

ICD-10 is here — don't miss out on training!

Now that ICD-10 is here, it's important to ensure that you have all the training and instruction you need. Join us in a city near you to jumpstart your ICD-10 education, while also reinforcing core OASIS-C1 competencies. DecisionHealth's **Ultimate Coding & OASIS Training Series** has you covered during these two intensive boot camps, led by the leading home health experts in the nation. For more information and to register, go to <http://www.decisionhealth.com/ultimatetraining>.

In This Issue

Coding Basics: Get poisoning, adverse effects & underdosing right in ICD-10 **2**

Ask the Expert: Code end-stage renal disease **4**

Get updated on latest ICD-10 guidance **5**

Average coder salary by title **6**

Average coder salary by education level **7**

New infection, heart condition codes could be coming to ICD-10 **10**

Poisoning, adverse effect & underdosing tool; Salary survey charts **Extra**

2015 Home Health Coders' Salary Survey

Home health coders' salaries rise dramatically with arrival of ICD-10

Home health coders' average salary is up 25% when compared to just five years ago, as it continues to increase every year.

Specifically, home health coders expect to make almost 2% more in 2015 than they did in 2014, and 8% more than in 2013.

They'll make an average of \$62,867 in 2015, compared to the \$61,856 they made in 2014 and the \$57,974 they made in 2013, according to the results of *Diagnosis Coding Pro for Home Health's* 2015 Home Health Coders' Salary Survey of 200 coders. Also, note in *(see Salaries, p. 5)*

Work through the maze to code arthritis accurately, avoid upcoding

Determine the specific location (right knee, left hip, etc.) and specific disease process (such as osteoarthritis or rheumatoid arthritis) behind a patient's arthritis diagnosis to properly code it and generate the appropriate revenue for your agency.

For example, if all you have is a statement of "arthritis," you must assign the non-specific M19.90 (Unspecified osteoarthritis, unspecified site), according to the alphabetic index. However, this code earns no case-mix points as CMS has stressed that the most specific ICD-10 code should be assigned.

(see Arthritis, p. 8)

Don't miss live chats with coding experts!

Save the following dates for the upcoming monthly, live Q&A sessions, during which subscribers to *Diagnosis Coding Pro* will be able to ask all their coding questions in an online forum, and coding experts will provide answers. You can find links to the chats at <http://codingcenter.decisionhealth.com/articles/detail.aspx?id=520540&tab=1>. Take note of upcoming chats, that take place 12 - 12:45 ET on the dates listed below:

- ▶ Fri, Nov. 13, 2015
- ▶ Fri, Jan. 8, 2016
- ▶ Fri, Dec. 11, 2015
- ▶ Fri, Feb. 12, 2016

CB Coding Basics

Get poisoning, adverse effects & underdosing right in ICD-10

By Regenia Simmons, RN, BSN, HCS-D, COS-C

Poisoning and adverse effect coding has changed in ICD-10 and the entirely new concept of underdosing has been introduced. So now's the time to make sure you keep the concepts straight or risk coding errors that could call your claims into question and/or impact a patient in the future.

To understand these concepts and ensure you get them right on your claims, let's look at the definitions of poisoning, adverse effects and underdosing.

A **poisoning** occurs when any substance, *taken incorrectly*, interferes with normal body functions after it is swallowed, inhaled, injected or absorbed. Examples of poisoning may include an error in the dispensing of a prescription medication, an intentional overdose of a drug, an interaction between drugs and alcohol or non-prescribed drugs interacting with prescribed drugs.

In contrast, an **adverse effect** is a harmful and/or undesired effect that results from a medication or other substance that was *taken correctly*. The "taken correctly" part is critical to understanding the concept.

Examples of adverse effects may include tachycardia, delirium, gastrointestinal hemorrhaging, renal failure or respiratory failure.

Finally, **underdosing**, which is a new concept in ICD-10, happens when a patient takes less medication than what the physician prescribed; this often leads to an exacerbation or relapse or a current medical condition. [I.C.19.e] [See the Tool of the Month for further guidance on poisoning, adverse effects and underdosing]

How to find the right codes

Codes capturing each of these situations are found in Chapter 19 (Injury, poisoning and certain other consequences of external causes), in the code categories spanning T36 (Poisoning by, adverse effect of and underdosing of systemic antibiotics) to T50 (Poisoning by, adverse effect of and underdosing of diuretics and other and unspecified drugs, medicaments and biological substances).

Coding for poisoning and adverse effects has changed in ICD-10. The prior code set required a minimum of three codes (one for the poisoning or adverse effect itself, one for the resulting symptoms and finally the appropriate E code to identify the drug or chemical).

Now, depending on the particulars of the situation, just two codes may be enough to fully capture the

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, HCS-D,
1-612-834-6896
mgustafson@decisionhealth.com

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

DISTRIBUTION RIGHTS AND COPYRIGHT

All content is copyrighted and may not be excerpted or copied in part, nor do such rights provide for re-sale or competitive use of editorial. To request permission to make photocopy reprints of *Diagnosis Coding Pro for Home Health* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number. Copyright violations will be prosecuted. *Diagnosis Coding Pro* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations, contact: Steve McVeary at 1-301-287-2266 or email him at smcveary@ucg.com.

CEUs

Each issue of *Diagnosis Coding Pro for Home Health* is approved for 1.0 HCS-D CEU from the Board of Medical Specialty Coding (BMSC). To earn your newsletter CEUs, you must take a short online quiz at ceus.coursewebs.com/courses/DiagnosisCodingPro/includes/register.asp.

Diagnosis Coding Pro is published monthly by **DecisionHealth**, Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878-7364. Price: \$447/year. Copyright 2015.

THE DECISIONHEALTH PLEDGE OF INDEPENDENCE

At DecisionHealth, the only person we work for is you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry.

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status to 1-855-225-5341 (toll-free), or email customer@decisionhealth.com.

FREE INTERNET FORUM

To join our free subscriber email exchange, register at <http://listserv.ucg.com/cgi-bin/listserv/listserv.pl/homecarecoding-l>.

