Stay calm and code on: ICD-10 to simplify depression coding

You won’t need extra detail about a patient’s depression diagnosis to assign F32.9 (Major depressive disorder, single episode, unspecified) in ICD-10, as that is the default code in the new code set for depression not otherwise specified.

Currently, you have to assign the non-specific 311 (Depression NOS) unless the patient's physician specifically states that a patient is experiencing a single episode of major depressive disorder, which would allow you to code 296.20 (Major depressive disorder, single episode, unspecified), says Michelle Mantel, HSC-D, quality assurance manager for Gentiva Home Health in Atlanta, Ga.

(see Depression, p. 7)

Capture pressure ulcers correctly to protect outcomes, reimbursement

Continue to code stage 3 and 4 pressure ulcers, even if the wounds have closed, or you could be forfeiting valuable risk adjustment and negatively impacting your agency's outcomes.

Stage 3 and 4 pressure ulcers, the most severe of these wounds, never heal even though they may close, according to the Wound, Ostomy and Continence Nurses Society (WOCN).

The word “healing” that’s used in one of the responses to M1320 (Status of Most Problematic Pressure Ulcer that is Observable) often confuses coders into thinking that the more severe pressure wounds, (see Pressure ulcers, p. 8)

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Tackle the ICD-10 transition with a 6-part CD training series designed to get your entire agency ready for this colossal shift. From budgeting to coding to documentation, our expert speakers will help you overcome the transitional roadblocks standing in your agency’s way. Get all the resources you need without leaving your agency. Bonus: BMSC has approved 6 HCS-D and 6 HCS-O CEUs for this webinar series. Learn more at https://store.decisionhealth.com/Product.aspx?ProductCode=TA2471CD.
Prepare now to prevent ICD-10 productivity losses after Oct. 1.

Start dual coding charts now and track the extra time it takes to assign ICD-10 codes to help determine what additional resources you’ll need to lessen the impact on your productivity.

Maurice Frear, HCS-D, currently dual codes two charts per week, but plans to increase that number as the implementation date draws closer, says the coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va.

Frear’s approach is right on target, says Brandi Whitemeyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Remember that it’s going to take 70% longer to code a claim in ICD-10 in the first year, according to CMS data based on Canada’s transition to ICD-10.

And while 61% of the coders think that they’ll ultimately return to their normal productivity levels after an initial drop, data suggests this may be wishful thinking.

Home health agencies can expect a 54% decline in coding productivity in the first year post ICD-10 implementation, and, data indicates that the heightened complexity of ICD-10 will mean permanently lower productivity — likely 20% less than it is now, according to CMS.

That means if most coders are currently able to complete an average of six to 10 records daily, which is the range that most respondents to Diagnosis Coding Pro’s 2015 Home Health Coders’ Productivity Survey reported, they can expect to complete only four to eight records in an ICD-10 environment, even after full productivity following implementation is reached [CPH, 3/15].

Increase education, work overtime, outsource coding

Investing in training and education (31%) and working longer hours or overtime (19%) are the two strategies most often reported by home health coders as the way they’re planning to stem productivity losses in ICD-10, according to survey results.

Other strategies include focusing on quality improvement (3%) and reorganizing job roles (5%). One respondent’s plan is simply to quit before ICD-10 is implemented.

Some agencies are planning to adjust current productivity standards to account for the extra time ICD-10 will demand. One respondent reported that the agency expects coding to take 30% longer than it currently does and will reassess this expectation quarterly.

Terry Hatch, HCS-D, coder for North Kansas City Hospital Home Health in North Kansas City, Mo., is currently putting in about two hours a week of ICD-10 preparation, which also includes working with and training a back-up coder.
Agencies must prepare now because no matter how good a coder you are now, if you’re not familiar with working in an ICD-10 environment, you’re going to struggle, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

You can’t expect to just think you can code a certain way today and then abruptly switch to coding a completely different way tomorrow and think it’ll go smoothly, she says.

