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## Diabetic eye, injury codes dominate coming FY2017 code changes

You soon may have a way to capture the use of oral hypoglycemic medications on home health claims, thanks to the coming addition of code Z79.84 (Long term (current) use of oral hypoglycemic drugs).

The new drug use code is just one of the proposed 1,943 new, 422 revised and 305 deleted diagnosis codes released March 22 by the Centers for Disease Control (CDC) and expected to take effect on Oct. 1. The CDC will post the final FY2017 code changes in June.

Chapters 4 (Endocrine, nutritional and metabolic diseases, E00-E89), 13 (Diseases of the musculoskeletal system and connective

*(see Code changes, p. 5)*

## Capture liver conditions accurately, ensure compliant claims

Code both end-stage liver disease (K72.90) and cirrhosis (K74.60) if a patient has been diagnosed with both conditions or you'll be submitting incomplete Medicare claims that don't accurately reflect the patient's condition.

It's necessary to include both conditions if both have been diagnosed because not all patients who have end-stage liver disease also have cirrhosis, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Cirrhosis is a condition in which the liver has started to scar and can result from the progression of other forms of liver disease, such

*(see Liver conditions, p. 6)*

## Prepare for 2,600+ code changes!

After years of no change, your agency is going to be inundated with new and revised codes. Gather your staff and join Trish twombly, RN, BSN, HCS-D, HCS-O, COS-C, CHCE, on **Thur., June 9, form 1 to 2:30 p.m. ET**, to get a detailed overview of the code changes and how they will impact your home health coding. What are you waiting for? Go to [www.decisionhealth.com/conferences/A2668](http://www.decisionhealth.com/conferences/A2668) to register.

## CB Coding Basics

### Navigate the deep waters of DVTs in ICD-10

By Melissa Williamson, HCS-D

ICD-10 has dramatically expanded the detail with which you can code deep vein thrombosis (DVT).

DVT is a condition in which a blood clot develops in a deep vein, usually in the lower leg or thigh. These clots may be considered acute or chronic conditions.

ICD-10 offers codes that allow you to differentiate whether the diagnosis involves the right leg, left leg, both legs, or an unspecified leg. ICD-10 also offers codes to more specifically identify the vein in which the clot is located: femoral, iliac or popliteal, another specified vein or no specified vein at all.

Codes capturing DVTs are found in Chapter 9 (Diseases of the circulatory system) in category I82.- (Other venous embolism and thrombosis).

The category further breaks down into subcategories I82.4- (Acute embolism and thrombosis of deep veins of lower extremity) and I82.5- (Chronic embolism and thrombosis of deep veins of lower extremity) depending on whether the clot is acute or chronic.

The fifth character identifies the vein, such as iliac or popliteal, and the sixth character identifies

laterality — right, left or bilateral. For example, I82.433 corresponds to Acute embolism and thrombosis of popliteal vein, bilateral.

You'll find these codes by searching the alphabetic index under "Embolism, vein, lower extremity." Note that a search in the index for "Thrombosis, deep" leads to "Embolism, vein, lower extremity."

Like any other diagnosis, coding and sequencing for acute and chronic DVTs are dependent on physician documentation.

#### First determine acute vs. chronic

Look for key clues in the patient's record to help you determine whether the DVT is acute or chronic.

For example, when a patient is admitted to the hospital for the first time with a DVT that wasn't there before, this is likely to be considered an acute DVT. But a DVT in a patient who's had one before is a clue that you may be dealing with a chronic condition.

Other times, the physician will admit a patient to the hospital with a history of DVT, who may be having trouble with preventative anticoagulant medication, for the purpose of installing a device called an inferior vena cava umbrella, which is done to help prevent clots.

When the condition is **not acute**, you then need to figure out whether the DVT is an old, resolved condition

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**Product Manager:** Maria Tsigas  
1-301-287-2305  
[mtsigas@decisionhealth.com](mailto:mtsigas@decisionhealth.com)

#### Editorial:

**Editor:** Megan Gustafson, HCS-D,  
1-612-834-6896  
[mgustafson@decisionhealth.com](mailto:mgustafson@decisionhealth.com)

**Technical Editor:** Tricia A. Twombly  
BSN, RN, HSC-D, CHCE, COS-C  
[ttwombly@decisionhealth.com](mailto:ttwombly@decisionhealth.com)

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or a condition that’s still under treatment. If the DVT is an old diagnosis, but treatment is ongoing, you’re dealing with a chronic DVT.

