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Navigate the gray areas of coding non-pressure ulcers, ensure correct claims

Assign L97.213 (Non-pressure chronic ulcer of right calf with necrosis of muscle) to capture the severity of a non-pressure ulcer, such as an arterial or stasis ulcer, **only when** there is evidence of muscle necrosis in the wound, according to the Coding Clinic.

Necrosis **must** be evident in the muscle or bone to use an L97.-code (Non-pressure chronic ulcer of lower limb, not elsewhere classified) with a sixth character of "3" (corresponding to muscle necrosis) or "4" (corresponding to bone 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.

(see **Ulcers**, p. 6)

How to choose between tobacco use, dependence codes to keep claims accurate

Assign Z72.0 (Tobacco use) for patients who are obviously using tobacco but for whom you're unable to obtain physician confirmation of dependence.

Don't assign a code for tobacco dependence, such as F17.210 (Nicotine dependence, cigarettes, uncomplicated) based solely on a clinician's witnessing a patient using tobacco or you could be inadvertently saddling a patient with a psychiatric diagnosis that could be problematic.

Conversely, you would use code F17.210 (Nicotine dependence, cigarettes, uncomplicated) for a patient who's been described by the physician in the medical record as "a smoker," according to Q4 2013 Coding Clinic guidance.

(see **Tobacco**, p. 9)

2017 Home Health ICD-10-CM Coding Manual

With over 2,600 code changes, you can't afford to make a mistake. To code claims accurately, you need a resource that is more than just the code set. Make sure you have the ICD-10 coding manual that's created specifically for home health coders: The **2017 Complete Home Health ICD-10-CM Diagnosis Coding Manual**. Visit <http://www.decisionhealth.com/icd10> to pre-order your copy.

Be aware of new NPUAP staging definitions that will impact coding

When a wound has slough or eschar, it's not a Stage 2 wound, according to recent guidance from the National Pressure Ulcer Advisory Panel (NPUAP).

Agencies often mark a shallow Stage 3 wound with slough or eschar as a Stage 2 on OASIS responses, because the wound is not deep, says Brandi Whitemyer, HCS-D, independent home health & hospice consultant.

This is a costly mistake that results in a loss of clinical points and potentially \$500 or so per episode, she says. This clarification supports the knowledge never to mark an ulcer with slough or eschar of any type as Stage 2 on the OASIS but rather at least a Stage 3 if those are present in the wound bed.

This is just one of the many changes the NPUAP announced April 13 to its staging definitions. The NPUAP also added the term "pressure injury" to replace "pressure ulcer" and decided Arabic numbers should be used in names of the stages instead of Roman numerals. That's in line with changes made in OASIS-C2.

In addition, the term "suspected" has been removed from the Deep Tissue Injury diagnostic label, and the panel agreed upon additional pressure ulcer definitions including those related to Medical Device Related Pressure Injury and Mucosal Membrane Pressure Injury.

CMS is still deciding whether it will adopt these definitions as official guidance to be used when clinicians answer the OASIS form.

Descriptions provide clarity in staging

The new NPUAP descriptions provide clarity for clinicians when staging wounds, veteran home care consultants say. The most confusion has existed on the difference between Stage 2 and Stage 3 pressure injuries, when an ulceration is actually an injury and how skin damage resulting from a medical device should be assessed.

In the past, a Stage 2 wound was described as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. The new description defines Stage 2 as a wound bed that is "viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present."

That differs from a Stage 3 wound that was previously described where "slough may be present but does not obscure the depth of tissue loss." The revised description states that "slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds."

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Often pressure ulcers are understaged, say Deborah Ritter and Sue Kennedy, co-owners and founders of RitKen and Associates, LLC. Ritter and Kennedy, who both attended the April NPUAP meeting where the changes were made, say the revisions will have clinicians focus on the depth of the wound rather than tissue damage.

