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Master key ICD-10 conventions, guidelines to prepare for transition

In a significant change from ICD-9, you must take note of the five ICD-10 chapters (7, 13, 15, 19 and 20) that contain code categories **requiring** a seventh character and/or fourth, fifth and/or sixth character placeholders, or risk having your claims rejected after Oct. 1.

For example, you can't just assign T20.37 (Burn of third degree of neck), found in Chapter 19 (Injury, poisoning and certain other consequences of external causes), for a patient coming to home health for routine treatment of a third degree thermal burn to the neck.

(see *ICD-10 conventions & guidelines*, p. 6)



Transition to ICD-10

Combination codes simplify sepsis coding

Assign just one combination code, A40.9 (Streptococcal sepsis), to capture sepsis caused by a streptococcal organism in ICD-10.

This condition currently requires two codes in ICD-9: First, 038.0 (Streptococcal septicemia) for the infecting organism, then 995.91 (Sepsis) to indicate that it caused sepsis.

Choosing the right sepsis code(s), and sequencing them correctly, is a confusing task for even the most seasoned coders. And distinguishing among the plethora of terms used to describe the condition, such as bacteremia and septicemia, is particularly troublesome, says Cynthia Cooke, HCS-D, clinical coding/OASIS

(see *Sepsis*, p. 8)

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Warning: Hospice claims are being returned; change coding processes now

Almost 40% of hospices have had records returned for incorrect coding since Oct. 1, 2014, according to the results of *Diagnosis Coding Pro's* Hospice Coding Survey of 131 hospice coders.

Of those who've had claims returned for correction, nearly 30% report having between one and five claims returned, while 8% have had six to 10 records returned, according to survey results.

Hospice coders and clinicians are having to make drastic changes to their coding practices, requiring far more frequent collaboration to determine patients' terminal diagnoses since Medicare started returning to provider (RTP) claims with primary terminal diagnoses of debility (799.3), adult failure to thrive (783.7) and unspecified or manifestation dementia conditions (such as 294.21, Dementia, unspecified, with behavioral disturbance). [*CPH, 11/14*]

Consider that while 37% of survey respondents reported they frequently assigned unspecified dementia codes as the primary terminal diagnosis because the record lacked further diagnostic detail **prior to** Oct. 1, 2014, 84% of them stopped doing so completely after the RTP edit went into effect.

The hospice industry is undergoing a transition similar to the one that home health went through in 2000 when the PPS system was first introduced, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

For an industry that historically hasn't placed a lot of emphasis on coding, and that's been used to assigning a single terminal diagnosis, which was often a vague condition that didn't fully explain why the patient was nearing death, this new RTP edit is creating a significant learning curve, she says. [*For more survey results, see charts on pg. 3*]

Coding dementia is the biggest challenge

That primary hospice diagnoses of unspecified dementia or vascular dementia just aren't acceptable anymore is what independent coding consultant Toni Beasley, who is based in Chelsea, Ala., is telling her hospice clients, many of whom she says were not aware of the coding restriction.

One of Beasley's hospice clients had eight hospice records returned without payment in the first billing cycle after Oct. 1, 2014. They were all hospice patients who were continuing on service and had unallowable diagnoses as their primary reason for hospice care that hadn't been changed to account for the edit.

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 Gustafson, 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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Now she’s stressing that, “we’re going to have to build a bigger picture of what’s going on with this patient,” Beasley says.

Those eight records, though they weren’t outright denied but rather just needed to be re-coded and resubmitted, caused a cash flow interruption and significant panic to the agency.

It’s the dementia diagnoses that are giving hospices the most trouble — either finding an etiology or obtaining physician confirmation of a more specific form of the disease that’s acceptable as a primary reason for hospice care, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

And while records are being returned, not every hospice agency has completely stopped assigning the unacceptable dementia codes in the primary position, according to survey results.

Consider that 15% of survey respondents are **still assigning** unspecified dementia codes (like 294.21, Dementia, unspecified, with behavioral disturbance) and 10% are still assigning dementia manifestation codes (like 294.11, Dementia in conditions classified elsewhere with behavioral disturbance) as primary when they’re unable to get an etiology, according to survey results.

