic bronchitis with a code from the J44.- category. You won't need an additional code from the J43.- category, because the J43.- category lists "emphysema with chronic (obstructive) bronchitis (J44.-)" in its Excludes 1 notes, meaning the two diagnosis can never be assigned together, according to coding conventions.

Remember that codes from the J44.- category cover both chronic obstructive bronchitis and chronic obstructive asthma, so if a patient's diagnosis includes both of those, one code from J44.- will suffice, according to tabular instruction.

Q: The patient's chart indicates that COPD is the focus of care, but the diagnosis of COPD is all I have. Can I code J44.9 in the primary position?

A: Yes, you can assign J44.9 (Chronic obstructive pulmonary disease, unspecified) in the primary position on a home health claim as it is a valid code and if you have no further information beyond "COPD," J44.9 is your only option, says Brandi Whitemyer, HCS-D, an independent home health and hospice consultant in Canton, Ohio.

However, you should make every effort to find a more specific code because code J44.9 is a non-specific code that implies that the patient has a chronic lung disease that is stable, which begs the bigger question of why your agency would admit a patient with a stable disease, Bird says.

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

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

Tip: Don't assign J40 (Bronchitis, not specified as acute or chronic) unless all you know about the diagnosis is just the word "bronchitis," Twombly says. Code J40 is a very non-specific code that only captures bronchitis. If you know that the diagnosis has been specified as acute bronchitis or chronic obstructive bronchitis, J40 is not where you should be.

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

A: Capture this diagnosis with J44.0 (Chronic obstructive pulmonary disease with acute lower respiratory infection). Then, assign an additional code for the acute bronchitis infection, according to tabular instruction.

If the COPD is also acutely exacerbated, you'll need to assign J44.1 (Chronic obstructive pulmonary disease with (acute) exacerbation) too, according to tabular instruction.

This is based on the fact that that J44.0 is listed in an Excludes 2 note on J44.1, which indicates that the code for the acute bronchitis infection on top of the chronic obstructive bronchitis does not also capture any exacerbation and therefore it must be coded separately if present, according to coding conventions.

Q: I have a patient who came to home health to be treated for pneumonia who also has COPD. Can I assume, because of the pneumonia, that the patient's COPD is exacerbated and code it with J44.1?

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

Consider a case involving a patient who comes to home health on antibiotic therapy to treat a case of pneumonia, who is also experiencing an acute exacerbation of COPD with emphysema and chronic obstructive asthma.

It would require three separate codes to capture everything: First, J18.9 (Pneumonia, unspecified organism), then J44.0 (Chronic obstructive pulmonary disease with acute lower respiratory infection) and finally, J44.1 (Chronic obstructive pulmonary disease with (acute) exacerbation). The pneumonia and COPD with acute infection are sequenced first due to the focus of care being on the patient's treatment for pneumonia.

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

Q: If a patient is said to have chronic obstructive asthma and extrinsic asthma, do I have to code them both or does J44.- cover both condition?

A: This scenario will require two codes, J44.9 and a code from the J45.- category to capture the specific type of

extrinsic asthma. Both codes are required because J44.9 is listed under Excludes 2 at the J45.- category, indicating that the conditions covered by J44.9 and the J45.- codes are separate conditions and may be coded on the same claim when both are present, according to coding conventions.

Q: Do I have to code smoking or tobacco use in a COPD patient, or is this optional?

A: Yes. You have to assign a code to capture a patient's use, past use, or exposure to tobacco, such as Z72.0 (Tobacco use) with certain conditions in ICD-10, including COPD, according to tabular instruction. This rule also applies to certain other respiratory codes and some cardiac codes.

Scenario: Pneumonia, COPD

A 79-year-old man comes to home health to continue recovery from pneumonia, for which he was just hospitalized. He also has COPD, which his physician stated has now decompensated due to the pneumonia.