CONFERENCES

Diagnosis Coding Pro holds seminars to help you meet your diagnosis coding challenges. For program schedules, email conference@decisionhealth.com or go to www.decisionhealth.com.



Association of
**Home Care Coding
& Compliance**



Board of
**Medical Specialty
Coding & Compliance**

scenario thanks to combination codes available in the aforementioned categories (T36 to T50).

For poisoning, combination codes include both the substance that was taken and the intent (i.e. intention, unintentional, etc.). Consider T37.0x1D (Poisoning by sulfonamides, accidental (unintentional), subsequent encounter).

Similarly, adverse effects also required an E code in ICD-9 to specify the drug or chemical involved, but ICD-10 now provides a combination code that includes both, such as T36.0x5D (Adverse effect of penicillins, subsequent encounter).

For poisonings, adverse effects and underdosing, the symptom(s) that result from each must be also be coded, but how they're sequenced depends directly on what situation (poisoning, adverse effect or underdosing) is at hand.

Know what you're dealing with to sequence correctly

Don't confuse a poisoning with an adverse effect or an underdosing, because the way you sequence these scenarios is exactly the opposite.

Consider that if you're dealing with a poisoning, you must sequence the poisoning code (such as T37.0x1D, Poisoning by sulfonamides, accidental (unintentional), subsequent encounter) **before** the code for whatever condition it caused, such as nausea with vomiting (R11.2). Then, assign additional code(s) for all other resultant health issues that are occurring.

But if the patient is experiencing an adverse effect from a substance taken correctly, the resulting condition (such as R04.0, Epistaxis) must be coded ahead of the adverse effect code (T45.515D, Adverse effect of anticoagulants, subsequent encounter). Then, assign the code for the condition (such as I48.91, Atrial fibrillation) that necessitated the drug that caused the adverse effect.

Similar to adverse effects, if you're dealing with an underdosing, code the condition being treated first, such as I50.21 (Acute systolic (congestive) heart failure, for example), then code the underdosing (such as T50.2x6D, Underdosing of carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, subsequent encounter).

Additionally, if there's a reason for the underdosing, such as financial hardship (Z91.120, Patient's intentional

underdosing of medication regimen due to financial hardship), assign that code last.

How to use the table of drugs and chemicals

Start with the Table of Drugs and Chemicals to help you keep poisoning, adverse effect and underdosing codes straight. However, do not code directly from the Table of Drugs and Chemicals. Always verify the code in the tabular.

There are six columns in the Table: The first four columns are the poisoning codes and specify intent, the fifth column lists adverse effects and the sixth and final column lists underdosing codes.

The base code with four characters, such as T40.2- (Poisoning by, adverse effect of and underdosing of other opioids) is the same in all the columns. The fifth, sixth and seventh characters indicate the specific situation (i.e. poisoning/intent, adverse effect and underdosing).

Here's a breakdown of the possible sixth characters:

- 1, 2, 3 or 4 indicates a poisoning and specifies the intent as follows:
 - "1" for accidental, unintentional poisoning
 - "2" for poisoning, intentional self-harm
 - "3" for poisoning, assault
 - "4" for undetermined poisoning (note however that "undetermined" poisoning should not be coded unless clearly stated in the physician's documentation that the intent of the poisoning cannot be determined)
- 5 indicates an adverse effect
- 6 indicates an underdosing

Remember that most poisoning, adverse effect and underdosing codes require a seventh character (such as "D" for subsequent encounter or "S" for sequela).

Scenario: Unintentional overdose of narcotic painkiller

A 66-year-old patient was having severe pain and took prescribed pain medication, Percocet, to treat it. After 15 minutes he wasn't experiencing relief, so he took another dose, ignoring the label that specified to take one dose every three to four hours as needed. He later developed severe abdominal pain and persistent nausea and vomiting, leading to a trip to the ER. He was later admitted to home health to manage the resulting nausea and vomiting and abdominal pain.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Poisoning by other opioids, accidental (unintentional), subsequent encounter	T40.2x1D		
M1023b: Nausea with vomiting, unspecified	R11.2		
M1023c: Unspecified abdominal pain	R10.9		

Rationale:

- The patient took more pain medication than was prescribed, so therefore this scenario involves a poisoning. Thus, the poisoning code is sequenced first. [I.C.19.e.5.b]
- The resulting conditions of the poisoning, the nausea, vomiting and abdominal pain, directly follow.

Scenario: Nose bleed, hematuria, atrial fibrillation

A 70-year-old woman is taking Coumadin for atrial fibrillation. She soon develops a severe nose bleed and bloody urine.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Epistaxis	R04.0		
M1023b: Hematuria, unspecified	R31.9		
M1023c: Adverse effect of anticoagulants, subsequent encounter	T45.515D		
M1023d: Unspecified atrial fibrillation	I48.91		

Rationale:

- The patient took the drug as prescribed and experienced an adverse effect.
- The conditions caused by the drug (the epistaxis and hematuria) are coded first, followed by the adverse effect code, in accordance with coding guidelines. [I.C.19.e.5.a]
- The reason the Coumadin medication was prescribed, atrial fibrillation, is coded following the adverse effect code.

Scenario: Exacerbated chronic systolic heart failure, intentional underdosing

A 75-year-old female patient who is on a fixed income. Thinking to save money, she cut her Lasix pills in half to make them last longer. She was later hospitalized with an acute exacerbation of her chronic systolic heart failure and is soon after admitted to home health to continue

recovery. She will receive skilled nursing, therapy and medical social worker services to address her financial hardship and resulting non-compliance.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Acute on chronic systolic (congestive) heart failure	I50.23		
M1023b: Underdosing of loop [high-ceiling] diuretics, subsequent encounter	T50.1x6D		
M1023c: Patient's intentional underdosing of medication regimen due to financial hardship	Z91.120		

Rationale:

- The patient intentionally took less of her medication than she was prescribed due to financial hardship. Therefore this is an underdosing.
- The condition resulting from the underdosing (an acute exacerbation of chronic systolic heart failure) is coded first followed by the code for the underdosing (T50.1x6D), in accordance with coding guidelines. [I.C.19.e.5.c]
- The reason for the intentional underdosing (financial hardship) is also coded to fully describe the scenario.