But if the DVT is an old condition for which the patient is **not being treated**, do not assign a code from I82.- but rather Z86.718 (Personal history of other venous thrombosis and embolism).

### Tips for coding DVTs

Use these three additional tips to help guide your coding of DVTs:

**Tip:** Default to acute if the record isn’t clear as to whether the DVT is acute or chronic, according to the alphabetic index.

**Tip:** Include code Z79.01 (Long term (current) use of anticoagulants) when a patient with a DVT is being treated with anticoagulant drugs. These drugs come with certain risks, such as bleeding, that require monitoring. Also, remember to code Z51.81 (Encounter for therapeutic drug level monitoring) if your agency will be monitoring the patient’s PT/INR levels.

Additionally, note that many DVT codes include a subcategory level “use additional code” note that instructs the coder to assign Z79.01 if applicable.

**Tip:** Don’t take a prescription for anticoagulant drugs to mean that the patient must have an acute DVT. These may be prescribed for prophylactic purposes in patients with chronic DVTs or they may be used for other reasons.

### Scenario: Acute venous embolism

A 70-year-old man was hospitalized due to swelling of his left lower extremity. He was in a lot of pain and the color of the left limb was darker than his right. He was found to have a deep vein thrombosis of his left distal lower extremity. He was started on heparin IV for two days and was monitored closely. The IV was discontinued and the patient was discharged home on Coumadin. Skilled nursing was ordered for observation and assessment and to draw blood for PT/INR monitoring. The patient also has a history of diabetes and chronic systolic congestive heart failure (CHF).

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Acute embolism and thrombosis of unspecified deep veins of left distal lower extremity	I82.4Z2		
<b>M1023b:</b> Type 2 diabetes mellitus without complications	E11.9		
<b>M1023c:</b> Chronic systolic (congestive) heart failure	I50.22		
<b>M1023d:</b> Encounter for therapeutic drug level monitoring	Z51.81		
<b>M1023e:</b> Long term (current) use of anticoagulants	Z79.01		

#### Rationale:

- Since the patient was just diagnosed with a DVT and is actively being treated for it, it’s coded as an acute DVT. Also, if the DVT isn’t specified acute or chronic, code it as acute.

- The patient’s other comorbidities, diabetes and chronic systolic CHF, will impact the plan of care so they both are coded.

- Nursing will be drawing blood for PT/INR, and will be reporting the results to the physician for Coumadin dose change orders. Capture that with Z51.81, followed by Z79.01 to capture the long-term anticoagulant use.

### Scenario: Total knee replacement, warfarin

A 65-year-old man is admitted to home care for surgical aftercare after undergoing a right total knee replacement due to primary osteoarthritis in that joint. He’s taking warfarin for prophylactic purposes. He also has COPD.

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Aftercare following joint replacement surgery	Z47.1		
<b>M1023b:</b> Chronic obstructive pulmonary disease, unspecified	J44.9		
<b>M1023c:</b> Presence of right artificial knee joint	Z96.651		
<b>M1023d:</b> Long term (current) use of anticoagulants	Z79.01		

#### Rationale:

- The patient is receiving routine aftercare following a joint replacement, making Z47.1 the appropriate primary code choice.

- The fact that the patient is taking warfarin should not be taken to mean he has a DVT or a history of DVT. Thus, if it a DVT diagnosis can't be confirmed with the physician, don't code it.
- In this case, like many patients who undergo joint replacements, the patient is taking an anticoagulant prophylactically.
- When a patient is taking an anticoagulant drug over a long period of time, Z79.01 should be coded, as these drugs come with certain risks, such as bleeding, and thus needed to be tracked.

### Scenario: Chronic venous embolism

A 72-year-old male patient was hospitalized for exacerbation of COPD, during which his medications were changed. He is currently on a tapering dose of prednisone. He also has diabetes and recently was started on insulin. He also takes Coumadin and receives private lab work to measure his PT/INR. While confirming the patient's medications the plan of care with his physician, the visiting nurse discovered that the patient has a chronic deep vessel thrombosis of his right tibial vein that was diagnosed three years ago. The exacerbated COPD is the focus of care.