Code the scenario:

Primary and Secondary Diagnoses			M1025 Additional diagnoses	
M1021a	Pneumonia, unspecified organism	J18.9		
M1023b	Chronic obstructive pulmonary disease with acute lower respiratory infection	J44.0		
M1023c	Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1		

Rationale:

- As the focus of care, the pneumonia is coded in the primary position.
 - Two codes for COPD are assigned, as is necessary to describe the presence of COPD with a lower respiratory infection as well as the COPD with an acute exacerbation.
- Megan Batty (mgustafson@decisionhealth.com)

CB Coding Basics

Don't lose your mind over mental health coding, ensure accurate claims

By Mike Purvis, HCS-D

Accurately code mental health diagnoses to ensure that the care of these important conditions is appropriately accounted for as well as to avoid assigning an incorrect and potentially stigmatizing diagnosis to a patient.

Mental health disorders, such as depression, bipolar disorder and schizophrenia, are a reality in the home health population. Consider that nearly 60 million people ages 18 or older suffer from mental disorders in the United States, according to the National Institute of Mental Health (NIMH).

ICD-10 codes for mental health are found in Chapter 5 (Mental, behavioral and neurodevelopmental disorders), and available codes range from F01.- (Vascular dementia) to F99 (Mental disorder, not otherwise specified).

Depression is commonly seen in the home health population and is a significant complicating factor for elderly patients. In fact, the OASIS assessment (in item M1730) requires that patients be screened for depression symptoms. Bipolar disorder and schizophrenia are less common diagnoses but do also occur and have the potential to seriously impact a patient’s care and recovery.

Tip: Code mental health disorders as primary (M1021a) **only when they are the home health focus of care.** If the home health agency is not providing psychiatric nursing services or training a caregiver to provide an aspect of care specific to the mental disorder, the psychiatric condition should not be the focus of care but may be assigned a secondary diagnosis that has the potential to impact the plan of care.

Understand schizophrenia to code correctly

Do not confuse schizoaffective disorder and schizophrenia and mistakenly assign a code for one disorder when the other one has been diagnosed. This is a common mistake. These codes can only be assigned if a physician has made the diagnosis.

Schizophrenia is a chronic, disabling brain disorder that can cause symptoms such as hearing voices and paranoia, according to National Institutes of Health.

Patients with schizoaffective disorder can have symptoms of schizophrenia as well as symptoms of a mood disorder such as bipolar disorder and are often at first misdiagnosed with either of those conditions, according to the National Alliance on Mental Illness (NAMI).

Schizophrenia can take various forms. Most of the codes for conditions specifically described as schizophrenia are found in the F20.- (Schizophrenia) category. Within the F20.- category, there are eight individual codes for various forms of the disorder,

including F20.0 (Paranoid schizophrenia) and F20.2 (Catatonic schizophrenia).

Codes for schizoaffective disorders are found in the F25.- category (Schizoaffective disorders) and include options for bipolar type (F25.0), depressive type (F25.1), other schizoaffective disorders (F25.8) and unspecified schizoaffective disorder (F25.9)

If all you know is that the patient has schizophrenia, you must code F20.9 (Schizophrenia, unspecified), according to the alphabetic index. However, it’s always a good idea to thoroughly search the medical record to ensure you’re coding to highest level of specificity.

Tip: Pay particularly close attention to the Excludes 1 and Excludes 2 notes when coding schizophrenia and schizoaffective disorder if your patient also has diagnoses of depression and/or bipolar disorder. Many types of depression and bipolar disorder are listed in the Excludes 1 and 2 notes for codes between the F20.- and F25.- categories.

Scenario: Paranoid schizophrenia

A patient was admitted to home health with a primary diagnosis of paranoid schizophrenia. Skilled nursing will instruct the patient’s caregiver on how to give injections of Haldol.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Paranoid schizophrenia	F20.0		

Rationale:

- Skilled nursing is providing teaching to the caregiver on the administration of the Haldol injection. Thus, the psychiatric diagnosis can be coded primary.

Find key facts to get right code for bipolar disorder

Pay attention to the type of bipolar disorder with which a patient has been diagnosed in order to assign the most accurate code. Clinical documentation will be the key to determining this.

Bipolar disorder is a chronic mental illness that causes dramatic shifts in a person’s mood, from manic highs to depressive lows, according to NAMI. It’s coded as a mood disorder between the categories of F30.- (Manic episode) and F39 (Unspecified mood [affective] disorder).