About the author: Regenia Simmons, RN, BSN, HCS-D, COS-C, is the coding and OASIS Specialist for FirstHealth Home Care in West End, N.C. She has worked for FirstHealth for more than 30 years as a nurse in a variety of areas before beginning her home care coding career in 2006.

? Ask the Expert

Code end-stage renal disease

Question: We have a hospice patient and the nurse wants to use end-stage renal disease (ESRD) as the primary hospice diagnosis. However, the patient also has hypertension and the coding guidelines say to code hypertension first. Is it OK to put the ESRD at the top since it is the terminal diagnosis and then follow it with the hypertension code?

Answer: No, you may not code end-stage renal disease before hypertension for hospice. Coding guidelines must be followed at all times and hospice cases are no exception.

If end-stage renal disease with hypertension is the stated terminal diagnosis, assign I12.0 (Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease) first and then N18.6 (End stage renal disease). [I.C.9.a.2]

Remember that hypertension and chronic kidney/renal disease are always assumed to be connected, regardless of whether the patient's medical record specifically reports them as such, according to coding guidelines. [I.C.9.a.2]

Editor's note: *The Ask the Expert answers were provided by Jean Bird, RN, HCS-D, utilization review supervisor for the Mid-Atlantic region at Gentiva in Fall River, Mass. Submit your questions to mgustafson@decisionhealth.com.*

Get updated on latest ICD-10 guidance

Now that ICD-10 is here, it's imperative to stay up-to-date on the latest guidance and instruction. Here's what you need to know now:

- **Code pleural effusion as a separate diagnosis in a heart failure patient ONLY if the pleural effusion merits a particular intervention or treatment** beyond what's being done for the heart failure, according to an Aug. 26 webinar from the Coding Clinic. Pleural effusion is commonly seen with heart failure, is usually minimal and generally doesn't receive separate treatment beyond treatment for the heart failure. For more information, view the slides from the webinar, which can be downloaded at <http://www.ahcentraloffice.com/august26>.

- **Assigning a 6th character to indicate muscle or bone necrosis for a non-pressure ulcer from the L97.- category must be based on provider documentation** and must indicate the presence of necrosis, according to two letters received by an individual on July 28 and Sept. 18, 2015 from the Coding Clinic in response to a specific question. Coding experts were surprised by this guidance as they believed that just seeing muscle or bone, without it being necrotic, would've been enough to assign the code.

However, coding experts agree that you should not assign a code for unspecified severity, L97.219 (Non-pressure chronic ulcer of right calf with unspecified severity), if the patient's non-pressure ulcer extends into muscle tissue but the muscle is not necrotic. A better choice would be L97.212 (Non-pressure chronic ulcer of

right calf with fat layer exposed) in this instance. Coding experts are considering proposing the addition of new codes to describe ulcer severity levels not currently captured by the code set.

- **Continue coding closed stage 3 and 4 pressure ulcers based on provider documentation if they meet the coding guidelines for reporting [I.C.12.a]**, according to two letters received by an individual on May 1 and July 28, 2015 from the Coding Clinic in response to a specific question. Coding experts agree that these pressure ulcers should be coded because they're reportable and are captured in the OASIS integumentary section. However, if six other diagnoses are demanding more time and attention on a patient's plan of care, code those first.

- **Understand that the current unresolved controversy about whether to use a seventh character of "A" (initial encounter) or a "D" (subsequent encounter) only applies to scenarios involving complications**, coding experts say. In all other cases where a seventh character is required, including fractures and injuries, "D" or "S" (sequela) are the only appropriate choices for home health.

Furthermore, because the guidelines have not changed and there's been no official guidance mandating the use of "A," coding experts recommend that home health continue to assign "D" for all claims until written confirmation mandating the use of "A" is released. Keep in mind that many software systems will not accept an "A" seventh character. Stay tuned to future coverage in *Diagnosis Coding Pro for Home Health* on this important issue.
— Megan Gustafson (mgustafson@decisionhealth.com)