The four pressure injury stages indicated the extent of tissue damage and were revised based on questions NPUAP received from clinicians attempting to diagnose and identify the stage of pressure injuries.

How to stage: Injury from medical device

The new NPUAP guidance clarifies how to distinguish between a mucosal ulcer and a pressure injury when the injury occurs on a mucosal membrane, says J'non Griffin, owner and president of Home Health Solutions in Carbon Hill, Ala.

Consider an ulcer caused by use of a catheter: If the ulceration is connected to a mucosal membrane such as the urethra/meatus, this would be a mucosal ulcer. If the catheter made an ulceration against any skin such as the thigh, this would be a pressure injury and staging would be done. The new guidelines state that injury from a medical device would be staged, Griffin explains.

Previously, no clear guidance existed for determining how to categorize a wound that resulted from a medical device.

The previous designation “unstageable” described the wound as having “full thickness tissue loss in which the base of the ulcer is covered by slough ... and/or eschar ... in the wound bed.”

But the revised guidelines add additional pressure injury definitions stating that “if the pressure injury generally ‘conforms to the pattern or shape of the device,’ then it should be staged. If the mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury, the guidelines state, then due to the anatomy of the tissue these ulcers cannot be staged.”

Still, confusion may come if the OASIS assessment does not change the verbiage to match the new descriptions, Griffin says. — *Kathy Gambrell* (kgambrell@decisionhealth.com)

Related links: For the NPUAP new definitions visit <http://tinyurl.com/gvnvhvg>. View schematic artwork reflecting the changes in stages for pressure injury at <http://bit.ly/1p0NMaE>.

CB Coding Basics

Embrace simplicity with diabetes codes to achieve accurate coding

By Lynn Collins, RN, BSN, HCS-D, HCS-O

ICD-10 combination codes have brought a new level of simplicity to a complex disease. This is because many of the diabetic conditions commonly coded in home health need only one or two codes.

For example, just one code is necessary for diabetic macular edema in ICD-10, which is E11.311 (Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema). This one code captures the diabetes and the manifestation it's caused: retinopathy with macular edema.

Diabetes is a complex disease where the body is unable to produce or respond to the hormone insulin, which ultimately causes elevated glucose levels. Over time, elevated glucose levels, which can also be described as “high blood sugar,” can cause a variety of health issues.

Diabetes-related health issues are known as manifestations. Diabetic manifestations can affect many areas of the body, from the eyes (such as with retinopathy) to the kidneys (such as with diabetic chronic kidney disease) to the nervous system (such as with diabetic polyneuropathy and the feet (such as with diabetic foot ulcers).

How to find the right diabetes code

Begin your search for the proper diabetes code(s) where you would for any other condition, in the alphabetic index. Search under “diabetes” and then scroll to the most specific term necessary to describe the type. Then, verify the code you find in the tabular.

Diabetes codes are found in Chapter 4 (Endocrine, Nutritional & Metabolic Diseases) and they are grouped into five separate categories ranging from E08.- (Diabetes mellitus due to underlying condition) to E13.- (Other specified diabetes mellitus).

The diabetes code categories correspond to the type of diabetes. The two most common types of diabetes, which are also the two most commonly coded, are type 1 and type 2. In type 1 diabetes, the pancreas does not produce insulin; in type 2, the pancreas produces insulin but the body cannot use it properly.

Type 1 diabetes codes are found in the E10.- category (Type 1 diabetes mellitus) and type 2 diabetes codes are found in the E11.- category (Type 2 diabetes mellitus).

Type 2 diabetes is by far the most common type of diabetes. In fact, you may assume a patient's diabetes is type 2 unless the medical record states another type.

Tip: Remember to always assign Z79.4 (Long term (current) use of insulin) for a type 2 diabetic, or anyone with diabetes that isn't type 1, who is dependent on insulin. But never assign Z79.4 for a type 1 diabetic. All type 1 diabetics are insulin-dependent but not all type 2 diabetics require it.