To properly code bipolar disorder, you'll need to know the following information:

- Whether it's a single episode versus a recurrent one
- Whether it's mild, moderate or severe
- Whether the condition has psychotic features
- Whether the patient is in partial or full remission

For example, F31.10 (Bipolar disorder, current episode manic without psychotic features, unspecified) captures a patient with who's experiencing a current episode of bipolar characterized by mania who is not also experiencing psychosis.

However, if you're unable to get more information about the patient's bipolar disorder, the appropriate code to use is F31.9 (Bipolar disorder, unspecified), according to the alphabetic index.

Tip: Notice that depression is included in the codes at the F31.- category, according to tabular instruction via an Excludes 1 note. Thus, when a patient is said to have both bipolar and depression, you don't have to assign a separate code for depression.

Scenario: Bipolar disorder

A 62-year-old woman is admitted to home health with a primary diagnosis of a current episode of severe bipolar disorder with depression and psychotic features. She has a psych nurse handling her case who will be teaching on new bipolar medications. She is also receiving therapy to address her gait issue which is related to primary osteoarthritis in both knees.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Bipolar disorder, current episode depressed, severe, with psychotic features	F31.5		
M1023b: Bilateral primary osteoarthritis of knee	M17.0		

Rationale:

- Because the patient's focus of care is the bipolar and she'll be receiving care from a psych nurse, bipolar is an appropriate primary diagnosis.
- Though the patient is experiencing gait issues, the code for the underlying cause (bilateral primary osteoarthritis) is coded instead of the symptom code, in accordance with coding guidelines.

See through the haze to accurately code depression

Assign a code from the F33.- category (Major depressive disorder, recurrent) for a patient with depression that's specified as a depressive reaction, endogenous depression, major depression, reactive depression or seasonal depression.

ICD-10 codes for various forms of depression are found in categories F32.- (major depressive disorder, single episode) and F33.- (major depressive disorder, recurrent).

Similar to codes for bipolar disorder, ICD-10 depression codes also include options to indicate whether the depression is mild, moderate or severe, whether it's a single or recurrent episode, whether there are also psychotic features and whether the patient is in partial or full remission.

For example, F32.3 corresponds to Major depressive disorder, single episode, severe with psychotic features. If all you know is that the patient has depression, however, the correct code to use is F32.9 (Major depressive disorder, single episode, unspecified), according to the alphabetic index.

Tip: Search the alphabetic index under "disorder" to find the correct code for depression that is specified as "recurrent."

Scenario: Major depressive disorder

A 42-year-old woman is diagnosed with major recurrent depression and is admitted to home health for education and medication monitoring from a psych nurse. She also consumes a large amount of coffee and is documented as having caffeine dependence.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Major depressive disorder, recurrent, unspecified	F33.9		
M1023b: Other stimulant dependence, uncomplicated	F15.20		

Rationale:

- Because the patient's primary diagnosis is documented as major recurrent depression and she'll be receiving care from a psych nurse, the appropriate code for M1021a is F33.9.
- Since the caffeine dependence is documented, F15.20 is assigned to capture this diagnosis.

About the author: Mike Purvis has been HCS-D certified since 2009 and works as a contract coder for Selman-Holman and Associates. He lives in Charlotte, N.C. with his wife and three children.



Ask the Expert

Code unspecified vs. uncertain neoplasm

Question: What's the difference between a neoplasm of uncertain behavior and an unspecified neoplasm?

Answer: The term “neoplasm of uncertain behavior” is a specific pathologic diagnosis that is referring to a lesion whose behavior cannot be predicted. A neoplasm of uncertain behavior is currently benign, but there's a chance that it could undergo malignant transformation over time.

By contrast, if a neoplasm is unspecified, this means that a biopsy has not been done or that the results aren't back yet.

Editor's note: Submit your questions to mgustafson@decisionhealth.com.

FY2017 guidelines

(continued from p. 1)

The heart conditions that can be assumed to be connected to hypertension and therefore coded as hypertensive heart disease range between I51.4 (Myocarditis, unspecified) and I51.9 (Heart disease, unspecified), according to the alphabetic index.