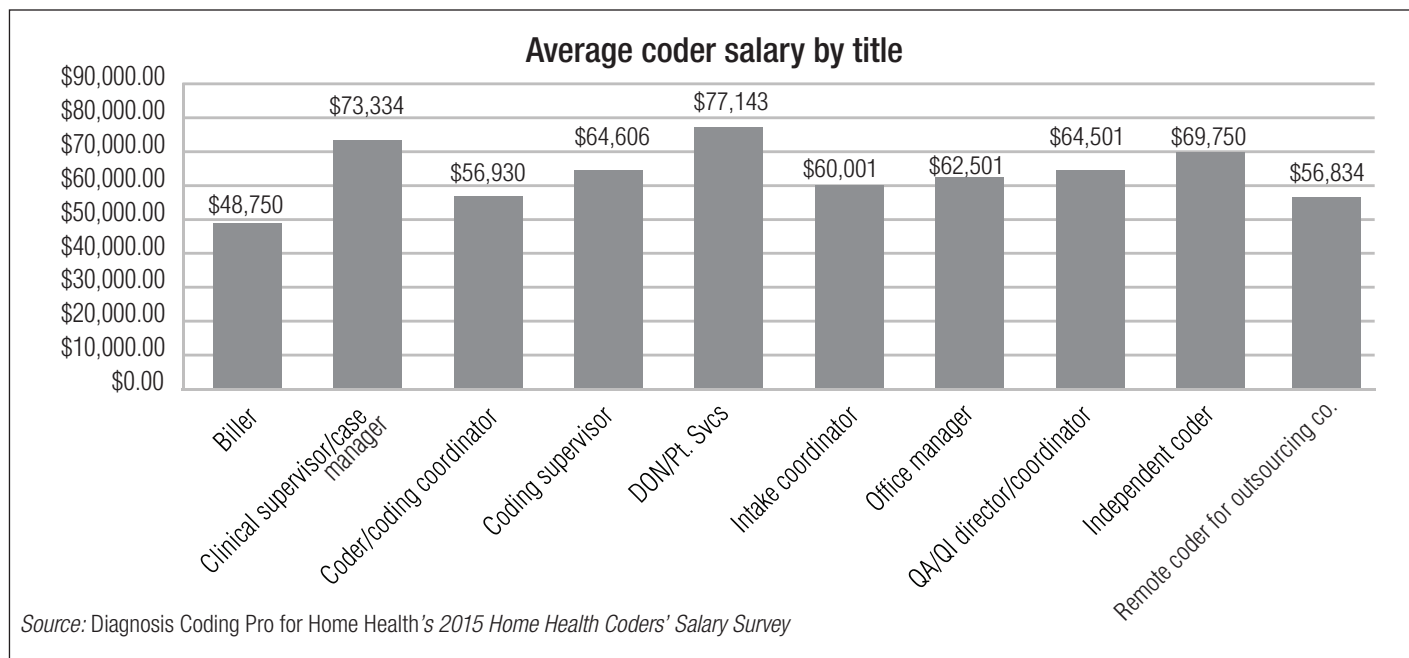
Salaries

(continued from p. 1)

2010, home health coders reported an average \$50,307 salary.

Several factors may be behind the recent salary increase, not the least of which is the ICD-10 implementation, with its dramatically increased workload and agencies' need for highly skilled coders, says Judy Adams, HCS-D, president of Adams Home Care Consulting in Asheville, N.C.

Additionally, the fact that many older coders have retired and been replaced by new coders who are typically hired at higher salaries could also be contributing to the overall pay bump, Adams says.



Further, some agencies may be opting to use registered nurses, who usually command higher salaries, as their coders because these employees typically have a broader skill set that enables them to also do OASIS review and can therefore perform “double duty,” says Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas.

This trend is proven in the data as survey respondents’ titles ran the gamut from coders and coding coordinators to QI directors, OASIS reviewers and directors of nursing, to those who work for outsourced coding companies as well as those who independently contract with agencies for coding and/or OASIS services. And some survey respondents fit into more than one of these categories simultaneously.

While the majority — 75% — is employed full-time by agencies, 6% work as independent contractors and 3% work both full-time for an agency and part-time for an outsource coding company. Most of the coders contacted by *Diagnosis Coding Pro for Home Health* reported some type of hybrid arrangement.

For example, one coder interviewed said she works for two different outsourcing companies, one full-time and one part-time, another said she works as an in-house coder for an agency but coding is just a small part of her overall job description, and another codes full-time for an agency in addition to taking in coding work from multiple independent contracts during off hours. (*Every survey respondent contacted by Diagnosis Coding Pro for Home*

Health spoke on the condition of anonymity in order to protect their personal and proprietary financial information.)

In general, the “average” home health coder who’s on track to make almost \$63,000 is between 56 and 60 years old, has a title of coder or coding coordinator, is HCS-D certified, holds a bachelor’s degree and has worked in home health between five and nine years.

Furthermore, part-time, contract coding and OASIS review work performed remotely continues to contribute substantially to coders’ individual bottom lines. Consider that a coder doing on-the-side coding contract work took in an **additional** \$31,548, on average, in 2014, according to survey results. [*CPH, 5/14*]

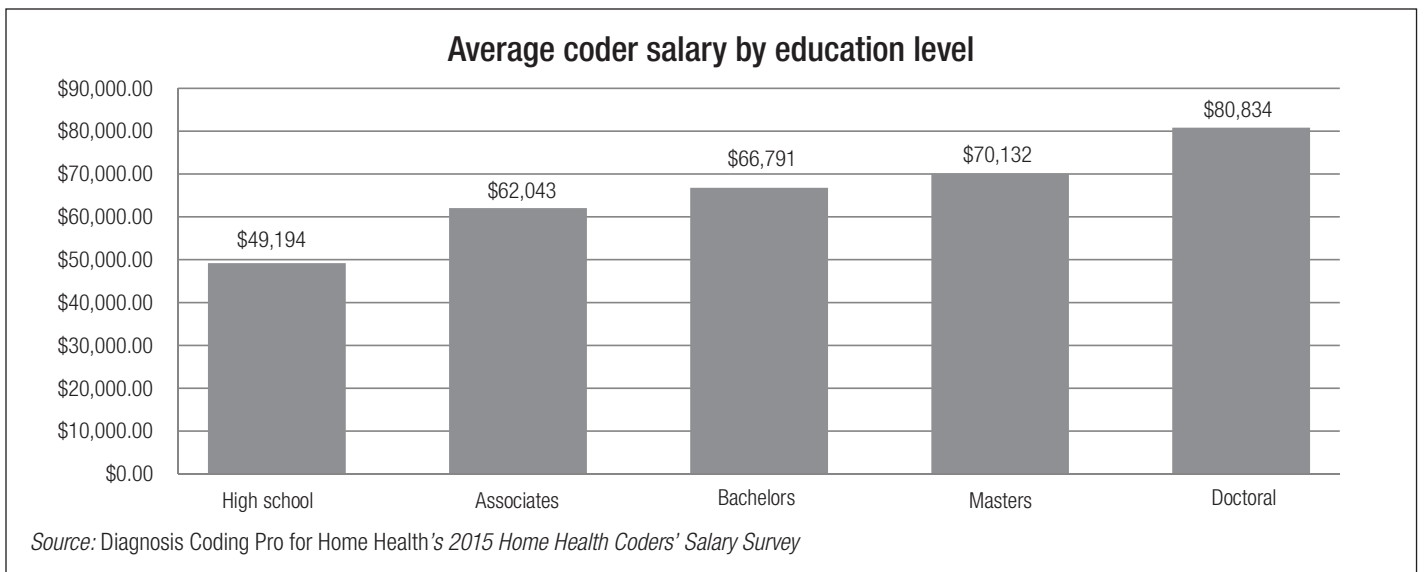
However, Adams is uncertain as to how long the upward salary trend will continue once ICD-10 is fully implemented, coders become more experienced and productivity levels stabilize.

“I’m guessing the increase may be mostly temporary,” she says.

ICD-10’s financial benefits mostly for contractors

HCS-D certified coders stand to reap financial benefits — and many already are — from the increasing demand for their skills now that ICD-10 has arrived. But the increase in pay seems to be mostly limited to those who are working on a per-chart basis for outsource companies or as contractors for agencies.