Yet, 22% of the survey’s respondents say their agencies either have no plans or they don’t know what the plans are for addressing the impact of ICD-10 on productivity. [See chart above for how agencies are preparing for ICD-10]

Margie Fitzgerald doesn’t know what her agency’s plans are for staffing and maintaining productivity throughout the ICD-10 transition. But she also doesn’t know, with a quota of 20 charts a day, how they’re going to keep up without hiring another coder, says Fitzgerald, HCS-D, who codes part-time for OSF Healthcare in Peoria, Ill.

But almost half (48%) of survey respondents said their agencies are not planning to hire additional coders to keep up with ICD-10. Just 9% said their agencies are going to do additional hiring while 14% said their agencies might hire more coders and 29% don’t know.

A slightly higher percentage of respondents (10%) say their agencies are planning to outsource at least some of their coding when ICD-10 takes effect, according to survey results.

Inova VNA Home Health in Fairfax, Va., where Anne Anastasio, HCS-D, is the utilization review coordinator, is planning to hire another coder.

And though more than 75% of its coding is completed in-house, some outsourced coding services are currently used by FirstHealth Home Care in West End, N.C., says Regenia Simmons, HCS-D, the agency’s coding specialist. Simmons hopes that her agency will make more use of outsourcing when ICD-10 takes effect.

For those agencies who are currently utilizing outsourced coding services, start having some records be dual coded, Whitemyer says. This will enable your agency to see, in a limited capacity, what the cost of outsourcing and its impact on productivity will be in ICD-10. — Megan Gustafson (mgustafson@decisionhealth.com)

**Coding Basics**

**Breaking isn’t so bad in ICD-10: How to code fractures**

*By Cynthia Cooke, RN, BSN, COS-C, HCS-D, BCHH-C*

Prepare to do something you’ve never done as a home health coder — assign current fracture codes as primary and secondary diagnoses.

The major difference for home health coders in ICD-10 is that you’ll assign the current fracture code in M1021 (primary) and/or M1023 (secondary) versus assigning an aftercare code with a corresponding entry in M1024 like you do now in ICD-9. Fracture code selections are also more specific in ICD-10, with a single code encompassing all the necessary components of the fracture as well as the care given.

ICD-10 fracture codes capture, in one single code, the specific fractured bone, its laterality, the location of the fracture within the bone, whether it’s open or closed, dislocated or not, whether the healing is normal or complicated (i.e. mal-union or non-union), if there are sequela (late effects), and the episode of care being provided (initial or subsequent). The new code set also offers code options that will show that the fracture has a specific etiology, like osteoporosis.

**Start with the basics to code correctly**

Just like in ICD-9, you’ll find fracture codes in two separate chapters: Chapter 13 (Diseases of the Musculoskeletal System) and Chapter 19 (Injury, Poisoning and Certain Other Consequences of External Causes).

Fractures classified to Chapter 13 include pathological fractures (M80.- and M84.4-), stress fractures (M84.3-),

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**Source:** 2015 Diagnosis Coding Pro Home Health Coders’ Productivity Survey

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fatigue fractures of the vertebrae (M48.4-) and collapsed vertebrae (M48.5-).

Fractures classified to Chapter 19 include traumatic fractures and other injuries. Note that in ICD-10, all injuries are organized by body region rather than by type of injury. Additionally, all ICD-10 fracture codes are categorized by body region in both chapters.

Get to the source of the fracture

First, understand the key differences between pathological and traumatic fractures so that you can code them accurately in ICD-10.

Pathological fractures occur as a result of a weakening of the bone structure in conditions such as osteoporosis, neoplastic disease, metabolic conditions or infection. What's distinctive about this type of fracture is that it would otherwise not occur if the bone were not weakened by disease.

Traumatic fractures, by contrast, are the result of external influences, or trauma, that cause damage to the bone. Examples of trauma would be a fall, an accident or an assault.

To correctly code a pathological fracture, look closely at the documentation to determine what disease process is the source of the fracture. If it's osteoporosis, and no cause of the osteoporosis is documented, code it as age-related osteoporosis and assign a code from M80.0- (Age-related osteoporosis with current pathological fracture).