Additionally, conditions categorized to I50.- (Heart failure) can also be assumed to be connected to hypertension when both occur based on the “see Hypertension, heart” note that falls under “with” in the alphabetic index.

You must follow the word “see” to where it leads before you can be assured that you've arrived at the right code, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. The “see” is a mandatory instructional note that falls among the coding conventions.

Additionally, heart failure conditions coded to the I50.- category are mentioned in the updated FY2017 hypertensive heart disease guideline as assumed to be connected to heart disease unless another etiology has been given. [I.C.9.a.1]

This guideline update amounts to a monumental shift: Previous long-standing guidelines stipulated that the

physician must connect a patient's hypertension with his or her heart disease or heart failure in order to assign the combination code, and only chronic kidney disease was allowed to be assumed to be related to hypertension.

The shift will be keenly felt by coder Maurice Frear, HCS-D, who says that seeing heart failure patients with hypertension is “almost a daily occurrence” and only very rarely does he see someone with heart failure who doesn't have also have hypertension..

As a result, Frear will be making less use of I10 (Essential hypertension, unspecified).

“Of course [the new guidelines are] going to change the way I code,” says Frear, a coder for Bon Secours Home Health and Hospice Services of Virginia Beach

Take note of assumptions allowed by “with” convention

While the updated FY2017 guidelines don't take effect until Oct. 1, the updated “with” convention on which the new guidelines are based has been in effect since the Q2 2016 Coding Clinic update which provided diabetes and diabetic manifestations as examples of the convention's application. [CPH, 7/16]

Clarifying language about the general “with” convention was published in section I.A.15 of the FY2017 official coding guidelines, having been updated to be in agreement with the Coding Clinic guidance. Based on this, most experts believe coders may begin to assume a connection between hypertension and heart disease now.

“I agree it's wide open to start coding hypertensive heart disease because the ‘with’ was effective in March 2016 and conventions trump guidelines,” says Lisa Selman-Holman, HCS-D, principal of Selman-Holman and Associates and the coding service CoDR — Coding Done Right in Denton, Texas.

Additionally, **after Oct. 1**, osteomyelitis can be assumed to be a manifestation of diabetes when both are diagnosed absent another stated etiology. This is because osteomyelitis is included under “with” in the diabetes listing in the alphabetic index in the FY2017 code set, which goes into effect on that date.

This assumption, however, **should NOT be made until Oct. 1** because the current FY2016 code set does not include osteomyelitis under “with” in the diabetes listing in the alphabetic index.

Tip: Assign both combination codes when a patient who has diabetic chronic kidney disease also has hypertension, according to coding guidelines. For example, you'd code E11.22 (Type 2 diabetes mellitus with diabetic chronic disease), **and** I12.- (Hypertensive chronic kidney disease) along with N18.- (Chronic kidney disease) and kidney disease).

This is based on the long-standing guideline that hypertension and CKD are always assumed to be connected, as well as the new interpretation of “with,” which stipulates that diabetes and CKD are assumed to be connected unless another etiology is given. Furthermore, “the hypertension is not another etiology in [this] case,” says Brandi Whitemyer, HCS-D, an independent home health and hospice consultant in Canton, Ohio.

Other notable FY2017 guidelines changes

Here's a brief summary of additional guidelines changes that will go into effect on Oct.1:

- **Assign both pressure ulcer codes** (one for the ulcer at its initial stage and one for the ulcer at the stage to which it progressed), **at recertification, follow-up or resumption of care**, when a patient's pressure ulcer has progressed to a worse stage during the admission. Clarification on this guideline is currently being sought, but in the meantime, sequence the pressure ulcer stage codes according to the seriousness of the condition, Twombly says. [I.C.12.a.6]

- **The pressure ulcer guideline update that specifies that a pressure ulcer present on admission** but healed at discharge should be coded at the stage it was at admission does not apply to home health coders, experts agree. The term “present on admission” refers only to hospitals. [I.C.12.a.5]

- **An update to the definition of the Excludes 1 convention** was written into the guidelines clarifying that coders may assign codes that are separated by Excludes 1 notes as long as the two conditions aren't related. The guidelines provided the example of a patient with sleep-related teeth grinding (G47.63) and psychogenic dysmenorrhea (F45.8). If unsure as to whether two excluded conditions are related, query the physician. [I.A.12.a]