Tip: Do not assign Z79.4 if a patient is using insulin only on a short-term basis to bring down high blood sugar. Only assign Z79.4 if the patient is on long-term insulin.

Notice patterns to code manifestations properly

You'll also notice that all diabetic manifestations, no matter the specific type of diabetes, are coded the same way, with the fourth and fifth characters specifying the particular health issue the diabetes has caused.

For example, when diabetes has caused neurological manifestations, the codes will carry a fourth character of "4," such as with E11.4- (Type 2 diabetes with neurological complications). The fifth character then identifies the specific type of neurological manifestation, such as with E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy).

Tip: Note that sometimes a sixth character is required to further specify a diabetic manifestation, such as macular edema (E11.311, Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema).

Tip: Understand that sometimes an additional code is needed to fully describe the condition. For example, E11.22 (Type 2 diabetes mellitus with diabetic chronic kidney disease) requires you to also use a code from N18.- (Chronic kidney disease (CKD)) to capture the stage of chronic kidney disease.

Here's a quick view of some of the available fourth and fifth characters that capture different diabetic manifestations:

- **.2 – Kidney complications**
 - .21 – diabetic nephropathy
 - .22 – diabetic chronic kidney disease
- **.3 – Ophthalmic complications**
 - .31 – unspecified diabetic retinopathy
- **.4 – Neurological complications**

- .43 – diabetic autonomic polyneuropathy
- **.5 – Circulatory complications**
 - .51 – diabetic peripheral angiopathy without gangrene

Note: Codes for diabetic skin conditions, including diabetic foot ulcers, are captured with a fourth character of "6," which indicates an "other specified complication" and fifth character of "2," which says that the "other specified complication" is a skin complication. A sixth character is then required to indicate the specific type of skin complication, such as E11.621 (Type 2 diabetes mellitus with foot ulcer).

Additionally, with a diabetic foot ulcer, an additional code must be assigned to denote the site and severity of the ulcer, such as L97.421 (Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin).

Tips for accurate coding

Here are four more tips to help you ensure that you get your diabetes coding right:

• **Remember that "uncontrolled," "out of control" or "poorly controlled" diabetes** is coded to diabetes with hyperglycemia in ICD-10. Diabetes with hyperglycemia codes will carry a fourth character of "6" and a fifth character of "5," such as with E11.65 (Type 2 diabetes mellitus with hyperglycemia). This should be coded in addition to any other diabetic manifestation the patient may have.

• **Code diabetic PVD as diabetic angiopathy.** Diabetic angiopathy is a circulatory condition that would be coded with a fourth character of "5."

• **Do not confuse diabetic angiopathy and venous stasis.** Angiopathy is a condition of the arterial system whereas venous stasis impacts the venous system. Venous stasis is not a manifestation of diabetes.

• **Understand that there is no unique code for diabetic osteomyelitis.** To code this condition, assign a fourth character of "6" and a fifth character of "9," for the diabetes (like E10.69, Type 1 diabetes mellitus with other specified complication) and then include another code for the osteomyelitis, such as M86.161 (Other acute osteomyelitis, right tibia and fibula).

Scenario: Uncontrolled diabetes

A 70-year-old woman is admitted to home health with a primary diagnosis of uncontrolled type 2 diabetes. She has been newly prescribed insulin and requires

instruction on its administration, as well teaching on the disease process and management of other medications. She also has a history of PVD.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Type 2 diabetes mellitus with hyperglycemia	E11.65		
M1023b Peripheral vascular disease, unspecified	I73.9		
M1023c Long term (current) use of insulin	Z79.4		

Rationale:

- The patient's diabetes was stated to be uncontrolled, and is thus coded as diabetes with hyperglycemia with E11.65.
- The patient's PVD is a relevant comorbidity, but not linked to diabetes, and is therefore coded separately with I73.9.
- The patient is insulin-dependent but not a type 1 diabetic so Z79.4 must be assigned.