If the cause of the patient's osteoporosis is something other than age, capture it with a code from M80.8- (Other osteoporosis with current pathological fracture). Tabular instructions will direct you to assign an additional code from Chapter 19 if the osteoporosis resulted from using a particular drug.

For all pathological fractures related to osteoporosis, you'll need to assign an additional code from the M89.7- category (Major osseous defect) to identify major osseous defect, if there is one documented.

Cancer, or neoplastic disease, can also cause pathological fractures. If the patient's pathological fracture was caused by cancer, capture it with a code from the M84.5- category (Pathological fracture in neoplastic disease).

If a patient's pathological fracture is documented as due to another specified disease that isn't osteoporosis or cancer, assign a code from M84.6- (Pathological fracture in other disease). For both cancer and other specified causes of pathological fractures, you need to assign an additional code for the underlying condition that caused the fracture.

If no known cause of the pathological fracture is documented, choose a code from M84.4- (Pathological fracture not elsewhere classified).

Prepare for increased trauma fracture specificity

ICD-10 offers coders many more options for coding traumatic fractures. The level of detail available to code accurately will require a great deal more knowledge about anatomy and physiology, as well as the diagnostic categories for fractures.

Traumatic fracture codes in ICD-10 are found in the ranges of S02.- (Fracture of skull and facial bones) to S92.- (Fracture of foot and toe, except ankle) in Chapter 19. There are unique codes for specific clinical descriptors such as open, closed, displaced or non-displaced, greenstick, comminuted, transverse and others.

Additionally, you should become familiar with the Gustilo fracture classification system which classifies open fractures according to their severity. Progression goes from grade I to IIIIC. This classification system applies to categories S52.- (Fracture of forearm), S72.- (Fracture of femur) and S82.- (Fracture of lower leg, including ankle) and must be confirmed by physician documentation.

Stress fractures, also known as fatigue fractures, are caused by repeated impact and use over time. They are captured by codes in the M84.3- (Stress fracture) category. Stress fractures of the vertebrae and collapsed vertebrae are coded to M48.4- (Fatigue fracture of vertebra) and M48.5- (Collapsed vertebra, not elsewhere classified).

Learn to use the seventh character

All fracture codes in ICD-10, whether they're describing pathological or traumatic bone breaks, will need a seventh character to identify the type of encounter for which the patient is being seen.

The only appropriate seventh characters for home care are those indicating subsequent encounters. You will choose seventh character D, E, or F for routine healing; G, H or J for delayed healing; K, M or N for non-union; P, Q or R for mal-union; or S for sequela (late effects).
More tips for coding fractures in ICD-10

Here are four more tips to help you code fractures accurately in ICD-10:

• Code a fracture in a patient with known osteoporosis as a pathological fracture, even if the patient sustained the fracture after minor trauma, such as a fall, if that minor trauma would not normally break a healthy bone. If you’re unsure about a patient’s fracture, query the physician.

• Pay close attention to the Excludes 1 (means “not coded here”) and Excludes 2 (means “may be coded”) notes under each section which indicate that certain fractures can and cannot be coded on the same claim.

• Code a fracture not specified as open or closed as closed, and a fracture not specified as displaced or non-displayed as displaced, according to coding guidelines.

• Be sure to always assign a seventh character or the code will be considered invalid and the claim will reject.

Scenario: Pathological fracture in osteoporosis

A 77-year-old woman tripped over her oxygen tubing and fell, suffering a fracture of the greater tuberosity of the left humerus. She has COPD and osteoporosis which has caused a major osseous defect in the same bone that just fractured. Home health was ordered for skilled nursing and physical and occupational therapy.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1025 Additional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021: Age-related osteoporosis with current pathological fracture, left humerus, subsequent encounter for fracture with routine healing</td>
<td>M80.022D</td>
</tr>
<tr>
<td>M1023: Major osseous defect, left humerus</td>
<td>M89.722</td>
</tr>
<tr>
<td>M1023: Chronic obstructive pulmonary disease, unspecified</td>
<td>J44.9</td>
</tr>
<tr>
<td>M1023: Other fall on same level, subsequent encounter</td>
<td>W18.39xD</td>
</tr>
</tbody>
</table>

**Rationale:**

• The patient has osteoporosis and suffered a fall that shouldn’t have resulted in a fracture. As a result, the fracture is considered pathological.