- **Coders do not need to assign the bilateral code for a condition if a previous encounter resolved the condition on one side of the body,**

and the present encounter is treating the other side. For example, don't assign a code for bilateral cataracts if the patient's right eye cataract was treated and resolved and the present episode is caring for cataracts in the left eye. Instead, only assign the code to indicate the left side where the condition still exists. [I.B.13]

- **Coders should assign Z79.84 (Long-term (current) use oral hypoglycemic drugs) for patients with diabetes who routinely use oral hypoglycemic drugs.** While the guideline says that either Z79.4 (Long term (current) use of insulin) **or** Z79.84 should be assigned, for diabetic patients who use both insulin and oral hypoglycemic drugs, both codes can and should be assigned, according to the presence of an Excludes 2 note at Z79.84. Excludes 2 notes mean, “have both, code both,” says Selman-Holman. [I.C.4.a.3]

- **Code also any hypertensive disease, such as I10 (Essential hypertension unspecified), for a patient with a documented hypertensive urgency, emergency or crisis** that's captured by the I16.- category (Hypertensive crisis) and sequence the codes based on the reason for the encounter. [I.C.9.a.10]

- **For coma scale and NIH stroke scale (NIHSS) codes**, code assignment may be based on medical record documentation from clinicians who are not the patient's provider such as an emergency medical technician. However, the associated diagnosis (such as acute stroke) must be documented by the patient's provider. [I.B.14]

- **For a poisoning in which the intent is unknown**, code it as accidental intent. [I.C.19.e.5.b]
— Megan Batty (mgustafson@decisionhealth.com)

Complications

(continued from p. 1)

incision became infected and required active treatment during the home health admission.

Coding the scenario this way is compliant with the official coding guidelines which specify to code the fracture itself, instead of a surgical aftercare code, with the appropriate seventh character to denote a subsequent encounter for routine healing. [I.C.19.c.1]

It also remains in compliance with December 2015 Coding Clinic guidance that instructs coders to use the seventh character “A” for initial encounter when a patient is undergoing “active treatment” for the condition

described by the code, such as IV antibiotics for an infected surgical wound. [CPH, 1/16]

Capturing these scenarios this way hasn't been a problem for Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston, who has seen and coded cases like this in which the fracture is healing normally but the surgical incision is infected.

Tip: Ensure documentation **clearly** states that the **fracture is healing normally** and **only the incision site is infected**, to back up your code choices, Blevins says.

Tip: Note that this **only** applies if the infection solely involves the incision and not the bone, says Lisa Selman-Holman, HCS-D, principal of Selman-Holman and Associates and the coding service CoDR — Coding Done Right, in Denton, Texas. If the fracture itself is complicated, S82.301D would not be the correct code choice because the care required would no longer be considered routine.

Once a complication, always a complication

Continue to code an infected surgical wound as a complicated wound even after the infection resolves, and signify its progressing healing through the use of the seventh character, for example going to "D" from "A" once the infection resolves, according to Coding Clinic guidance.

For example, you'd assign T81.4xxA (Infection following a procedure, initial encounter), B95.62 (Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere) and L03.311 (Cellulitis of abdominal wall) for an abdominal surgical wound infected with MRSA and cellulitis.

However, if the cellulitis and infection resolve and the wound still requires ongoing care, continue to code it with T81.4xxD (Infection following a procedure, subsequent encounter) and drop the B95.62 and L03.311.

This guidance, a concept entirely new in ICD-10, is proving to be a stumbling block to many. Using seventh characters on complication codes, particularly going from "A" to "D" once the complication resolves, confuses many home health coders, says Selman-Holman.

"It is really difficult for some, because the complication is gone, to code the complication with a D," she says. Many coders struggle with continuing to assign a complication code for a wound that's no longer complicated and want to use an aftercare code instead, thinking they should now be coding routine healing.

Code injury, not aftercare, when joint replacement treats a fracture

Continue to assign the injury code, for example S72.001D (Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing), for patient who underwent a joint replacement to treat a hip fracture.