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1		
<b>M1023b:</b> Type 2 diabetes mellitus without complications	E11.9		
<b>M1023c:</b> Chronic embolism and thrombosis of right tibial vein	I82.541		
<b>M1023d:</b> Long term (current) use of insulin	Z79.4		
<b>M1023e:</b> Long term (current) use of anticoagulants	Z79.01		

#### Rationale:

- As the focus of care, COPD with exacerbation is coded as primary.
- Diabetes will impact plan of care and is coded as well.
- The physician has confirmed the patient has a chronic DVT of the right calf and that is in the tibial vein. Thus, I82.541 is the correct code.

- Long term (current) use of insulin is coded per coding guidelines for a patient who isn't a type 1 diabetic who is dependent on insulin.
- Code Z79.01 is included because the patient is on long-term Coumadin, in accordance with tabular instruction that tell the coder to assign it if applicable.
- Because a private lab handles the PT/INR monitoring, Z51.81 is not assigned in this scenario.

**About the author:** *Melissa Williamson, HCS-D, Utilization Review Coder for Kindred at Home has six years' experience in the home care field and earned her HCS-D credential in 2014.*

## Ask the Expert

### Code diabetes, knee osteoarthritis

**Question:** *Do you also code E11.9 (Type 2 diabetes mellitus without complications) as an additional code if you are coding a diabetic foot ulcer with E11.621 (Type 2 diabetes mellitus with foot ulcer)?*

**Answer:** No, you should only code E11.621. Code E11.9 (Type 2 diabetes mellitus without complications) may not be coded with any other diabetes diagnosis code.

Remember that if there is a diabetic complication of any kind, such as a foot ulcer, then E11.9, which describes diabetes with **no** complications, is an incorrect code choice.

Furthermore, E11.621 is a combination code that communicates both that the patient has type 2 diabetes and that the type 2 diabetes has caused a foot ulcer.

**Question:** *If a patient has osteoarthritis (OA) primary, right knee, documented as a pre-op and post-op diagnosis after a right knee replacement, can OA of the right knee be included in M1023?*

**Answer:** No. Do not code primary OA of the right knee in M1023 after a patient has had a right knee replacement. The OA in that joint has been effectively removed by the joint replacement and is no longer present. You may, however, code primary OA of the right knee in M1011 and M1017, as applicable.

**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](mailto:mgustafson@decisionhealth.com).*

## Code changes

*(continued from p. 1)*

tissue, M00-M99) and 19 (Injury, poisoning and certain other consequences of external causes, S00-T88) received the bulk of the changes, which were focused heavily on eye conditions and fractures.

The 2,670 total changes represent the first major update to the ICD-10-CM since a partial code freeze went into effect in 2011 in preparation for the implementation of the new code set.

The majority of the changes include 260 new diabetes combination codes for reporting manifestations, 152 new codes added to the musculoskeletal chapter including those for bunions and cervical spine disorders, and 885 new codes in Chapter 19, the majority of which are fracture codes.

Though at face value the sheer number of code changes seems staggering, many of them merely represent the same code with different seventh characters or consist of the deletion of a code that doesn't specify laterality with the subsequent addition of new codes broken down by right, left and bilateral.

For example, **S03.4xxA** (Sprain of jaw, initial encounter), **S03.4xxD** (Sprain of jaw, subsequent encounter) and **S03.4xxS** (Sprain of jaw, sequela) are counted as three deleted codes within Chapter 19, which received the most changes of all — 1,245 total. *[For a chapter-by-chapter view of the code changes, see the Tool of the Month]*

### Uneven specificity puzzles experts

While some areas of the code set received a stunning degree of additional specificity, other areas were seemingly left neglected, to the consternation of home health coders.

Consider that **all** of the 260 new diabetes combination codes capture some form of a diabetic ophthalmic manifestation, allowing the coder to further specify which eye, or both, is affected.

For example, E11.321 (Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema) will be deleted and replaced with four new codes that correspond to diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema of the right eye (E11.3211), left eye (E11.3212), bilateral eyes (E11.3212) or unspecified eye (E11.3219).