Comparatively, a smaller number of survey respondents (8%) are still assigning adult failure to thrive and debility as a patient’s primary hospice diagnoses when they’re unable to get more detail about the patient’s health status, according to survey results.

But those agencies that aren’t changing their coding practices will ultimately have to or face going out of business, Adams says.

Edit slows coding processes, increases workload

The inability to assign adult failure to thrive, debility and especially unspecified dementia is forcing hospice coders to become detectives, scouring through patient records and consulting with clinicians and physicians to find a diagnosis that won’t result in a returned claim, which has slowed coding efficiency and created more work for everyone.

Gone are the days when Beasley received a hospice record, coded it and sent it back to the client. Now,

How many hospice comorbidities do you typically assign?

These data represent the number of additional comorbid diagnoses assigned on hospice claims.

Number of comorbidities	Percentage of respondents
0	3%
1 to 2	34%
3 to 4	47%
More than 5	17%

What are the top 5 comorbidities most frequently assigned on hospice records?

These are the conditions most frequently reported as comorbidities on hospice records.

Condition	Rank
Congestive heart failure	1
COPD	2
Diabetes	3
Dementia	4
Hypertension	5

Source: Diagnosis Coding Pro Hospice Coding Survey

she’s being asked to consult with clinicians to find an appropriate terminal diagnosis.

She recently had a case involving a patient with vascular dementia and had to inform the agency that the condition couldn’t be the patient’s terminal diagnosis. She advised the agency to consult the patient’s primary care physician and family, to see if there was another diagnosis to consider.

Beasley recommend that issues such as whether the patient has shown a recent decline in appetite, has lost weight, is bedbound, has bedsores or is having trouble swallowing be considered in arriving at a suitable terminal diagnosis. — Megan Gustafson (mgustafson@decisionhealth.com)

Editor’s note: For further coverage of hospice coding issues, see the online version of this story at www.HHCodingCenter.com

CB Coding Basics

Apply known principles to keep sequela coding straight in ICD-10

By Anne Q. Anastasio RN, BSN, HCS-D, COS-C

Get ready to code sequelae, or late effects, in a completely different way.

In ICD-10, you'll **generally** code the actual illness or injury that caused the patient to have a sequela, or late effect condition, but you'll indicate that the illness or injury is not a current condition with the use of the seventh character "S."

For example, a contracture of the left knee that formed after a third-degree burn of the left lower leg would be coded first with M24.562 (Contracture, left knee) and then with T24.322S (Burn of third degree of left knee, sequela). Note, the seventh character 'S' indicates sequela (or late effect).

By contrast, in ICD-9 you would code 718.46 (Contracture of joint, lower leg) and then 906.7 (Late effect of burn of other extremities). The code for the injury itself, 945.35 (Burn of lower limb(s), full-thickness skin loss [third degree NOS], knee) is **not** assigned at all.

While distinguishing between sequela and complications, and figuring out how to code them, is a common source of coding confusion, coders can find clarity in knowing that the same principles you currently apply to whether the condition is a sequela (late effect) or a complication will apply in ICD-10.

ICD-10 guidelines define sequela (late effects in ICD-9) as conditions that are caused by an illness or injury but that arise **after** the illness or injury has resolved, such as the contracture from a burn mentioned above.

Sequela sequencing mostly the same in ICD-10

Despite the change that will require you to **generally** code the actual injury or illness with the "S" seventh character, the way you'll code sequela/late effects in ICD-10 will basically follow how you code them now.

You'll sequence the condition you're treating (such as the contracture) first, and then you'll immediately follow it with the code for the injury that caused it (in ICD-9, you'd assign the corresponding late effect code).

However, there are two exceptions to this sequencing rule in ICD-10. One occurs when a residual condition code

and its corresponding injury code are a part of an etiology-manifestation pair or when the tabular instructs otherwise. Etiology-manifestation pairs and tabular instructions are both official coding conventions, which always supersede official coding guidelines in the event of a conflict.

For example, tabular instructions at F48.2 (Pseudobulbar affect) call for the coding of the causing injury first, such as S06.340S (Traumatic hemorrhage of right cerebrum without loss of consciousness, sequela).

A second exception exists when the sequela code for the initial injury or illness is a combination code that includes the residual condition, such as I69.351 (Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side).