The aftercare code Z47.1 (Aftercare following joint replacement surgery) is **not appropriate** in these types of scenarios, says Nelly Leon-Chisen, director of coding and classification for the American Hospital Association, which publishes the Coding Clinic's quarterly updates. Leon-Chisen confirmed this guidance during her session at DecisionHealth's 14th annual Home Health Coding Summit in Chicago.

This guidance amounts to a substantial change from how the care of joint replacements done to treat fractures is coded. Previous wisdom held that once the fractured bone is surgically excised and replaced with a prosthetic joint, the fracture no longer exists and the aftercare code is the only logical choice. — Megan Batty (mgustafson@decisionhealth.com)

And yet, that's exactly what the guidance instructs and T81.4- (Infection following a procedure) remains the appropriate code choice in this scenario, but it would receive a seventh character of "D," according to Coding Clinic guidance. [CPH, 3/16]

Scenario: Hip fracture, infected wound

A 73-year-old man fractured his left hip and underwent an ORIF procedure to repair it. His fracture is healing normally but the surgical incision site is infected. He arrives in home health with orders for wound care and is still taking oral antibiotics to treat the infection. He will also receive physical and occupational therapy. He also has type 2 diabetes and PVD, both of which are currently stable.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Infection following a procedure, initial encounter	T81.4xxA		
M1023b: Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing	S72.002D		
M1023c: Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51		
M1023d: Long term (current) use of antibiotics	Z79.2		

Rationale:

- The incision site is still requiring active treatment for infection and this is coded with an “A” for initial encounter.
- The fracture is healing normally and is thus coded with “D.”
- No specific link between the diabetes and PVD is established but because they are linked in the index via the term “with,” they are coded as connected.
- The patient continues to take antibiotics and thus Z79.2 is coded to capture this.

Scenario: Healing infected surgical wound

A 67-year-old man is being recerted for another episode of home health to continue wound care to abdominal surgical wound. He underwent surgery to remove his gallbladder to treat severe cholecystitis two-and-a-half months ago and the wound became infected with cellulitis and E. coli. The cellulitis and infection have now resolved but wound care is still required. He also has primary osteoarthritis in both knees and chronic systolic heart failure.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Infection following a procedure, subsequent encounter	T81.4xxD		
M1023b: Chronic systolic (congestive) heart failure	I50.22		
M1023c: Bilateral primary osteoarthritis of knee	M17.0		

Rationale:

- The infection and cellulitis have resolved and thus aren’t coded. But the wound was previously complicated and thus should still be coded with a complication code. The seventh character “D” signifies that the wound has progressed into the healing phase.
- Cholecystitis is not coded because it was resolved by the surgical removal of his gallbladder.
- The patient’s heart failure and osteoarthritis will impact his healing and are thus coded as comorbidities.

Scenario: Wrist fracture, staph infection

A 70-year-old woman fell while roller skating and fractured the shaft of her left ulna. The fracture was repaired with surgery and the surgical incision site later became infected with pseudomonas bacteria and required IV antibiotics in the hospital. She is admitted to home health still under treatment for the infection, but now taking oral antibiotics. She has a history of breast cancer that was treated five years ago and was stated as eradicated in the medical record.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Infection following a procedure, initial encounter	T81.4xxA		
M1023b: Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere	B96.5		
M1023c: Unspecified fracture of shaft of left ulna, subsequent encounter for closed fracture with routine healing	S52.202D		
M1023d: Long term (current) use of antibiotics	Z79.2		
M1023e: Personal history of malignant neoplasm of breast	Z85.3		
M1023f: Fall from non-in-line roller-skates, subsequent encounter	V00.121D		

Rationale:

- The patient is still receiving active treatment for her incision site infection, making T81.4xxA the most correct primary diagnosis code.
- The fracture is healing normally and is thus coded with a seventh character of “D.”
- Since the patient is still taking antibiotics after receiving IV antibiotics in the hospital, Z79.2 is assigned.
- She has a history of breast cancer that is said to be eradicated, making Z85.3 the appropriate code choice to capture this.
- The external cause code to describe the fall is assigned, though it is not required. It helps to better describe the circumstances that led to the fracture. A seventh character “D” is assigned to the external cause code to match the injury code seventh character, in accordance with coding guidelines.— *Megan Batty (mgustafson@decisionhealth.com)*

Quick Guide to Diabetic Manifestations Under Subterm “with”

Use the tables below to quickly determine which conditions may be assumed, *as best practice*, as diabetic manifestations in the absence of another stated etiology, in accordance with Q2 2016 Coding Clinic guidance.