One East Coast-based coder will make a projected minimum of \$80,000 in part-time independent contract



work this year, in addition to her full-time salary of \$104,000.

Note that the vast majority of survey respondents reported that they won't be receiving any kind of bonus, or other incentive, other than agency-paid education or certification expenses, for achieving proficiency or maintaining productivity throughout the ICD-10 implementation.

More specifically, 44% of survey respondents said they didn't receive a raise last year. Of those who didn't receive a raise, the percent increase was between 1.1 and 3%.

Some survey respondents even indicated that it's simply a job requirement or that their skills need to be sufficient if they wish to keep their jobs. Furthermore, few agency coders who spoke with *Diagnosis Coding Pro for Home Health* indicated that they were required to maintain a certain quota or to complete a particular number of charts per day.

Yet those who are taking in work through outsourced coding companies or who are cutting their own deals with agencies to do their coding and/or OASIS review (versus contract employment for an outsourcing outfit) appear to be cashing in, with their income potential tied directly to the number of charts they're able to complete.

One Texas-based coder, who works full-time for a coding company, makes an hourly wage amounting to about \$36,000 annually. She won't receive any kind of bonus once ICD-10 arrives or any additional compensation for dual coding. She received a 1% raise last year and does not have a specific chart quota to meet.

She is HCS-D certified and holds a bachelor's degree but does not have a clinical background. A non-compete

agreement prevents her from seeking additional part-time, per-chart coding work.

On the other hand, a Midwest-based coder, who makes \$60,000 annually in her full-time remote position for an outsourced coding company performing coding, OASIS review and chart audits, works an additional 25 hours per week doing coding and OASIS review for another outsourced coding company.

As a registered nurse with an associate's degree who is both coding and OASIS-certified, she's paid \$20 a chart for coding and \$30 a chart for coding and OASIS review. During the two months that home health agencies had to dual code their claims, she made an additional \$12 a chart, all adding up to a projected extra \$20,000 to \$30,000 this year.

The previously mentioned East Coast coder independently contracts with 10 additional agencies for whom she performs coding and OASIS review in addition to her full-time job. She makes anywhere between \$20 and \$40 a chart for coding alone and between \$40 and \$60 a chart for coding and OASIS review, and codes an additional 10 to 20 charts a day in contract work.

The number of charts completed per day most often reported by coders — by one third of survey respondents — ranges between 11 and 15. Another 32% code between six and 10 charts a day. Only 2% code more than 30 a day.

Generally, the going per-chart rate for contract coding/OASIS review work is between \$10 and \$15 a chart for coding alone and between \$20 and \$30 for coding and OASIS review, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

“Average” home health coder difficult to define

As in years past, those who perform coding, OASIS and auditing duties for home health continue to be a highly variable group responsible for a large number of tasks. The complexity of the duties coders perform tends to be directly related to their compensation, with the jobs demanding a higher level of training and/or education commanding a comparatively higher pay rate.

OASIS review is the single most commonly reported duty in addition to coding charts, according to survey results. Additionally, 63% of survey respondents also perform education and training of staff. Other reported responsibilities include billing and face-to-face matters.

The job title that makes the most is director of nursing/patient services, with an average salary of \$77,143, according to survey results. By contrast, the lowest paid position is that of biller, at \$48,750. (*See Salary by title chart on pg. 6*)

Education also is clearly tied to increased compensation. The average salary increased for each level of education achieved, with coders holding a bachelor's degree making almost \$20,000 more per year than those who just have a high school diploma, according to survey results. (*See Salary by education level on pg. 7*)

Where you work also matters. Coders who live in the Mid-Atlantic region take in the most every year, about \$67,667, while those who reside in the Midwest, with the average salary of \$58,089, make almost \$10,000 less per year. [*See Salary by geographic location on the Tool of the Month insert*]

A Montana-based survey respondent codes three records a day on average and spends the majority of her time working with quality and compliance. Hers is a director-level full-time position for a home health agency and pays her an annual salary of \$71,000.

While this coder does not have nursing training, she holds two bachelor's degrees as well as a master's degree and is responsible for managing others. — *Megan Gustafson (mgustafson@decisionhealth.com)*

Arthritis

(continued from p. 1)

The code you **would** assign if you're able to determine that, for example, the patient's arthritis is osteoarthritis that's impacting both knees, M17.0 (Bilateral primary osteoarthritis of knee), will earn up to

four case-mix points depending on episode timing and therapy utilization.

The number of available codes to capture arthritis conditions has exploded in ICD-10 due to increased specificity and the ability to now capture laterality (left, right or bilateral), says Arlynn Hansell, HCS-D, a physical therapist and the owner of Therapy and More in Cincinnati, Ohio.

Yet this change has served to worsen the confusion that was already present when coding arthritis, particularly when coders don't get the necessary detail in order to assign the more specific codes, Hansell says.

Consider that while the 715 series (Osteoarthritis and allied disorders) captured most osteoarthritis conditions in ICD-9, dozens of codes spanning multiple categories now exist for the same purpose.

For example, there's M16.12 (Unilateral primary osteoarthritis, left hip) and M19.012 (Primary osteoarthritis, left shoulder) for osteoarthritis. Then there's the M05- (Rheumatoid arthritis with rheumatoid factor) and M06- (Other rheumatoid arthritis) categories for some forms of rheumatoid arthritis conditions, just to name a few.

In a post-ICD-10-era, when record scrutiny is intense and bottom lines are tight, it's more important than ever to ensure that you're receiving all the reimbursement to which you're entitled without putting your records at risk for upcoding charges.

Understand arthritis differences to code correctly

Arthritis codes are found in Chapter 13 (Diseases of the musculoskeletal system and connective tissue, M00-M99) and the code categories in which you begin your search will be dictated by the specific type of arthritis the patient has.

Osteoarthritis results from aging and wear and tear on the joints and is the most common type of arthritis seen in home care, Hansell says. Codes for these conditions span five categories from M15- (Polyosteoarthritis), M16- (Osteoarthritis of hip), M17- (Osteoarthritis of knee), M18- (Osteoarthritis of first carpometacarpal joint) and M19- (Other and unspecified osteoarthritis).