Tip: Never assign the code for the acute version of an illness or injury code with the sequela version on the same claim. For example, you can't ever assign S06.2x4D (Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, subsequent encounter) together with S06.2x4S (Diffuse traumatic brain injury with loss of consciousness of 6 hours to 24 hours, sequela).

Scenario: Contracture of ankle and foot

A 28-year-old man is admitted to home care after surgery to release scar tissue on his left ankle and foot due to contractures caused by a third degree burns that he suffered on multiple sites of his left ankle and foot the year prior. He'll also receive physical therapy for exercise and gait training. The burn was caused by an accidental splashing of lye on his ankle and foot.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Contracture, left ankle	M24.572		
M1023: Contracture, left foot	M24.575		
M1023: Corrosion of third degree of multiple sites of left ankle and foot, sequela	T25.792S		
M1023: Toxic effect of corrosive alkalis and alkali-like substances, accidental (unintentional), sequela	T54.3x1S		

Rationale:

• Unlike in ICD-9, ICD-10 codes for contracture allow for the specific side of the body to be specified, such as M24.572 for contracture of left ankle.

- The code for the actual injury (the corrosion burn) that left the patient with contractures is assigned, with a seventh character “S” to indicate that it’s resolved but has left a sequela condition.
- Note that ICD-10 offers unique codes for burns caused by a heat source (thermal burns) and burns caused by corrosive chemicals (corrosion burns).
- An additional code to identify the source of the corrosive lye burn is included here. The code was located in the Table of Drugs and Chemicals. Refer back to the Tabular List for further instruction.
- Note the absence of a therapy or rehab code (similar to V57.1, Other physical therapy). The code for the condition that is necessitating the therapy is all that’s needed in therapy-only cases in ICD-10.

About the author: Anne Q. Anastasio, RN, BSN, HCS-D, is the utilization review coordinator for Inova VNA Home Health in Fairfax, Va. During her tenure at Inova, she has been involved in quality audits, OASIS and ICD-9 review and staff education. Reach Anne at [anne.anastasio@inova.org](mailto:anastasio@inova.org).



Ask the Expert

Code portocaval shunt malfunction, Alzheimer’s with dementia

Question: What ICD-9 code would you use for a portocaval shunt malfunction?

Answer: Code a portocaval shunt malfunction with 996.1 (Mechanical complication of other vascular device, implant or graft). A portocaval shunt is a treatment for portal hypertension. It diverts blood from the around the liver into the inferior vena cava thus reducing pressure in the portal veins.

Locate the code in the Alpha index by first searching under “Malfunction,” and then to “vascular graft or shunt.”

Question: How would Alzheimer’s with vascular dementia be coded in ICD-10?

Answer: Code Alzheimer’s disease with vascular dementia first with G30.9 (Alzheimer’s disease, unspecified) then with F02.80 (Dementia in other diseases classified elsewhere without behavioral disturbance) and finally with F01.50 (Vascular dementia without behavioral disturbance).

Coding Clinic issues ICD-10 guidance on stroke sequela, 7th character & more

Code unilateral weakness documented as resulting from a stroke as hemiplegia/hemiparesis, according to guidance received from the American Hospital Association’s Coding Clinic.

However, when unilateral weakness is *not* clearly linked to a stroke, or another brain injury or disorder, it *cannot* be assumed to be hemiplegia/hemiparesis, according to the guidance sent as a response to an inquiry.

The Coding Clinic also addressed in its response recent confusion over which seventh character designation is appropriate depending on the type of care the patient is receiving.

The guidance communicated that even if home health is providing a continuation of care that was received in an acute care setting, such as to a dehiscenced surgical wound, it does *not* constitute an “initial encounter” that would take a seventh character of “A,” according to the Coding Clinic.

Therefore, home health care to a dehiscenced external operation wound should be captured with T81.31xD (Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter), with a seventh character “D” for subsequent encounter, according to the guidance.