Category	Manifestation
E08.- (Diabetes mellitus due to underlying condition)	amyotrophy - E08.44 arthropathy NEC - E08.618 autonomic (poly) neuropathy - E08.43 Charcot's joints - E08.610 chronic kidney disease - E08.22 dermatitis - E08.620 foot ulcer - E08.621 gangrene - E08.52 gastroparesis - E08.43 glomerulonephrosis, intracapillary - E08.21 glomerulosclerosis, intercapillary - E08.21 hyperglycemia - E08.65 hyperosmolarity - E08.00 hypoglycemia - E08.649 ketoacidosis - E08.10 Kimmelstiel-Wilson disease - E08.21 mononeuropathy - E08.41 myasthenia - E08.44 necrobiosis lipoidica - E08.620 nephropathy - E08.21 neuralgia - E08.42 neuropathic arthropathy - E08.610 neuropathy - E08.40 periodontal disease - E08.630 peripheral angiopathy - E08.51 polyneuropathy - E08.42 renal tubular degeneration - E08.29 retinopathy - E08.319
E09.- (Drug or chemical induced diabetes mellitus)	amyotrophy - E09.44 arthropathy NEC - E09.618 autonomic (poly) neuropathy - E09.43 Charcot's joints - E09.610 chronic kidney disease - E09.22 dermatitis - E09.620 foot ulcer - E09.621 gangrene - E09.52 gastroparesis - E09.43 glomerulonephrosis, intracapillary - E09.21 glomerulosclerosis, intercapillary - E09.21 hyperglycemia - E09.65 hyperosmolarity - E09.00 hypoglycemia - E09.649 ketoacidosis - E09.10 Kimmelstiel-Wilson disease - E09.21 mononeuropathy - E09.41 myasthenia - E09.44 necrobiosis lipoidica - E09.620 nephropathy - E09.21 neuralgia - E09.42 neuropathic arthropathy - E09.610 neuropathy - E09.40 periodontal disease - E09.630 peripheral angiopathy - E09.51 polyneuropathy - E09.42 renal tubular degeneration - E09.29 retinopathy - E09.319

Category	Manifestation
E10.- (Type 1 diabetes mellitus)	amyotrophy - E10.44 arthropathy NEC - E10.618 autonomic (poly) neuropathy - E10.43 Charcot's joints - E10.610 chronic kidney disease - E10.22 dermatitis - E10.620 foot ulcer - E10.621 gangrene - E10.52 gastroparesis - E10.43 glomerulonephrosis, intracapillary - E10.21 glomerulosclerosis, intercapillary - E10.21 hyperglycemia - E10.65 hypoglycemia - E10.649 ketoacidosis - E10.10 Kimmelstiel-Wilson disease - E10.21 mononeuropathy - E10.41 myasthenia - E10.44 necrobiosis lipoidica - E10.620 nephropathy - E10.21 neuralgia - E10.42 neuropathic arthropathy - E10.610 neuropathy - E10.40 periodontal disease - E10.630 peripheral angiopathy - E10.51 polyneuropathy - E10.42 renal tubular degeneration - E10.29 retinopathy - E10.319
E11.- (Type 2 diabetes mellitus)	amyotrophy - E11.44 arthropathy NEC - E11.618 autonomic (poly) neuropathy - E11.43 Charcot's joints - E11.610 chronic kidney disease - E11.22 dermatitis - E11.620 foot ulcer - E11.621 gangrene - E11.52 gastroparesis - E11.43 glomerulonephrosis, intracapillary - E11.21 glomerulosclerosis, intercapillary - E11.21 hyperglycemia - E11.65 hyperosmolarity - E11.00 hypoglycemia - E11.649 Kimmelstiel-Wilson disease - E11.21 mononeuropathy - E11.41 myasthenia - E11.44 necrobiosis lipoidica - E11.620 nephropathy - E11.21 neuralgia - E11.42 neuropathic arthropathy - E11.610 neuropathy - E11.40 periodontal disease - E11.630 peripheral angiopathy - E11.51 polyneuropathy - E11.42 renal tubular degeneration - E11.29 retinopathy - E11.319