Diagnoses of diabetic retinopathy are seen in home health but rarely is the documentation specific enough

to know which eye is impacted or whether it's mild or severe, says Regenia Simmons, HCS-D, coding and OASIS specialist for FirstHealth Home Care in West End, N.C.

But in stark contrast to all the ways home health coders will have to capture diabetic retinopathy, they'll still have **no specific code** to capture aftercare following surgery to the musculoskeletal system *[CPH, 11/14]*.

"I was really hoping for a Z code for aftercare of the musculoskeletal system. It wasn't there," says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

"I think it's nice that we've got all this detail on [eye conditions], but there are places where we've got no detail," says Ann Rambusch, HCS-D, president of Rambusch3 Consulting in Georgetown, Texas.

Rambusch specifically pointed to the current dearth of options in the L97.- category (Non-pressure chronic ulcer of lower limb, not elsewhere classified) for coding the severity of non-pressure chronic ulcers that have penetrated muscle tissue or bone tissue, for example, but where necrosis isn't present *[CPH, 4/16]*.

In fact, three of the most common home health diagnosis categories received little to no changes at all — Chapter 10 (Diseases of the respiratory system, J00-J99) only received four new codes, Chapter 12 (Diseases of the skin and subcutaneous tissue, L00-L99) also only received four new codes, two of which are for postprocedural hematoma, and Chapter 1 (Certain infectious and parasitic diseases, A00-B99) received no new, revised or deleted codes.

### Important new codes for home health

While many of the new and revised codes are not commonly assigned in home health, there are still several significant changes that **will** impact your coding. Here are some key items to be aware of before Oct. 1:

- The aforementioned **Z79.84** for long-term use of oral hypoglycemics. As of yet there hasn't been a way to capture use of these drugs, which are prescribed frequently to type 2 diabetics and present certain risks, such as hypoglycemia, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

- A new category (**I16.-**) and three new codes for hypertensive urgency (**I16.0**), emergency (**I16.1**) and crisis (**I16.9**). These codes could be assigned in M1011 (Inpatient diagnosis) and M1017 (Diagnoses requiring medical or treatment regimen change within past 14

days) as these conditions are often the reason for a patient's hospitalization but typically resolve prior to the home care admission, says Pallavi Sheth, HCS-D, clinical coding coordinator for the VNA of Englewood, N.J.

Consider that these new codes **also** have use in helping to justify, when coded in M1017 for example, why a patient might need to be recertified for another episode of care to treat hypertension that recently exacerbated and required hospitalization, Whitemyer says. Right now, the only code available is I10 (Essential (primary) hypertension), which gives no detail about the severity of the diagnosis.

- The current code **I69.31** (Cognitive deficits following cerebral infarction) is set to be deleted and replaced with eight new codes in that subcategory that allow for greater specificity in capturing cognitive sequelae of strokes, such as **I69.311** (Memory deficit following cerebral infarction) and **I69.312** (Visuospatial deficit and spatial neglect following cerebral infarction).

These new codes will be useful to Sheth, who has encountered patients who've suffered memory deficits following strokes. The current code I69.31 doesn't quite fit, she says.

And thankfully, cognitive is the one area of post-CVA deficits where home health does seem to get some specific diagnostic information, Whitemyer says.

- Nine new codes within the **T83.0-** category (Mechanical complication of urinary (indwelling) catheter) for displacement (**T83.021-**), leakage (**T83.031-**) and other mechanical (**T83.091-**) complications. Note that these codes are complications and require the use of seventh character for initial encounter (A), subsequent encounter (D) or sequela (S). These codes are likely to be useful to home health; Sheth says she sees leakage of urinary catheters "all the time."

- A new code for drug-induced constipation (**K59.03**) as well as irritable bowel syndrome (IBS) with constipation (**K58.1**). Constipation can be a problem in elderly patients, particularly when using opioid painkillers and a specific code for IBS with constipation "has been needed for a long time," Twombly says.

- A new code specifically to capture pre-diabetes (**R73.03**). Currently, pre-diabetes is captured with the vaguer R73.09 (Other abnormal glucose).