The Coding Clinic also released ICD-10 guidance in the third and fourth quarters of 2014. Most noteworthy for home health was guidance that a femoroacetabular impingement of the hip should be captured with a code from the M25.85- (Other specified joint disorders, hip) category, as there is no more specific code for this condition in ICD-10, according to Q4 2014 Coding Clinic. [CPH, 3/15] — Megan Gustafson (mgustafson@decisionhealth.com)

Editor’s note: For coverage of the March 2015 ICD-10 Coordination & Maintenance Committee Meeting, view the online version of the issue at www.HHCodingCenter.com.

You need all three codes because there is a directive at the G30.- category (Alzheimer’s disease) to use an additional code to identify dementia with or without behavioral disturbance, from the F02.8- category (Dementia in other diseases classified elsewhere). As no behavioral disturbance is indicated in the question, F02.80 is correct.

Note also the Excludes 2 note at F02.- that includes the codes category for Vascular dementia, F01.5-. Remember that an Excludes 2 note in ICD-10 indicates the excluded code is **not** captured by the current code, and therefore it should, if present, be coded also. Again, because no behavioral disturbance is mentioned, F01.50 is correct for the vascular dementia.

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.

ICD-10 conventions & guidelines

(continued from p. 1)

Instead, the correct code would be T20.37xD (Burn of third degree of neck, subsequent encounter). The seventh character “D” indicates that the episode of care is subsequent (as opposed to initial, i.e. the emergency room), according to ICD-10 coding conventions.

Additionally, the “x” placeholder, assigned in the sixth position, is used because while the code requires a seventh character, it contains less than six characters. Because the seventh character must be assigned in the seventh position, a placeholder “x” is used to fill in the empty sixth position, in accordance with ICD-10 coding conventions. [I.A.4]

Burn codes fall into ICD-10 categories that require the assignment of a seventh character. When a seventh character is required on a code category, it applies to all codes within that category, unless tabular instructions direct otherwise. [I.A.5]

Understanding and correctly using the seventh character, which is an ICD-10 coding convention, is one of the biggest changes coming with the new code set as well as one most likely to be confused or simply neglected, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

And the mistake won't be without consequence: Forgetting to assign the seventh character to the codes that require it will render the code invalid and cause the claim to reject.

Rejected claims due to coding errors will be an interruption to timely claim processing that agencies simply won't be able to afford in an ICD-10 world, given that the highly complex new code set is already expected to permanently lower coder productivity, says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va. [CPH, 4/15]

So as coders ramp up their preparations for ICD-10, building a solid foundation of knowledge of the rules that govern the use of the codes — the official conventions and guidelines — is an imperative first step, Twombly says.

Learn what's new: Excludes 1 & 2

ICD-10 is ushering in a new era of Excludes notes, with a new convention that specifies two distinct types. Excludes 1 notes mean “NOT CODED HERE,” or that the code itself

and the code listed in the Excludes 1 note **cannot** be coded together, according to the convention. For example, an acquired and congenital form of the same disease cannot be coded on the same claim. [I.A.12.a]

Excludes 2 notes, by contrast, are less exclusive and only mean that the condition described by the code and the condition in the Excludes 2 note **are not usually included together**. However, if both exist, they **can** both be coded together, according to the convention. An example of this may be chronic bronchitis and acute bronchitis. [I.A.12.b]

Coders who fail to grasp this new convention may continue to interpret all ICD-10 Excludes notes the same way they do the Excludes notes currently in ICD-9, which is to simply avoid coding both conditions at the same time, Frear says.

Taking that approach, however, will mean violating a coding convention and potentially not coding something that should be coded, he says.

Know what's different: Neoplastic anemia sequencing, wound severity

You'll be violating ICD-10 official coding guidelines if, after Oct. 1, you continue to sequence anemia in neoplastic disease before the neoplasm that's causing it, even when the anemia is the focus of the home health admission. The malignancy must be coded as the principal diagnosis, according to coding guidelines. [I.C.2.c.1]

The sequencing of anemia in neoplastic disease in ICD-10 is the opposite of how the condition is currently sequenced in ICD-9, a change that can confuse coders, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md. In ICD-9, anemia caused by neoplastic disease, when it's the focus of care, is coded before the actual neoplasm.

Also, now's the time to spur your agency's clinicians to document more thoroughly the depth and severity of a patient's ulcer as many agencies simply aren't accustomed to the level of detail that ICD-10 wound codes will require, says Lynn Speckels, HCS-D, vice president of Healthcare ConsultLink in Fort Worth, Texas.