(Continued on next page)

Category	Manifestation
E13.- (Other specified diabetes mellitus)	amyotrophy - E13.44 arthropathy NEC - E13.618 autonomic (poly) neuropathy - E13.43 Charcot's joints - E13.610 chronic kidney disease - E13.22 dermatitis - E13.620 foot ulcer - E13.621 gangrene - E13.52 gastroparesis - E13.43 glomerulonephrosis, intracapillary - E13.21 glomerulosclerosis, intercapillary - E13.21 hyperglycemia - E13.65 hyperosmolarity - E13.00 hypoglycemia - E13.649 ketoacidosis - E13.10 Kimmelstiel-Wilson disease - E13.21 mononeuropathy - E13.41 myasthenia - E13.44 necrobiosis lipoidica - E13.620 nephropathy - E13.21 neuralgia - E13.42 neuropathic arthropathy - E13.610 neuropathy - E13.40 periodontal disease - E13.630 peripheral angiopathy - E13.51 polyneuropathy - E13.42 renal tubular degeneration - E13.29 retinopathy - E13.319

***Tip:** Cataracts are often an age-related disease, particularly in the home health population. They are rarely seen in Type 2 diabetes, the most common form of the disease. Therefore, ensure a patient's cataract is truly related to diabetes before coding it as such.

****Tip:** All potential manifestations of diabetes that would have to be classified under an NEC (not elsewhere classified) code should, **for best practice**, be confirmed with the physician before being coded as such.

Tip: Never assign the code, in any of the diabetes categories, for unspecified complication, such as E11.8 (Type 2 diabetes mellitus with unspecified complications). If your agency is treating a patient's diabetes complication, you should know what it is.

Beware! Any condition that could fall within the categories listed below should, **as best practice**, be confirmed as linked to the patient's diabetes before being coded as such.

Category	Get physician confirmation before coding:
E08.- (Diabetes mellitus due to underlying condition)	cataract - E08.36* circulatory complication NEC - E08.59** kidney complications NEC - E08.29** neurologic complication NEC - E08.49** ophthalmic complication NEC - E08.39** oral complication NEC - E08.638** renal complication NEC - E08.29** skin complication NEC - E08.628** skin ulcer NEC - E08.622**
E09.- (Drug or chemical induced diabetes mellitus)	cataract - E09.36* circulatory complication NEC - E09.59** neurologic complication NEC - E09.49** ophthalmic complication NEC - E09.39** oral complication NEC - E09.638** renal complication NEC - E09.29** skin complication NEC - E09.628** skin ulcer NEC - E09.622**
E10.- (Type 1 diabetes mellitus)	cataract - E10.36* circulatory complication NEC - E10.59** kidney complications NEC - E10.29** neurologic complication NEC - E10.49** ophthalmic complication NEC - E10.39** oral complication NEC - E10.638** renal complication NEC - E10.29** skin complication NEC - E10.628** skin ulcer NEC - E11.622**
E11.- (Type 2 diabetes mellitus)	cataract - E11.36* circulatory complication NEC - E11.59** kidney complications NEC - E11.29** neurologic complication NEC - E11.49** ophthalmic complication NEC - E11.39** oral complication NEC - E11.638** renal complication NEC - E11.29** skin complication NEC - E11.628** skin ulcer NEC - E11.622**
E13.- (Other specified diabetes mellitus)	cataract - E13.36* circulatory complication NEC - E13.59** kidney complications NEC - E13.29** neurologic complication NEC - E13.49** ophthalmic complication NEC - E13.39** oral complication NEC - E13.638** renal complication NEC - E13.29** skin complication NEC - E13.628** skin ulcer NEC - E13.622**

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