Then there's post-traumatic arthritis, which is arthritis resulting after some kind of trauma, and secondary arthritis, which is arthritis that's been caused by another disease, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

These conditions are also captured within those four osteoarthritis categories. For example, M19.132 captures post-traumatic osteoarthritis of the left wrist, while M19.242 corresponds to secondary osteoarthritis of the left hand.

Rheumatoid arthritis is a separate form of arthritis caused by a systemic autoimmune disease, Whitemyer says. Codes for these conditions are also found in Chapter 13, but in separate categories that fall under the Inflammatory arthropathies heading and span M05.- (Rheumatoid arthritis with rheumatoid factor) to M14.- (Arthropathies in other diseases classified elsewhere).

Like osteoarthritis, case-mix points are available for certain rheumatoid arthritis codes that specify particular joints, such as M06.011 (Rheumatoid arthritis without rheumatoid factor, right shoulder), while the non-specific code M06.9 (Rheumatoid arthritis, unspecified) does not impact reimbursement.

Dig for details, avoid assumptions & upcoding

Do not assign M17.11 (Unilateral primary osteoarthritis, right knee) if all you see in the documentation is “arthritis” and the patient reports pain in his right knee, Whitemyer warns.

While this may in fact be the case, the physician must specify that the arthritis is osteoarthritis and that it’s of the primary type and is localized to the right knee, she says. You cannot assign a code based on assumptions.

Furthermore, if you assign a more specific code than the information you have allows, and that code is worth points, as it is in the aforementioned scenario, you’ve just upcoded and put that claim at risk.

While it may seem fairly simple to determine which knee or hip, or both, is the site of the patient’s arthritis, diagnostic statements like “arthritis of leg” are still frustratingly common, Hansell says.

Sometimes a diagnosis may list osteoarthritis as the specific form of arthritis, but rarely is any further information made available, such as whether it’s primary or secondary, localized or generalized, she says.

And, Hansell has never seen the presence or absence of rheumatoid factor specified for a patient with rheumatoid arthritis, even though there is now an entire category of codes available for joints affected by rheumatoid arthritis both with (M05.-) and without (M06.0-) the serologic evidence of rheumatoid factor.

Tip: Keep asking for the detail you need, says Pallavi Sheth, HCS-D, clinical coordinator for the VNA

of Englewood, N.J. They’ll eventually get tired of the repeat questions and will eventually begin to give more information. This strategy appears to be working for Sheth as she reports seeing more referrals as of late with arthritis diagnoses specified as localized or generalized and primary or secondary.

3 more tips for accurate arthritis coding

Here are additional tips for keeping your arthritis coding above the fray and your records out of the hands of auditors in an ICD-10 world:

Tip: Use every document available to you to glean information about a patient’s arthritis diagnosis, Hansell says. For example, if all she sees at first is “knee arthritis,” she may look in the pain section of the OASIS assessment or the therapy note for more detail. And if she’s coding a recert, she may go back to the start of care record. When all else fails, she goes back to the contact person and requests more information.

Tip: Let knowledge about different types of arthritis lead you to important questions. Consider a patient with a diagnosis of arthritis that is limited to the right knee whose record also indicates she was recently in a car accident — this may be a time to ask about the possibility of traumatic arthritis, Hansell says. Generally, though not always, osteoarthritis occurs in bilateral joints because it’s the result of aging and general wear and tear and is unlikely to be confined to just one place. Similarly, rheumatoid arthritis is a systemic disease that is also unlikely to be confined to one joint. Of course, never code a diagnosis without physician confirmation.

Tip: Realize that laterality options in ICD-10 allow you to code unilateral primary osteoarthritis that may still be present in the left knee, for example, after the right knee was replaced. This settles a common source of confusion in ICD-9 that surrounded whether to continue to code osteoarthritis after joint replacement, Hansell says. If a patient’s arthritic right knee is replaced, don’t code M17.11 (Unilateral primary osteoarthritis, right knee). But you may code M17.12 (Unilateral primary osteoarthritis, left knee) if there’s osteoarthritis in the remaining left knee.

Scenario: Aftercare following joint replacement

A 69-year-old woman is admitted to home health following surgery to replace her left knee due to arthritis. She also has diagnoses of depression and diabetes. A call to the physician’s office determined

that her diagnosis is rheumatoid arthritis but no further information was given.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Aftercare following joint replacement surgery	Z47.1		
M1023b: Presence of left artificial knee joint	Z96.652		
M1023c: Rheumatoid arthritis, unspecified	M06.9		
M1023d: Type 2 diabetes mellitus without complications	E11.9		
M1023e Depression NOS	F32.9		

Rationale:

- As the focus of care, the aftercare following joint replacement surgery is the appropriate primary diagnosis code.
- While one specific joint was replaced, rheumatoid arthritis is a systemic disease that still exists following the replacement of that joint. Therefore, it is still coded.
- Without further information about the rheumatoid arthritis, the unspecified code must be assigned.
- A code from Z96.6- was sequenced after Z47.1to indicate the presence of an artificial joint, in compliance with tabular instruction.

Scenario: Bilateral osteoarthritis, HIV

A 77-year-old man comes to home health for physical and occupational therapy to address severe bilateral primary osteoarthritis of the knees and hips. His doctor has said he's not a candidate for joint replacement surgery due to advanced HIV disease and will instead learn adaptive techniques to better navigate his environment. He also has COPD and pneumonia, for which he's taking a course of oral antibiotics.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021: Bilateral primary osteoarthritis of knee	M17.0		
M1023: Bilateral primary osteoarthritis of hip	M16.0		
M1023: Human immunodeficiency virus [HIV] disease	B20		
M1023: Chronic obstructive pulmonary disease with acute lower respiratory infection	J44.0		
M1023: Pneumonia, unspecified organism	J18.9		

New infection, heart condition codes could be coming to ICD-10

Thirty-three diagnosis proposals, five pages of tabular addenda, four pages of index addenda and one page of Table of Drugs and Chemicals addenda were presented at the ICD-10 Coordination and Maintenance Committee Meeting, held Sept. 22-23.