Scenario: Diabetic foot ulcer

A 75-year-old man is admitted to home health for daily wound care for an ulcer on the plantar region of his left foot where the fat layer is exposed. The etiology of the ulcer is his type 1 diabetes. He also has a history of chronic diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD) and he is dependent on supplemental oxygen.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Type 1 diabetes mellitus with foot ulcer	E10.621		
M1023b Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed	L97.422		
M1023c Chronic diastolic (congestive) heart failure	I50.32		
M1023c Chronic obstructive pulmonary disease, unspecified	J44.9		
M1023c Dependence on supplemental oxygen	Z99.81		

Rationale:

- The patient is a type 1 diabetic with a diabetic foot ulcer, which is coded with the combination code E10.621. An additional code, L97.422, is assigned for the location and severity of the ulcer.
- The patient's chronic diastolic congestive heart failure and COPD are coded as relevant comorbidities as well as his use of oxygen.

About the author: Lynn Collins, RN, BSN, HCS-D, HCS-O has been working in home care for 25 years as a visiting nurse, nurse manager, intake nurse and intake manager. She currently oversees insurance authorization and oasis/coding departments at Crozer-Keystone Homecare and Hospice in Springfield, Pa.

Ask the Expert

Code care of a ureteral stent

Question: We have a patient with hydronephrosis status post placement of a ureteral stent. He is currently on antibiotics. Do I just code hydronephrosis and the status of the stent or is there an aftercare code that's appropriate for this?

Answer: Code this scenario first with Z48.816 (Encounter for surgical aftercare following surgery on the genitourinary system) as the primary diagnosis in M1021, then with N13.30 (Unspecified hydronephrosis) for the hydronephrosis and finally with Z96.0 (Presence of urogenital implants).

The aftercare code is appropriate because the patient underwent surgery to place the ureteral stent and thus requires surgical aftercare. The codes for the hydronephrosis and the presence of the stent further round out the patient's care needs.

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.

2017 hospice proposed rule: More hospices are coding compliantly

Continue to code all diagnoses on hospice claims as this aligns with coding guidelines and admissions requirements, and is an important step in collecting the

data necessary to further refine the hospice payment system, according to the proposed FY2017 Hospice Wage Index released April 21.

The proposed rule reiterates the directive outlined in the FY2016 rule, which is to assign all unresolved conditions regardless of whether they're related to the terminal condition. [CPH, 6/15]

What the rule curiously did not address is the controversy over whether hospices should follow inpatient coding guidelines which allow for the coding of "probable" or "suspected" diagnoses.

However, CMS's ICD-10 ombudsman Dr. William Rogers, MD, previously advised hospices to code only confirmed diagnoses and that guidance was later repeated by the Coding Clinic in its Q1 2016 update. [CPH, 4/16, 5/16]

More hospice claims are getting in line with this guideline, too. In FY2015, 37% of hospice claims reported only a single diagnosis, down from 49% in FY2014. Additionally, 63% of claims reported two diagnoses and almost half, 46%, reported at least three, according to the rule.

Furthermore, debility and adult failure to thrive, which were the first and sixth most common diagnoses in FY2013, did not even make the top 20 most common diagnoses in FY2015, according to the rule.

The top five most commonly reported principal diagnoses in FY2015 were Alzheimer's disease, congestive heart failure, lung cancer, chronic obstructive pulmonary disease and senile dementia, according to the rule.

This further suggests that hospices are becoming more compliant with the increasingly stringent coding rules that have been enacted over the last few years, including the directives to code more than one diagnosis and to avoid coding overly vague diagnoses, such as debility and unspecified dementia, in the primary position. [CPH, 9/14, 10/14] — Megan Gustafson (mgustafson@decisionhealth.com)

Editor's note: To view the proposed FY2017 Hospice Wage Index, go to <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-09631.pdf>.