Note that non-pressure ulcer codes are delineated by severity, which is determined by whether the wound is limited to the breakdown of skin, if it's exposed the fat layer or caused necrosis of muscle or bone. For example, code L97.114 corresponds to Non-pressure chronic ulcer of right thigh with necrosis of bone.

ICD-10 guidelines allow for clinicians to determine the stage of a pressure ulcer, as well as the severity of a non-pressure wound. The physician must diagnose the type of ulcer, but the code, which must include detail about the stage or severity, can be based on clinician documentation, according to coding guidelines. [I.B.14]

Tips for ensuring a smooth ICD-10 transition

Here are two more tips to help you grasp the conventions and guidelines that will help make you an accurate and efficient coder after Oct. 1:

- **Make the acquisition of adequate diagnostic information a part of referral process** instead of waiting until after the patient has been admitted, Speckels says. Most agencies do the latter, when it is much harder to get adequate detail.

- **Follow proper coding procedure in ICD-10, which involves search for a code in the index and then verifying it in the tabular**, instead of simply coding from a crosswalk or looking for an equivalent to the ICD-9 code you're accustomed to using. This approach may lead you only to an unspecified code, which may not be the correct ICD-10 code for the condition, Frear says.

For example, code 174.9 (Malignant neoplasm of breast (female), unspecified) crosswalks to C50.919 (Malignant neoplasm of unspecified site of unspecified female breast). Because ICD-10 offers codes that specify the left or right breast and you should know which breast is affected, C50.919 should **never** be assigned, Twombly says.

Scenario: Anemia in neoplastic disease, colon cancer

A 76-year-old man is admitted to home health with anemia caused by his cancer of the descending colon. The anemia is the focus of care. He also has hypertension and diabetic retinopathy with moderate non-proliferative diabetic retinopathy.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021	Malignant neoplasm of descending colon	C18.6	
M1023	Anemia in neoplastic disease	D63.0	
M1023	Type 2 diabetes mellitus with moderate non-proliferative diabetic retinopathy without macular edema	E11.339	
M1023	Essential (primary) hypertension	I10	

Rationale:

- Even though the patient's anemia is the focus of care, the neoplasm that is causing it is coded primary, in accordance with ICD-10 coding guidelines.
- As comorbidities that will impact his recovery from anemia and cancer, his diabetes, which has caused retinopathy, and his hypertension are also coded.
- Be aware that the ICD-10 code for the patient's diabetes includes the manifestation of moderate non-proliferative diabetic retinopathy, so it doesn't need to be coded separately.

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Scenario: Arterial ulcer causing muscle necrosis, congestive heart failure

A 90-year-old man is admitted to home health for wound care to an arterial ulcer on his left calf that has started to cause muscle necrosis. The ulcer was said to be the result of severe atherosclerosis of his native arteries. He also has hypertension and congestive heart failure.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021	Atherosclerosis of native arteries of left leg with ulceration of calf I70.242		
M1023	Non-pressure chronic ulcer of left calf with necrosis of muscle L97.223		
M1023	Heart failure, unspecified I50.9		
M1023	Essential (primary) hypertension I10		

Rationale:

- The ulcer was specified as arterial and having been caused by atherosclerosis, thus the combination code I70.242 is coded primary.
- The severity of the wound is specified as having caused muscle necrosis, necessitating the use of L97.223. The L97.- code is sequenced after the I70.- code in accordance with tabular instructions on both codes.

Scenario: Burn of palm

A 68-year-old man sustained a second degree burn to his left palm after accidentally pressing his hand down on a hot pan on the stove. He was admitted to home health to continue wound care to the site. He is a type 1 diabetic.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021	Burn of second degree of left palm, subsequent encounter T23.252D		
M1023	Type 1 diabetes mellitus without complications E10.9		
M1023	Contact with hot saucepan or skillet, subsequent encounter X15.3xxD		

Rationale:

- The appropriate seventh character “D” is used on the burn code, in accordance with coding

ICD-10: Which are conventions and which are guidelines?

The following is a sampling of several common coding rules, separated by whether it’s a coding convention or a coding guideline.