These proposals called for changes that, if finalized, have the potential to impact home health for diagnoses like *Clostridium difficile* infections, infections following procedures and heart conditions like atrial fibrillation and heart failure.

Specifically, three new codes to the A04.7- category (Enterocolitis due to *Clostridium difficile*) were proposed to capture a *Clostridium difficile* infection that is specified as initial, recurrent or not specified as recurrent.

Also regarding infections, five inclusion terms were proposed for deletion under T81.4 (Infection following a procedure), including "Sepsis following a procedure" and "Stitch abscess following a procedure."

Those deleted inclusion terms were then presented as new unique codes, including T81.48 (Infection following a procedure, other surgical site infection, Stitch abscess following a procedure) and T81.49 (Infection following a procedure, not elsewhere classified, Sepsis following a procedure).

The heart condition proposals included five new codes under I48.- (Atrial fibrillation and flutter), as well as revisions to non-essential modifiers, such as "left ventricular," and the addition of clarifying terms regarding ejection fraction under the heart failure codes at category I50.- (Heart failure).

The next meeting of the ICD-10 Coordination and Maintenance Committee will be March 9-10, 2016.

Editor's note: Comments on the proposals are due by Nov. 13 and should be sent to nchscd10@cdc.gov. View the proposals at http://www.cdc.gov/nchs/data/icd/Topic_Packet_09_22_15.pdf.

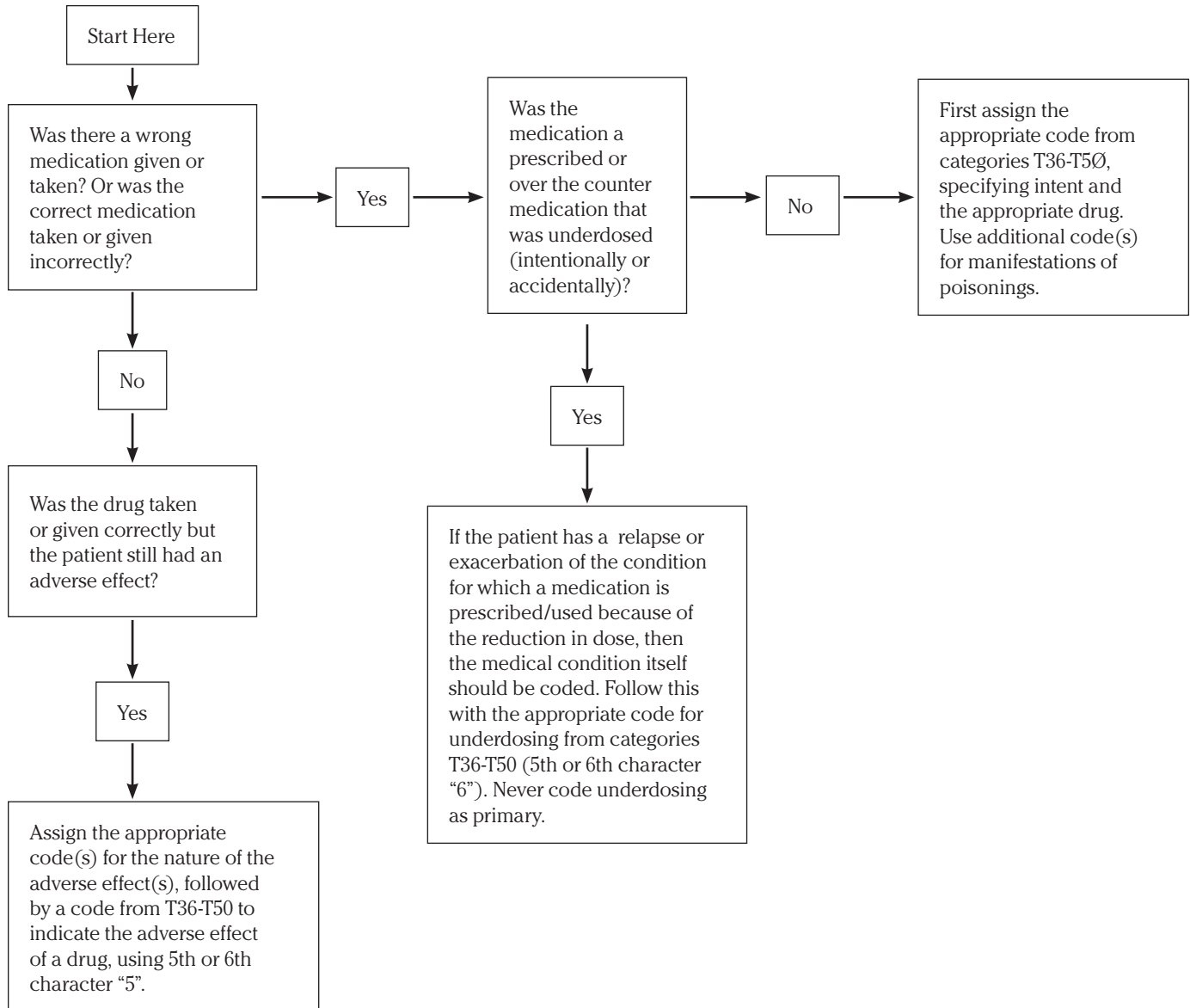
Rationale:

- The patient's arthritis has been specified as primary osteoarthritis in both hips and knees. Therefore, bilateral codes can be used.
- Though he has a pneumonia infection on top of his COPD, this does not automatically mean the COPD is exacerbated. Nothing in the description says that it is, so it is coded with J44.0.
- Without further detail about the pneumonia diagnosis, J18.9 is the most appropriate code.