Ulcers

(continued from p. 1)

"If all words in the code title do not match what is current with the wound, you cannot use the code," says

Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

This means that L97.213 could not be assigned for a non-pressure ulcer that has extended into the patient's muscle but for which there's no evidence of necrotic tissue. But this has left coders with questions about how to capture such ulcers as none of the code titles appear to fit exactly.

Until more definitive guidance is released, coding experts are advising to capture non-pressure ulcers that extend into muscle or in which bone is visible, but where there is **no necrosis**, with an L97.- code that carries the sixth character of "2" (corresponding to the fat layer exposed).

For example, you'd assign L97.212 (Non-pressure chronic ulcer of right calf with fat layer exposed) for a stasis on the right calf that extends into muscle tissue but isn't necrotic, Twombly says.

Tips for accurate wound coding

Here are four more tips to help guide you through the trickiest areas of coding non-pressure ulcers:

Tip: Look in the record for the terms that describe the wound, Twombly says. If muscle is visible in the wound, you can be assured that it has penetrated the patient's subcutaneous tissue and can, at the very least, be captured by an L97.- code with a sixth character "2."

Tip: Do not assume the presence of osteomyelitis in the bone exposed by a non-pressure ulcer means that there's bone necrosis, Twombly says. A physician must confirm muscle or bone necrosis before an L97.- code with a sixth character of "3" or "4" can be assigned.

Tip: Use the codes for unspecified wound severity, such as L97.219 (Non-pressure chronic ulcer of right calf with unspecified severity) as a last resort for when you've tried but failed to get more definitive information about the patient's wound, says Jean Bird, HCS-D, utilization review supervisor for the Mid-Atlantic region at Gentiva in Fall River, Mass.

This practice aligns with the coding guideline to always code to the highest level of specificity. In addition, using a more detailed wound severity code shows Medicare that your agency has done a more thorough wound assessment, Bird says.

Tip: Don't forget that codes from the L97.- category capture only the site and severity of a non-pressure ulcer and cannot be assigned alone. They require an etiology code, like E11.621 (Type 2 diabetes mellitus with foot ulcer),

that explains the disease process causing the wound to be assigned first, according to tabular instruction.

Scenario: Arterial ulcer showing muscle

A 67-year-old woman is admitted to home health for wound care to an arterial ulcer on her left calf. Muscle tissue is visible in the wound but there's no evidence of necrosis. She has atherosclerosis, which her physician specified is the cause of the arterial ulcer. She also has hypertension and insulin-dependent diabetes, which has caused retinopathy. Physician documentation also mentions that she's a heavy cigarette smoker.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Atherosclerosis of native arteries of left leg with ulceration of calf	I70.242		
M1023b Non-pressure chronic ulcer of left calf with fat layer exposed	L97.222		
M1023c Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema	E11.319		
M1023d Essential (primary) hypertension	I10		
M1023e Nicotine dependence, cigarettes, uncomplicated	F17.210		
M1023f Long term (current) use of insulin	Z79.4		

Rationale:

- As the focus of care, the arterial ulcer is coded primary. Because it was specified as having been caused by atherosclerosis and is on her left calf, I70.242 is the correct code.

- To capture the site and severity of the foot ulcer, an additional code from L97.- is required. In this case, because the ulcer has gone down to her muscle tissue but has not caused necrosis, the code describing muscle necrosis cannot be used. Therefore, it is coded with L97.222.

- She has diabetes that has caused retinopathy, requiring the assignment of E11.319. As a relevant comorbidity, her hypertension must also be coded. Because she's dependent on insulin but not stated to be a type 1 diabetic, Z79.4 is also required.

- A "use additional code" note on I70.242 requires the assignment of a code for tobacco use, if applicable. Because her physician has described as a heavy smoker, code F17.210 is warranted.

Scenario: Stasis ulcer showing bone

A 72-year-old man is admitted to home health for wound care to stasis ulcer, caused by varicose veins, to his right calf. Bone is visible in the wound but necrosis is not evident. He also has hypertension, a history of now-resolved prostate cancer and colostomy, for which he cares for independently, due to severe Crohn's disease in his large intestine.