Conventions	Guidelines
Etiology-manifestation sequencing	Look up code in the index first and verify in the tabular
Tabular instructions	Mandatory multiple coding
Punctuation (brackets, parentheses, colons)	Sequela or late effect sequencing
Includes & Excludes notes	Code to the highest level of specificity
Meanings of “and” and “with”	Avoid coding symptoms integral to a diagnosis

conventions, to denote the subsequent nature of the care being given.

- The external cause code indicating how the wound was sustained carries the same seventh character as the injury code, “D,” in accordance with coding guidelines. Two placeholder “x’s” are used here because the external cause code, X15.3-, has only four characters but requires a seventh character. Thus, the two empty places are filled with placeholder “x’s.”
- The patient’s type 1 diabetes has the potential to impact his ability to heal from the burn, so it is included as well. An additional code for insulin use is not required because it is assumed in type 1 diabetes. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Sepsis

(continued from p. 1)

nurse specialist for Concord Regional Visiting Nurse Association in Rochester, N.H.

The availability of combination codes that capture both the infecting organism and the resulting systemic inflammation that characterize sepsis will help to simplify the coding of sepsis conditions in ICD-10.

Understand sepsis conditions to choose correct codes

The key to choosing the right codes for sepsis and its related conditions is developing a solid grasp on the

definition of each piece of the disease process and what codes correspond to them.

Note the following definitions and the code choices in both code sets:

- **Bacteremia** is the presence of bacteria in the blood.

This term only indicates the *presence* of the bacteria; it does not imply an associated infection, says Sharon Molinari, HCS-D, a home health consultant in Henderson, Nev.

Code it in ICD-9: Capture bacteremia with 790.7.

Code it in ICD-10: R78.81 (Bacteremia) is the appropriate code. The way you code bacteremia in ICD-10 will remain the same.

- **Septicemia** is a systemic infection most often caused by the presence of pathological agents, such as bacteria or virus, in the bloodstream. When a systemic infection causes an inflammatory reaction, that is what's known as sepsis, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Code it in ICD-9: Septicemia is captured most often by the 038.xx series (Septicemia). If sepsis is also present, you must assign an additional code, 995.91 (Sepsis).

Code it in ICD-10: There is no code for septicemia in ICD-10. Instead, you're directed to a combination code from the A41.- category (Other sepsis), such as A41.9 (Sepsis, unspecified organism) for septicemia with no further detail. The A41.- category codes include both the underlying infection (septicemia) and the body's inflammatory reaction.

- **Systemic inflammatory response syndrome (SIRS)** is body's inflammatory reaction to an underlying infection or other assault such as trauma. It is *not* the infection or trauma itself, Molinari says. When SIRS happens as the result of infection, it is known as *sepsis*. In both code sets, the underlying reason for the SIRS (whether infection, trauma or something else) must be sequenced *before* the SIRS code.

Code it in ICD-9: Capture SIRS with a code from the 995.9x series (Systemic inflammatory response syndrome). Two codes are available for forms of SIRS not associated with infection, 995.93 (Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction) and 995.94 (Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction).

Code it in ICD-10: The SIRS codes are found in the R65.- category (Symptoms and signs specifically associated with systemic inflammation and infection). Codes for SIRS not caused by infection have a fourth character of "1" and a fifth character of "0" or "1" depending on whether there is also acute organ dysfunction.

- **Sepsis** is a systemic inflammatory response due to infection.

Code it in ICD-9: You first need to assign the code for the underlying systemic infection, such as 038.0 (Streptococcal septicemia) and then follow it with a code for sepsis, 995.91.

Code it in ICD-10: You do not need to assign a code for the underlying systemic infection in ICD-10 because it is included in the combination codes from the A41- category (Other sepsis). Simply locate the code for the correct type of infectious process that is causing the sepsis, such as A41.51 (Sepsis due to Escherichia coli [E. coli]).

- **Severe sepsis** is sepsis that has progressed to the point of causing organ damage.

Code it in ICD-9: A minimum of three codes is required to capture severe sepsis: First, a code for the underlying infection (such as 038.0, Streptococcal septicemia), then the code for the severe sepsis (995.92, Severe sepsis) and lastly a code for the specific form of organ damage, such as acute renal failure (584.9).