Scenario: Pathological fracture related to neoplasm

A 78-year-old woman with metastatic right breast cancer to the bone experienced sudden right leg pain as she stood up from bed. She received an x-ray and her physician diagnosed a neoplastic pathological fracture of the right tibia. Four months later an x-ray indicates it has not healed and patient is now bedbound. Skilled nursing and physical therapy have been ordered.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1025 Additional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021: Pathological fracture in neoplastic disease, right tibia, subsequent encounter for fracture with delayed healing</td>
<td>M84.561G</td>
</tr>
<tr>
<td>M1023: Secondary malignant neoplasm of bone</td>
<td>C79.51</td>
</tr>
<tr>
<td>M1023: Malignant neoplasm of unspecified site of left female breast</td>
<td>C50.912</td>
</tr>
<tr>
<td>M1023: Bed confinement status</td>
<td>Z74.01</td>
</tr>
</tbody>
</table>

**Rationale:**

• The neoplasm metastases caused the weakened bone, resulting in the pathological fracture. Therefore it’s coded as a pathological fracture in neoplastic disease.

• The metastatic bone cancer is sequenced before the primary breast malignancy due to the fact that, after the fracture itself, treatment is directed toward the metastatic site.

• Identification of the laterality of the breast cancer, as well as the bone, is necessary. If not specified the physician must be queried.

• The seventh character “G” indicates the complication of delayed healing.

• The Z code adds more information to capture that her patient is confined to her bed.
**Scenario: Traumatic fracture**

A 55-year-old man crashed his snowmobile into a tree and sustained multiple right rib fractures, an open comminuted right femur fracture type IIIA and a transverse right radial shaft fracture. He was admitted to home health for skilled nursing and physical therapy.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1025 Additional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021: Displaced comminuted fracture of shaft of right femur, subsequent encounter for open fracture type IIIA, IIIB, or III C with routine healing</td>
<td>S72.351F</td>
</tr>
<tr>
<td>M1023: Displaced transverse fracture of shaft of right radius, subsequent encounter for closed fracture with routine healing</td>
<td>S52.321D</td>
</tr>
<tr>
<td>M1023: Multiple fractures of ribs, right side, subsequent encounter for fracture with routine healing</td>
<td>S22.41xD</td>
</tr>
<tr>
<td>M1023: Driver of snowmobile injured in non-traffic accident, subsequent encounter</td>
<td>V86.52xD</td>
</tr>
</tbody>
</table>

**Rationale:**

- The patient's open femur fracture was Gustilo classified in the documentation, necessitating the use of the seventh character “F.”
- The radial fracture was not identified as displaced or not, so the default is displaced.
- Both the rib fracture and the external cause codes have only five characters and require a placeholder “X” in the sixth position before the seventh character is assigned.

**Scenario: Stress fracture**

A 67-year-old runner sustained a stress fracture of the left ankle. When the cast was removed the patient began using a treadmill against his physician's ordered activity restriction. After six weeks he had pain, and an x-ray showed mal-union of the fracture and it had to be surgically repaired. He was admitted to home health for physical therapy.

### Ask the Expert

**Code hypertensive retinopathy, CKD**

**Question:** I have a patient who has hypertension, stage 3 chronic kidney disease and hypertensive retinopathy. She was also recently in the hospital with acute renal failure but there was no mention of the hypertensive retinopathy problems during the hospitalization. How do I code this?

**Answer:** If the focus of care is the hypertensive retinopathy, code 362.11 (Hypertensive retinopathy) first, followed by 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified), and then 585.3 (Chronic kidney disease, Stage III (moderate)).