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Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Varicose veins of right lower extremity with ulcer of calf	I83.012		
M1023b Non-pressure chronic ulcer of right calf with fat layer exposed	L97.212		
M1023c Essential (primary) hypertension	I10		
M1023d Crohn's disease of large intestine without complications	K50.10		
M1023e Colostomy status	Z93.3		
M1023f Personal history of malignant neoplasm of prostate	Z85.46		

Rationale:

- As the focus of care, the stasis ulcer is coded primary. Because it was specified as having been caused by varicose veins, the correct code is I83.012.
- The severity of the ulcer doesn't fit neatly into any category available. Though bone is visible, there is no evidence of necrosis. Therefore, the closest, most accurate code assignment is L97.212.
- His comorbidities of hypertension and Crohn's disease should be included, as well as his colostomy. Because he cares for his colostomy independently, Z93.3 is the correct code choice.
- He has a history of prostate cancer that is now resolved; this is coded with Z85.46.

Scenario: Diabetic ulcer, osteomyelitis

A 55-year-old man is a type 1 diabetic and comes to home health with a diabetic ulcer on his left heel. Bone is visible in the wound. He also has a diagnosis of osteomyelitis in that foot, but his physician could not be reached to confirm whether the diabetes caused the osteomyelitis and whether there is necrosis of the bone seen in the ulcer. He'll receive IV antibiotics for the osteomyelitis but the focus of care is the ulcer.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Type 1 diabetes mellitus with foot ulcer	E10.621		
M1023b Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed	L97.422		
M1023c Osteomyelitis, unspecified	M86.9		
M1023d Encounter for adjustment and management of vascular access device	Z45.2		
M1023e Long term (current) use of antibiotics	Z79.2		

Rationale:

- No confirmation could be obtained about whether there is evidence of bone necrosis so the wound must be coded as extending only to the patient's fat layer.
 - While diabetes is a known cause of osteomyelitis, no connection can be assumed without physician confirmation. Since none could be obtained, it must be coded separately.
 - There is no detail regarding whether the patient's osteomyelitis is acute or chronic. Therefore, a more specific code, which would indicate the site and laterality of the infection, cannot be assigned and the unspecified M86.9 is used.
 - Because he receiving IV antibiotics, the codes Z45.2 and Z79.2 are used to capture this. No code for long-term insulin use is needed as he is a type 1 diabetic.
- Megan Gustafson (mgustafson@decisionhealth.com)

Editor's note: *The Association of Home Care Coding & Compliance, in conjunction with Diagnosis Coding Pro for Home Health newsletter, petitioned the ICD-10 Coordination & Maintenance Committee to consider adding new codes to the category L97.- that would provide specific language for the types of wound severity mentioned above. Several options for new codes were presented at the March 2016 meeting; however new codes won't be available until at least Oct. 1, 2017.*

Tobacco

(continued from p. 1)

The requirement to code tobacco use or exposure with certain common cardiac and respiratory conditions in ICD-10 (such as atherosclerosis, I70.- and COPD, J44.-) has led to confusion as to which codes are correct for which patients.

Two separate ICD-10 chapters, Chapter 5 (Mental and behavioral disorders) and Chapter 21 (Factors influencing health status and contact with health services), contain codes that capture tobacco use. In Chapter 5, codes are available in the F17.- category (Nicotine dependence) while Chapter 21 offers one non-specific status code, Z72.0 (Tobacco use).

Furthermore, the fact that the F17.- codes are found in the mental health chapters poses unique problems, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. For example, a psychiatric condition on a medical record could make it more difficult for that patient to obtain insurance in the future, including health and life insurance.

Yet only very rarely do physicians state explicitly that a patient is “tobacco dependent,” says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice Services in Virginia Beach, Va.

This leaves coders in the tricky position of trying to make a determination about a patient’s tobacco use to satisfy the mandate to capture it with particular diagnoses, while trying to decipher competing code options that mostly lack specific instruction.