Code it in ICD-10: Three codes are also required for severe sepsis in ICD-10. You'll first need the code for the underlying infection, such as A41.51 (Sepsis due to Escherichia coli [E. coli]), then the code for severe sepsis, such as R65.20 (Severe sepsis without septic shock) and then an additional code for the organ dysfunction it's causing, such as K72.00 (Acute and subacute hepatic failure without coma).

- **Septic shock** is a potentially lethal drop in blood pressure caused by severe sepsis resulting in acute organ failure. It cannot occur without the patient first having severe sepsis, Molinari says.

Code it in ICD-9: Four codes are required to capture septic shock. First, assign the code for the underlying infection, then the severe sepsis, then the code for septic shock and finally the code for the organ failure. For example, 038.0 (Streptococcal septicemia), 995.92, (Severe sepsis), 785.52 (Septic shock) and finally 518.81 (Acute respiratory failure).

Code in ICD-10: Just three codes are required due to the presence of a combination code for severe sepsis with septic shock. First assign the underlying infection (for example A41.51, Sepsis due to Escherichia coli [E. coli]), then code the severe sepsis combination code that indicates the presence of septic shock (R65.21, Severe sepsis with septic shock) and lastly code the associated organ failure (such as J96.00, Acute respiratory failure, unspecified whether with hypoxia or hypercapnia).

Tips to get sepsis coding right

Here are six more tips to ensure your sepsis coding is correct now, and in the future:

- **Don't think you can't code sepsis in home health,** Whitemyer says. Patients frequently come to home health still in active treatment for sepsis conditions. Furthermore, patients with sepsis conditions require a lot of care and if you code a less serious condition, the claim may not support the necessary level of nursing utilization, she says.

- **Use the presence of IV antibiotics as a clue that a patient may still have active sepsis and confirm with the physician,** Whitemyer says. Remember, only the physician can confirm a diagnosis of sepsis or that the sepsis is still an active condition.

- **Do not assume that a patient's organ failure is related to his sepsis** simply because both diagnoses are on the chart, Molinari. Physician documentation must establish the connection.

- **Assign 038.9 (Unspecified septicemia) in ICD-9 and A41.9 (Sepsis, unspecified organism) in ICD-10** for a patient diagnosed with sepsis but the infecting organism is unknown, Whitemyer says. If coding in ICD-9, an additional code for sepsis (995.91) is required. If coding in ICD-10, A41.9 is sufficient.

- **Query the physician for more detail if you see a diagnosis of urosepsis.** Urosepsis is a non-specific term that is not synonymous with sepsis and has no default code, according to ICD-10 official coding guidelines [I.C.1.b.d.ii]. Physicians often use the term to denote both septicemia and a urinary traction infection and should be asked to specify which they are referring to, Molinari says.

- **Obtain more information when you see a diagnosis of "sepsis syndrome."** This is a poorly defined term that needs to be elaborated upon before it can be correctly coded, according guidance from Q2 2012 Coding Clinic.

- **Code only the location of the infection, such as pneumonia (J18.9, Pneumonia, unspecified organism) in ICD-10,** if the documentation describes that the infection caused systemic inflammatory response syndrome (SIRS) but **not** sepsis. No other code is required to capture the SIRS in this scenario, according to guidance from Q3 2014 Coding Clinic.

Scenario: MRSA sepsis

A 72-year-old man is admitted to home health to continue treatment with a primary diagnosis of MRSA sepsis. He will receive IV antibiotic therapy until the infection completely resolves.

Code the scenario in ICD-9:

Primary and Secondary Diagnoses		M1024 Case-mix diagnoses	
M1020: Methicillin resistant Staphylococcus aureus septicemia	038.12		
M1022: Sepsis	995.91		
M1022: Fitting and adjustment of vascular catheter	V58.81		
M1022: Long-term (current) use of antibiotics	V58.62		

Rationale:

- Two codes are required to describe the sepsis: The infecting organism, the MRSA septicemia, is coded before the systemic inflammation due to the infection (sepsis).