- While it wasn't included on the initial list of changes, a new code for the Zika virus (**A92.5**) was proposed at the March 2016 meeting of the ICD-10 Coordination and

Maintenance Committee and is expected to be fast-tracked for inclusion in the coming FY2017 update.

— Megan Gustafson ([mgustafson@decisionhealth.com](mailto:mgustafson@decisionhealth.com))

**Editor's note:** View a scenario demonstrating the use of some of the new codes in the online version of this story at [www.HHCodingCenter.com](http://www.HHCodingCenter.com). To view the code changes, go to [ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Publications/ICD10CM/2017/NewICD10CMCodes\\_FY2017.txt](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/NewICD10CMCodes_FY2017.txt).

## Liver conditions

(continued from p. 1)

as viral hepatitis and alcoholic liver disease. Including the cirrhosis code in those patients whose diseases have progressed reflects this process and is an important piece of accurately capturing their health status, Whitemyer says.

Also, make note of that fact that the tabular instructions on both codes **do not** exclude the other, meaning that there's no reason why both codes couldn't be assigned on the same claim.

Deciphering the many liver diagnoses from each other and determining which to code for patients with multiple confirmed conditions is a source of confusion among coders, Whitemyer says.

Furthermore, when a patient's alcohol has led to liver disease, correctly capturing this process can also be a confusing undertaking in part because of the high number of ICD-10 codes that describe substance use, abuse and dependence, as well as the fact that the physician confirmation required to use them is often vague or just not there.

## Understand pathophysiology to code correctly

Understanding the etiology, or cause, of a patient's liver disease is key to coding it correctly.

Liver disease can be idiopathic, meaning it has no known cause, or congenital, meaning the patient was born with it. Most of the time in home health the cause of a patient's liver disease either isn't known or simply isn't stated in the record, Whitemyer says.

For example, the diagnosis may be stated just as "cirrhosis," she says. In that case, the correct code would be K74.60 (Unspecified cirrhosis of liver). A diagnosis of just "end-stage liver disease" or ESLD is captured with K72.90 (Hepatic failure, unspecified without coma).

Most of the codes that capture liver conditions are found in Chapter 11 (Diseases of the digestive system), and range from K70 (Alcoholic liver disease) through K77 (Liver disorders in diseases classified elsewhere).

However, congenital forms of liver disease, such as congenital cirrhosis (P78.81, Congenital cirrhosis (of liver)) and congenital liver disease (Q44.6, Cystic disease of liver) are captured with codes from Chapter 16 (Certain conditions originating in the perinatal period) and Chapter 17 (Congenital malformations, deformations and chromosomal abnormalities).

Liver diseases also can result from alcohol abuse, illegal drug use and even from use of certain prescribed or therapeutic drugs, such as steroids, antibiotics, non-steroidal anti-inflammatory drugs like Tylenol and ibuprofen, or statins, says J'non Griffin, HCS-D, principal of Home Health Solutions, LLC in Carbon Hill, Ala.

**Tip:** Notice that you no longer have to code hepatitis immediately before cirrhosis when a patient has both conditions, as was the case in ICD-9 due to a “code first” note on 571.5 (Cirrhosis of liver NOS). [CPH, 12/14]

Category-level tabular instruction for hepatitis at the ICD-10 equivalent K74.60 (Cirrhosis NOS) is simply a “code also” note, which does not have sequencing requirements. Thus if a patient with cirrhosis also has hepatitis, the hepatitis code need only appear somewhere on the claim, Whitemyer says.

### How to code alcohol-induced liver disease

Assign K70.9 (Alcoholic liver disease, unspecified) for a patient whose diagnosis has been

described as alcoholic liver disease, according to the alphabetic index.

Notice that within the K70.- category (Alcoholic liver disease) there are various options for more specified forms of alcoholic liver disease, such as alcoholic fatty liver (K70.0), alcoholic hepatitis

(K70.1-), alcoholic fibrosis and sclerosis (K70.2), alcoholic cirrhosis (K70.3-) and alcoholic hepatic failure (K70.4-).

The alcoholic hepatitis and alcoholic cirrhosis categories further break down into combination codes that specify whether the patient also has ascites, such as K70.31 (Alcoholic cirrhosis of liver with ascites).