Learn the difference between use and dependence

Gain a solid understanding of the differences between someone who merely uses tobacco and someone who is dependent on tobacco to help guide your queries and code choice determination.

An example of tobacco use that doesn’t rise to the level of dependence is someone who smokes only occasionally, such as once a month when out for drinks with friends, Twombly says.

This type of use doesn’t lead to symptoms of physical withdrawal when the person isn’t smoking, she says. Most home health patients don’t fall into this category.

By contrast, someone who is dependent on tobacco **will** experience physical withdrawal when tobacco is discontinued, Twombly says.

Note the ICD-10 index follows this reasoning. A search under “use” and then down to “tobacco” leads you directly to Z72.0. But, below “tobacco” is an essential modifier “with dependence,” which leads to another section of the index under “Dependence, drug, nicotine,” which leads to F17.200.

When Vonnie Blevins, HCS-D, sees a chart that says “tobacco use and dependence,” she codes dependence in accordance with official coding guidelines, which specify that when both use and dependence are documented, code dependence. [I.C.5.b.2]

Aim your efforts at physician education

Avoid giving physicians the impression that you’re wasting their time by placing a phone call solely to inquire whether a particular patient, especially one who obviously is a heavy user, is dependent on tobacco, or you could jeopardize an important relationship and referral source.

Instead, reach out to physicians to educate them about the requirement to code tobacco use and dependence in ICD-10 and why you need their determination on the question of whether a patient’s use rises to the level of dependence, Twombly says.

To address this dilemma, rely on the person at your agency to whom physician referral sources are most willing to listen, to teach them about the greater diagnostic detail that ICD-10 demands, Twombly says. Furthermore, it may be useful to remind physician offices that their ICD-10 grace period expires Oct. 1.

Tip: Keep a record of a conversation with a physician in which you ask him whether he agrees that a particular patient, who uses tobacco, is dependent on tobacco, Twombly says. If he does, that is enough confirmation, provided the conversation is clearly documented, to assign a code from F17.-.

Tip: Assign a more specific code for the particular tobacco product on which a patient is dependent, if you know it, in accordance with coding guidelines to code to the highest level of specificity. For example if a patient is dependent on cigarettes, F17.210 (Nicotine dependence, cigarettes, uncomplicated) is the appropriate choice over the unspecified F17.200. [I.B.2]

Scenario: COPD exacerbation, pneumonia

A 77-year-old man was recently hospitalized for exacerbated COPD with acute pneumonia due to

Streptococcus pneumoniae. He has been released into home health but is still undergoing treatment for pneumonia and is on new medications, as well as continuous oxygen, to control his COPD symptoms. His record reports that he has been a cigarette smoker for 30 years and continues to smoke despite his lung condition. The nurse notes that he was smoking when she arrived for the start of care visit.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1		
M1023b Chronic obstructive pulmonary disease with acute lower respiratory infection	J44.0		
M1023c Pneumonia due to <i>Streptococcus pneumoniae</i>	J13		
M1023d Nicotine dependence, cigarettes, uncomplicated	F17.210		
M1023e Dependence on supplemental oxygen	Z99.81		

Rationale:

- His exacerbated COPD is the focus of care and is coded primary. His pneumonia is still resolving and is thus warrants inclusions as well. Both COPD codes are assigned as they capture different diagnoses and are not excluded from each other.
- Because he is documented as being a “smoker” in the record, tobacco dependence can be coded. Tabular instructions at code J44.0 require the coding of tobacco use or dependence with COPD conditions, if applicable.
- Because his tobacco dependence is specified as cigarettes, the more specific F17.210 is assigned.