Hypertensive retinopathy codes to 362.11, and you must follow it with a code for the particular form of hypertension, according to coding guidelines [I.C.7.a.6].

The correct code for the patient's hypertension is determined by the fact that she also has chronic kidney disease, and there is an assumed relationship between hypertension and chronic kidney disease, according to coding guidelines. Therefore, you’d assign 403.90 followed by 585.3 to capture this [I.C.7.a.3].

**Editor’s note:** The Ask the Expert answers were provided by Jean Bird, RN, HCS-D, clinical coordinator at Gentiva in Fall River, Mass. Submit your questions to mgustafson@decisionhealth.com.
Depression

(continued from p. 1)

This coming change in ICD-10 confuses coders because they expect to need more diagnostic detail to use F32.9, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Other than this, the way you’ll code the common psychiatric diagnoses of depression and anxiety in ICD-10 will follow the way you currently code them in ICD-9, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

And, properly assigning depression and anxiety diagnoses is now more imperative than ever. Consider that all psychiatric diagnoses lost their case-mix status in the FY2015 final PPS rule amid concerns from CMS that they don’t significantly impact resource use [CPH, 12/14].

Now, the federal agency is watching to see whether these diagnoses will continue to be coded at the rate they had been, Twombly says.

Note similarities to ensure accurate coding

Find the ICD-10 codes that correspond to anxiety and depression in Chapter 5 (Mental and Behavioral Disorders), which is the same place they’re currently found, and assign them using the same processes and rules you apply now.

Depression diagnoses in ICD-10 are captured by the F32.- (Major depressive disorder, single episode) and F33.- (Major depressive disorder, recurrent) categories. The ICD-9 equivalents are found in the 296.2x (Major depressive disorder, single episode) and 296.3x (Major depressive disorder, recurrent episode) series.

As stated previously, the often-assign generic ICD-9 depression code 311 (Depression NOS) will be captured by F32.9 in ICD-10.

Anxiety conditions are grouped in the F41.- (Other anxiety disorders) category, and correspond to the ICD-9 codes from the 300.0x series (Anxiety states). For example, a diagnosis stated only as “anxiety” is captured with 300.00 (Anxiety state, unspecified) in ICD-9, and with F41.9 (Anxiety disorder, unspecified) in ICD-10.

And, just like in ICD-9, you can only code F41.8 (Mixed anxiety and depressive disorder) when the diagnostic statement specifically links a patient’s diagnoses of depression and anxiety, Mantel says. The ICD-9 equivalent is 300.4 (Depression with anxiety).

Tip: Look for the word “with” in the doctor’s diagnostic statement for a clue that the two can be coded together, Mantel says. Statements like “depression with anxiety” or “anxiety with depression” can be coded with 300.4 in ICD-9 and F41.8 in ICD-10. If the two diagnoses can’t be connected, code them separately with F32.9 and F41.9 (311 and 300.00 in ICD-9).

Tip: Don’t assume that diagnoses of anxiety and depression are connected simply because they’re on the same line in a physician’s dictation or are separated only by a comma, Mantel says. A statement like “anxiety, depression” should not be assumed to be “anxiety with depression.”

Tip: Understand that “anxiety and depression” is not equivalent to “anxiety with depression.” Only the word “with”
can be interpreted to mean “associated with” or “due to,” according to official coding guidelines [CPH, 5/13].

ICD-9 Scenario: Depression with anxiety

A 67-year-old woman is admitted to home health to receive B12 injections to treat her pernicious anemia. Her severe rheumatoid arthritis makes it impossible for her to self-inject. She also has severe anxiety with depression, for which she was recently prescribed new medications.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1024 Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020a: Pernicious anemia</td>
<td>281.0</td>
</tr>
<tr>
<td>M1022b: Rheumatoid arthritis</td>
<td>714.0</td>
</tr>
<tr>
<td>M1022c: Depression with anxiety</td>
<td>300.4</td>
</tr>
</tbody>
</table>

**Rationale:**
- As the focus of care and the reason why she cannot self-inject, pernicious anemia is coded primary and is immediately followed by the rheumatoid arthritis.
- Since the patient’s psych diagnosis was specifically written as anxiety with depression, it can be coded with 300.4.
- In ICD-10, codes to capture this scenario would be assigned in the following order: D51.0 (Vitamin B12 deficiency anemia due to intrinsic factor deficiency), M06.9 (Rheumatoid arthritis, unspecified) and F41.8 (Mixed anxiety and depressive disorder).