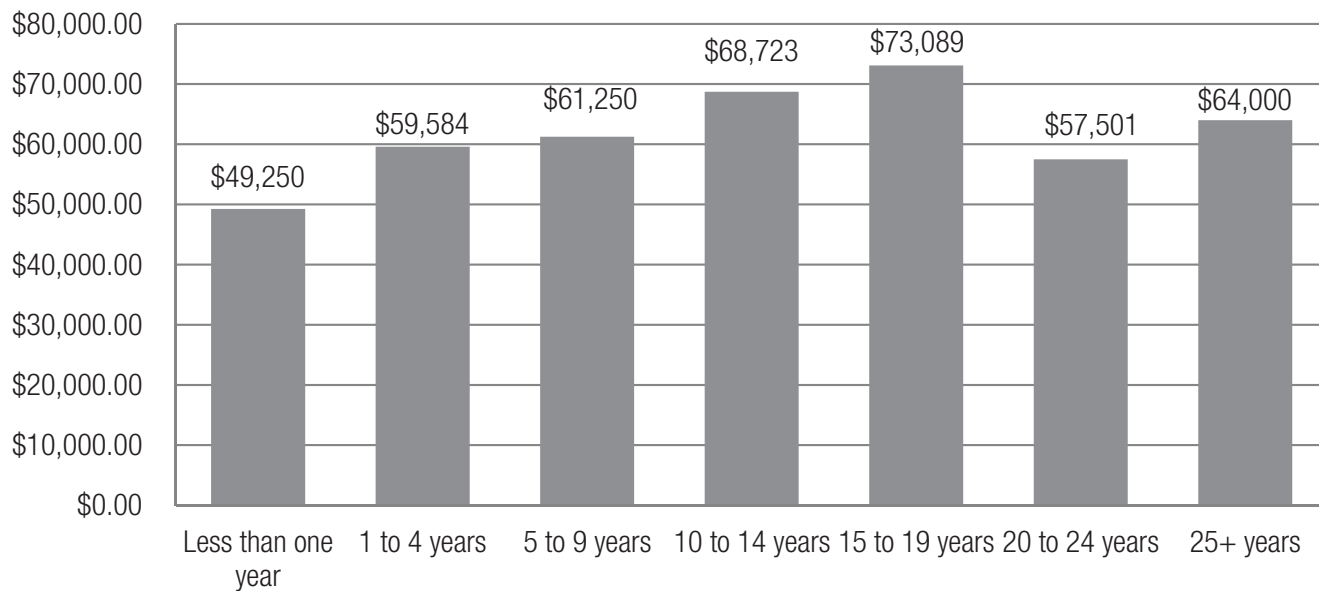
Editor's note: View more arthritis scenarios in the online version of this story at www.HHCodingCenter.com.

Poisoning, adverse effects & underdosing tool

Use the following decision tree, created by Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md., to help guide your coding of poisoning, adverse effects and underdosing scenarios.

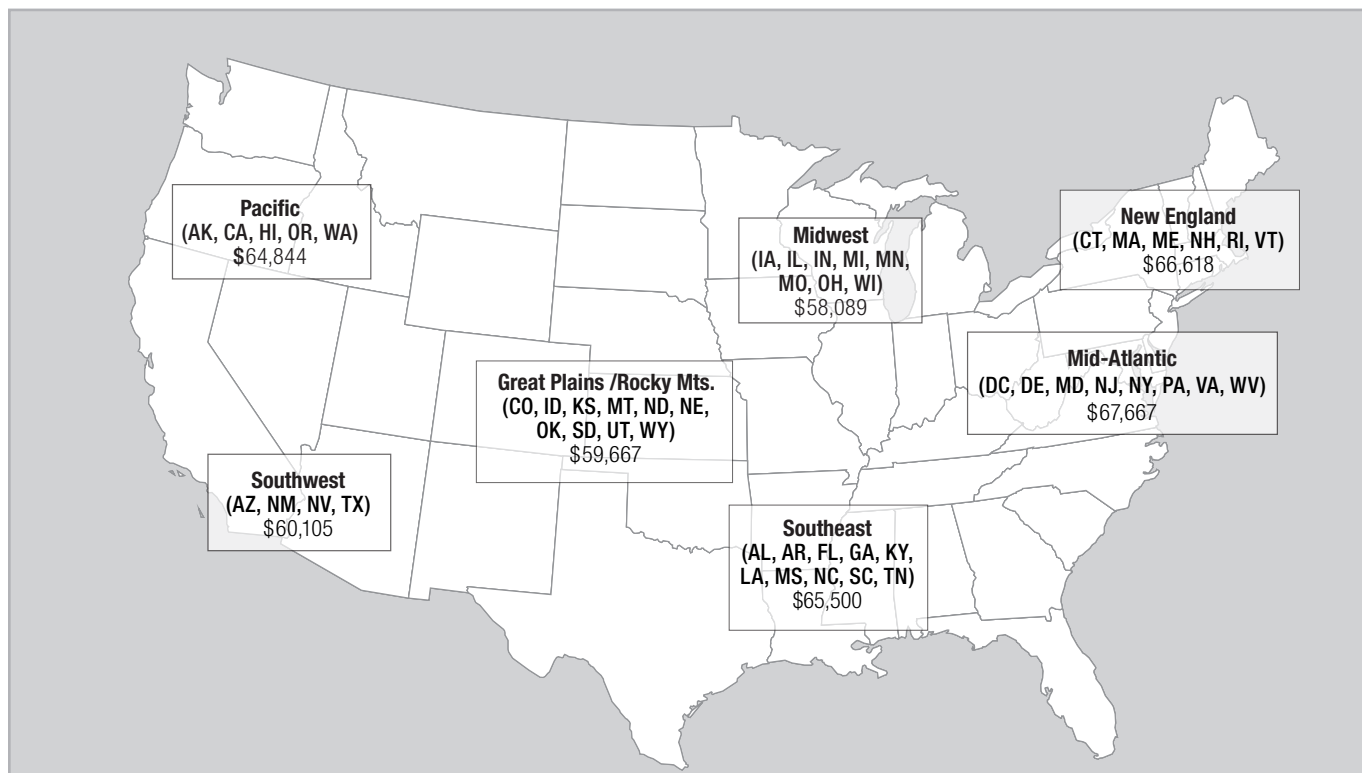


Average salary by years of experience in home health coding



Source: Diagnosis Coding Pro for Home Health's 2015 Home Health Coders' Salary Survey

Average salary by location



Source: Diagnosis Coding Pro for Home Health's 2015 Home Health Coders' Salary Survey