Scenario: Arterial ulcer, diabetes

A 55-year-old woman is admitted to home health for wound care to an arterial ulcer on her left calf. The wound has caused muscle necrosis and is the result of atherosclerosis. She has not had bypass surgery but is a type 2 diabetic who is dependent on insulin. While conducting the start of care visit, the nurse noticed a pack of cigarettes in the patient’s purse. She stated that

she doesn’t smoke every day but enjoys a cigarette or two when she visits the neighborhood bar with her friends. Her physician could not be reached to clarify her tobacco use and her record does not mention it.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a Atherosclerosis of native arteries of left leg with ulceration of calf	I70.242		
M1023b Non-pressure chronic ulcer of left calf with necrosis of muscle	L97.223		
M1023c Type 2 diabetes mellitus without complications	E11.9		
M1023d Long term (current) use of insulin	Z79.4		
M1023e Tobacco use	Z72.0		

Rationale:

- The patient’s ulcer is arterial caused by atherosclerosis, a diagnosis which requires coding of tobacco use, if applicable.
- Tabular instruction at the I70.- category level call for the use of an additional code to identify any tobacco use, if applicable. While there is evidence of tobacco use by the patient, nothing in the record supports a diagnosis of dependence and her physician could not be reached. Therefore, the code for use (Z72.0) must be assigned.
- Her insulin-dependent diabetes will impact her ability to heal from her wound, so it is coded as a relevant comorbidity. — *Megan Gustafson* (mgustafson@decisionhealth.com)

News brief

• **Palmetto relaxes HbA1c requirement.** Twice a year is enough for HbA1c test results for diabetics whose disease is stable and meeting treatment goals, according to updated Local Coverage Determination (LCD) L35132 from the Palmetto Medicare Administrative Contractor (MAC). However, for diabetes patients who aren’t meeting goals or who are requiring treatment changes, test results every 120 days will remain the expectation, according to the MAC. The policy revision went into effect May 5. [CPH, 3/15, 3/16] To view the LCD, go to <http://tinyurl.com/z97flhc>.

Diabetic Manifestations A&P Quick Reference

Use this quick reference guide, created by Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA-Approved ICD-10 Trainer, independent home health & hospice consultant, to help guide your coding of diabetes.

Terminology:

Manifestation Term	Physiology of Diabetic Manifestation
Diabetic Mononeuropathy	Damage to a specific nerve (also referred to as "focal neuropathy")
Diabetic Amyotrophy	Effects nerves in hips, thighs, buttocks resulting in weakness, usually one side (also referred to as "femoral neuropathy or proximal neuropathy")
Peripheral Neuropathy	Effects nerves of peripheral limbs, may result in ulceration, loss of protective sensation (Tip! Do not assign diabetic neuropathy, unspecified for patients with diabetic peripheral neuropathy)
Autonomic neuropathy	Control of internal organs - effects regulation of GI, GU, awareness of sensation (includes gastroparesis)
Diabetic Angiopathy	Oxidative stress due to persistent free insulin elevations and impaired lipid oxidation; damage occurs to endothelial lining of vessels, atherosclerosis may occur due to plaque buildup, vessel fragility occurs, increased risk for gangrene, ulcers
Diabetic Retinopathy	Excess glucose converts to sorbitol and accumulates with slow metabolism. Excessive and slow conversion to fructose, microvascular damage results in damage to retinal vessels
Proliferative Diabetic Retinopathy	Retinal neovascularization present - body attempts to revascularize damaged vessels (Tip! Code to the most specific degree diagnosed)
Non-Proliferative Diabetic Retinopathy	No retinal neovascularization present
Diabetic Macular Edema	Interstitial exudates build up in retina, microvascular damage, cyst formations, may result in thickening of the macular wall **Only occurs after the development of diabetic retinopathy**
Diabetic Renal Disease	Damage to microvessels due to persistent elevated blood glucose levels and increased vasoconstrictive mechanisms - results in impaired protein synthesis. Impairments in renal metabolism result in further systemic damage to micro- and macrovessel structure (Cyclic component) **Comorbid cardiovascular disease increases risk and expedites renal failure**

QUICK REFERENCE TO DIABETES BY TYPE