ICD-10 Scenario: Joint replacement, anxiety

A 75-year-old woman underwent a knee replacement to treat osteoarthritis that was stated to be localized to the knee that was replaced, which is her left knee. She will receive skilled nursing and physical therapy. She has severe generalized anxiety disorder, for which she has been prescribed new medications.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1025 Additional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021: Aftercare following joint replacement surgery</td>
<td>Z47.1</td>
</tr>
<tr>
<td>M1023: Generalized anxiety disorder</td>
<td>F41.1</td>
</tr>
<tr>
<td>M1023: Presence of left artificial knee joint</td>
<td>Z96.652</td>
</tr>
</tbody>
</table>

**Rationale:**
- The focus of care is the aftercare following the joint replacement, which is captured with Z47.1.
- Her anxiety diagnosis was specified as generalized anxiety disorder and thus is coded as such.
- Since the osteoarthritis was said to be localized to the knee that was replaced, it is a resolved condition and thus is not coded.
- The presence of the artificial knee is also captured, with Z96.652.
- In ICD-9, codes for this scenario would be assigned in the following order: V54.81 (Orthopedic aftercare following joint replacement), 300.02 (Generalized anxiety disorder) and V43.65 (Organ or tissue replaced by other means, knee joint). — Megan Gustafson (mgustafson@decisionhealth.com)

**Editor’s note:** See the online version of the story at www.HHCodingCenter.com for more scenarios.

Pressure ulcers

(continued from p. 1)
since they’ve closed, are healed and don’t need to be coded any longer, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

However, stage 3 and 4 pressure ulcers damage the tissue to the point where it is forever left vulnerable to further breakdown. It’s quite common for these wounds to re-open and thus they require continual monitoring by the agency, she says.

Agencies need to include preventative pressure relief measures due to the likelihood of a breakdown again in the same area, says J’non Griffin, HCS-D, senior consultant for Home Health Solutions, LLC in Carbon Hill, Ala.

And while pressure ulcer codes don’t carry case-mix points, their respective OASIS items do, so it’s imperative that you show Medicare the complete picture of your patient’s health as well as everything your agency is doing to improve it. And including codes for closed stage 3 and 4 pressure ulcers is an important piece of that, Twombly says.

**Tip:** Assign closed stage 3 and 4 pressure ulcers among the codes that go on the home health claim, Twombly says. While closed stage 3 or 4 pressure ulcer codes may not warrant inclusion in the top six diagnoses if they are not the focus of the admission, they should
be somewhere on the claim to ensure that the Medicare Administrative Contractor (MAC) gives your agency credit for monitoring the patient’s skin.

**Tip:** Code stage 3 and 4 pressure ulcers that re-open to the stage they were prior to closing, not what they currently appear to be, Griffin says. Clinicians frequently make mistakes when staging re-opened stage 3 and 4 pressure ulcers. [See the Tool of the Month for guidance on how to correctly answer OASIS-C1 item M1309 (Worsening in Pressure Ulcers)]

**Beware of common sequencing mistakes**

Sequence the code for the pressure ulcer stage immediately following the code for the pressure ulcer site, according to tabular instructions. For example, a stage 2 pressure ulcer to the heel would be coded first with 707.07 (Decubitus ulcer heel) and then 707.22 (Pressure ulcer stage 2).

Not assigning the stage code immediately following the site code is one of the most common errors coders make when capturing pressure ulcers, says Kammie Beversdorf, HCS-D, coding and OASIS review supervisor for BlackTree Healthcare Consulting in Conshohocken, Pa.