Code the scenario in ICD-10:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Sepsis due to Methicillin resistant Staphylococcus aureus	A41.02		
M1023: Encounter for adjustment and management of vascular access device	Z45.2		
M1023: Long term (current) use of antibiotics	Z79.2		

Rationale:

- Only one code is required to capture the MRSA sepsis in ICD-10 because it includes the sepsis as part of the combination code (A41.02).

Editor's note: The online version of this story (via www.HHCodingCenter.com) features an additional scenario.

Sepsis Coding Tool in ICD-9 and ICD-10

Follow the directions specified in this tool, created by Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md., to help you assign the right code(s) for sepsis and related conditions.

What's the diagnosis in ICD-9?

- **Bacteremia** – Code 790.7 (Bacteremia); use an additional code to identify causative organism (041.x, Bacterial infection in conditions classified elsewhere and of unspecified site).
- **Septicemia** – Choose a code from 038.xx (Septicemia) depending on the information given.
 - Is sepsis also present?
 - **Yes.** – also assign 995.9X (Sepsis or Severe Sepsis)
 - **No.** – 038.xx code is sufficient **Tip!** Query physician to verify that no diagnosis of Sepsis is present. In ICD-10, Septicemia may not be coded alone (codes for Sepsis include Septicemia).
- **SIRS (Systemic inflammatory response syndrome)** – Identify the underlying trauma or infection then choose a code from 995.9x (Systemic inflammatory response syndrome (SIRS)) depending on the information given.
 - SIRS is defined as a clinical response to an insult, infection or trauma. The causative infection or trauma should be coded first. **Tip!** 995.9x codes may never be assigned as primary!
- **Sepsis** – Code first the underlying systemic infection, such as 038.0 (Streptococcal septicemia), and then assign 995.91 for the sepsis
- **Severe sepsis** – Code first the underlying systemic infection, such as 038.0 (Streptococcal septicemia), then code 995.92 for severe sepsis, and finally code the specific type of organ failure, such as 584.9 for acute renal failure.
 - **Tip!** Severe Sepsis is defined as Sepsis with associated organ dysfunction.
- **Septic shock** – Code first the underlying systemic infection, such as 038.0 (Streptococcal septicemia), then code 995.92 for severe sepsis, then code 785.52 for septic shock and finally assign the code for the specific type of organ failure inherent to septic shock, such as 584.9 for acute renal failure.

What's the diagnosis in ICD-10?

- **Bacteremia** – Code R78.81 (Bacteremia).
- **Septicemia** – There is **NO** code for septicemia in ICD-10. Instead, you're directed to a combination 'A' code for sepsis to indicate the underlying infection, such as A41.9 (Sepsis, unspecified organism) for septicemia with no further detail. **Note:** 'A' codes for Sepsis in ICD-10 include both the underlying infection (septicemia) and the body's inflammatory reaction.
- **SIRS (Systemic inflammatory response syndrome)** –
 - First, determine if the SIRS is related to an infectious origin.
 - If Yes, assign a code for Sepsis.
 - Follow instructions for Sepsis coding and determine if organ dysfunction is present. If it is, you'll need to include a code from R65.2-, Severe Sepsis.
 - If No, assign a code first for the underlying cause of the SIRS (such as T67.0- for heatstroke), followed by R65.1- for SIRS of non-infectious origin.
- **Sepsis** – Choose the correct 'A' code to indicate the sepsis. Simply locate the code for the correct type of infectious process that is causing the sepsis, such as A41.51 (Sepsis due to Escherichia coli [E. coli]). **Note:** The underlying systemic infection and the body's inflammatory response to it are captured in one combination code.
- **Severe sepsis** – First choose the correct code for the underlying infection, such as A41.51 (Sepsis due to Escherichia coli [E. coli]), then code the severe sepsis, such as R65.20 (Severe sepsis without septic shock) and then assign an additional code for the organ dysfunction it's causing, such as K72.00 (Acute and subacute hepatic failure without coma).
- **Septic shock** — Code first the underlying infection (for example A41.51, Sepsis due to Escherichia coli [E. coli]), then code the severe sepsis combination code that indicates the presence of septic shock (R65.21, Severe sepsis with septic shock) and lastly code the associated organ failure (such as J96.00, Acute respiratory failure, unspecified whether with hypoxia or hypercapnia).

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