It’s perfectly acceptable to assign the stage code in the seventh position, and thus outside the top six, as long as it immediately follows the site code in the six position, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

However, don’t assign the same stage code twice if a patient happens to have two pressure ulcers of the same stage in different locations, Twombly says. You can only assign each unique ICD-9 code once, and breaking this rule will cause your claim to reject.

Capture a patient with more than one pressure ulcer of the same stage at different sites by first assigning both site codes and then assigning the stage code under both site codes, Twombly says.

For example, stage 3 pressure ulcers on the hip and the buttocks would be coded with 707.04 (Pressure ulcer hip) followed by 707.05 (Pressure ulcer buttocks). Then code 707.23 (Decubitus ulcer stage 3) immediately after both of them, she says.

**Watch for inaccurate staging to avoid ADRs**

Beware of assigning a stage 2 pressure ulcer as a patient’s primary diagnosis for more than one episode, as you could be putting your agency at risk for ADRs, claims denials and audits.

Coders should question the clinician if you see a stage 2 pressure ulcer remaining for longer than 30 days. Clinicians will often mark pressure ulcers as stage 2 when they really should be stage 3 based on WOCN and National Pressure Ulcer Advisory Panel (NPUAP) guidelines, Griffin says.

And the consequences of this mistake could be serious: repeated routine care to a stage 2 pressure ulcer is not considered a skilled service for which Medicare will pay, Whitemyer says.

So if the stage 2 pressure ulcer isn’t complicated by something such as infection or there isn’t another reason for your agency to be in the home, the medical necessity of the claim could come into question, and you could end up returning reimbursement to Medicare, she says.

Furthermore, a stage 3 ulcer incorrectly identified as a stage 2 will cost your agency points earned through OASIS item M1324 (Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable).

Consider that a stage 3 pressure ulcer will earn more points than a stage 2 in every single equation. In the second equation, the difference between the two amounts to 14 points.

“With case-mix scoring changing for 2015, it is more important than ever to have correct scoring of the OASIS for total points to calculate correctly for the agency,” Griffin says.

**Scenario: Stage 3 pressure ulcers, morbid obesity**

A 76-year-old woman has three stage 3 pressure ulcers and is admitted to home health for wound care. The ulcers are on her right heel, left ankle and buttocks. She is morbidly obese with a BMI of 41.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1024 Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1020a: Decubitus ulcer heel</td>
<td>707.07</td>
</tr>
<tr>
<td>M1022b: Decubitus ulcer ankle</td>
<td>707.06</td>
</tr>
<tr>
<td>M1022c: Decubitus ulcer buttock</td>
<td>707.05</td>
</tr>
<tr>
<td>M1022d: Pressure ulcer stage III</td>
<td>707.23</td>
</tr>
<tr>
<td>M1022e: Morbid obesity</td>
<td>278.01</td>
</tr>
<tr>
<td>M1022f: Body Mass Index 40.0–44.9, adult</td>
<td>V85.41</td>
</tr>
</tbody>
</table>
**Rationale:**

- All three of the patient's pressure ulcers are stage 3, and since the stage code can only be used once, it is assigned immediately after the third pressure ulcer site code, in accordance with tabular instructions to code the stage code following the site code.
- The patient is morbidly obese, and her specific BMI is also coded.

**Scenario: Dehisced surgical wound**

A 68-year-old man is admitted to home health for wound care to an externally dehisced surgical wound resulting from an emergency appendectomy performed two weeks ago. Two years ago, he underwent a below the knee amputation to treat gangrenous diabetic ulcers on his left foot and calf. He has severe depression, for which he takes medication that was just adjusted, as well as hypertension. He has diabetic peripheral angiopathy and is dependent on insulin. His chart indicates that he suffered a stage 4 ulcer pressure ulcer on his coccyx a year ago that is closed now but will need to be continually assessed for continued breakdown.

**Code the scenario:**

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>M1024 Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1020a:</strong> Disruption of external operation surgical wound</td>
<td>998.32</td>
</tr>
<tr>
<td><strong>M1022b:</strong> Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled</td>
<td>250.70</td>
</tr>
<tr>
<td><strong>M1022c:</strong> Peripheral angiopathy in diseases classified elsewhere</td>
<td>443.81</td>
</tr>
<tr>
<td><strong>M1022d:</strong> Depression NOS</td>
<td>311</td>
</tr>
<tr>
<td><strong>M1022e:</strong> Essential hypertension, unspecified</td>
<td>401.9</td>
</tr>
<tr>
<td><strong>M1022f:</strong> Decubitus ulcer lower back</td>
<td>707.03</td>
</tr>
</tbody>
</table>

**Additional diagnoses:** 707.24 (Pressure ulcer stage 4), V58.67 (Long-term (current) use of insulin), V49.75 (Lower limb amputation status, below knee)

**Rationale:**

- Though the stage 4 coccyx pressure ulcer is closed, it is at risk for further skin breakdown and this it is coded. The stage must follow the site, though one of the codes is out of the top six.
- The use of insulin code (V58.67) must be assigned because the patient is a type 2 diabetic who is dependent on insulin.

### Expect new wave of diabetes denials

Ensure there is a recent HbA1c test result in patients’ charts for whom you’re coding diabetes, or prepare to lose money or even face outright claims denials.

A new Local Coverage Determination (LCD) from the Palmetto Medicare Administrative Contractor (MAC) requires current – within 120 days – HbA1c test results be noted in the charts of diabetes patients. The directive applies to services performed on or after Dec. 30, 2014.

“Reasonable and necessary home health plans of care for Medicare beneficiaries with Type II diabetes must therefore include the monitoring and reporting of not only intermittent capillary blood/serum glucose levels but also quarterly (and no less often than 120 days) HbA1c levels,” the LCD says.

The directive includes both start of care and recert episodes and if current HbA1c results aren’t in the record, the agency cannot bill for the episode of care. Furthermore, if no current HbA1c result is on file for a start of care episode that began prior to Dec. 30, 2014, the test result must be obtained before a recert episode beginning on or after Jan. 1, 2015 can be billed, according to a January Ask the Contractor Call with Palmetto.

This requirement is new and it applies whether the claim lists diabetes as a primary or secondary diagnosis, says Vonnie Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston.

Without a current HbA1c test on file, it’s possible that the claim could be downcoded by however many points the diabetes diagnosis, when coded secondary, earned. If the claim is based on the diabetes diagnosis as the primary reason for care, the lack of a current HbA1c could result in the claim being completely denied, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

**Editor’s note:** To view the LCD, go to [http://go.cms.gov/1xFyTIL](http://go.cms.gov/1xFyTIL).
## M1309 Decision Matrix (based on CMS’ M1309 Algorithm)

Use this tool, developed by Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas, to help guide your response to OASIS item M1309 (Worsening Pressure Ulcer).

<table>
<thead>
<tr>
<th>CURRENT STAGE at Discharge</th>
<th>What was Pressure Ulcer at most recent SOC/ROC?</th>
<th>Report in M1309 as New or Worsened at Discharge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II</td>
<td>• Not Present  OR</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage II</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Stage III</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Stage IV</td>
<td>(Reverse staging not allowed)</td>
</tr>
<tr>
<td></td>
<td>• Unstageable</td>
<td></td>
</tr>
<tr>
<td>b. Stage III</td>
<td>• Not Present</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage III</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Stage IV</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Unstageable</td>
<td>(Reverse staging not allowed)</td>
</tr>
<tr>
<td>c. Stage IV</td>
<td>• Not Present</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage III</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage IV</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Unstageable</td>
<td></td>
</tr>
<tr>
<td>d. Unstageable due to slough or eschar</td>
<td>• Not Present</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage III</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stage IV</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Unstageable</td>
<td></td>
</tr>
<tr>
<td>Excludes:</td>
<td>• Ulcers covered w/ dressings or devices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Suspected DTIs</td>
<td></td>
</tr>
</tbody>
</table>

Source: © Rambusch3, November 2014 – Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas
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