Short-term heavy drinking, even just for a few days, can cause alcoholic fatty liver, Griffin says. More long-term heavy drinking can lead to alcoholic hepatitis. And over time, these conditions can progress into cirrhosis.

With any code from the K70.- category, you must assign an additional code for the patient’s alcohol use, abuse or dependence, according to tabular instruction. Alcohol use, abuse and dependence codes are found in the F10.- category (Alcohol related disorders).

Notice that the F10.- category offers a litany of options to capture alcohol, use, abuse and dependence with combination codes that also cover associated disorders including intoxication, delirium, psychosis and insomnia. For example, F10.121 corresponds to Alcohol abuse with intoxication delirium.

### More liver disease coding tips

Here are four more tips to help you keep your coding of liver conditions compliant:

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- Capture alcohol use described in the record as “ETOH” with a code from F10.9- (Alcohol use, unspecified), Whitemyer says. ETOH is an antiquated medical term that refers to alcohol use.

- Assign F10.988 (Alcohol use, unspecified with other alcohol-induced disorder) for a patient with alcoholic liver disease whose alcohol use isn’t further specified, says Griffin.

- Do not use a code that refers to alcohol “abuse” or “dependence” unless the physician specifically documents it as such, Whitemyer says. However, if the record includes a statement like “use and abuse,” code abuse.

- Code “alcoholism” as alcohol dependency, with F10.20 (Alcohol dependence, uncomplicated), according to alphabetic index.

### Scenario: Alcoholic cirrhosis with ascites

A 77-year-old man comes to home health with a diagnosis of alcoholic cirrhosis with ascites. He also has type 2 diabetes. The liver disease is the focus of care. He has a diagnosis of alcoholism but the medical record says it is in remission and he is not continuing to drink.

#### Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Alcoholic cirrhosis of liver with ascites	K70.31		
<b>M1023b:</b> Alcohol dependence, in remission	F10.21		
<b>M1023c:</b> Type 2 diabetes mellitus without complications	E11.9		

#### Rationale:

- The alcoholic cirrhosis is the focus of care and is therefore coded primary. Because he also has ascites, the combination code indicating the presence of ascites is assigned.

- His alcoholism is documented as documented as in remission, making F10.21 the appropriate code.

- Diabetes is an important comorbidity that always must be coded when present.

### Scenario: Hepatitis C, cirrhosis

A 65-year-old woman is admitted to home health after being diagnosed with cirrhosis, which her record says

is secondary to chronic hepatitis C infection. She will receive care in home health while awaiting a transplant.

#### Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Other cirrhosis of liver	K74.69		
<b>M1023b:</b> Viral hepatitis C NOS	B19.20		

#### Rationale:

- The appropriate code for cirrhosis in this case is K74.69 because the type of cirrhosis the patient has is covered in the clarifying terms under the code.

- The viral hepatitis C code is assigned in accordance with tabular instruction.

### Sequence drug-induced liver toxicity

You’ll need to assign at least three codes for a patient who experienced liver toxicity as an adverse effect of using certain drugs, such as Vancomycin, according to coding guidelines. [I.C.19.e.5]

Certain drugs, such as antibiotics like Vancomycin, are known to be hepatotoxic, meaning they can damage the liver. Patients who develop liver damage after correctly taking a drug are experiencing an **adverse effect** of that drug, which is a scenario that is subject to specific coding guidelines. [I.C.19.e.5] [CPH, 10/15]

To correctly capture these cases, you’ll first need to code the condition that resulted from the drug use, the liver toxicity. Drug-induced liver toxicity is coded as toxic liver disease with the K71.- category (Toxic liver disease), according to the alphabetic index.

If you have no further detail beyond just liver toxicity, code it with K71.9 (Toxic liver disease unspecified). However, the K71.- category offers code options for more specified forms of toxic liver disease, such as when it occurs with acute hepatitis (K71.2).

Then, you’ll need to assign the code for the adverse effect of the drug. In this case, the correct code would be T36.8x5D (Adverse effect of other systemic antibiotics, subsequent encounter). Finally, code the reason the patient was taking the drug in the first place, such as MRSA sepsis (A41.02), according to coding guidelines. [I.C.19.e.5]

**Tip:** Ask questions before coding cirrhosis as an adverse effect of prescription drug use to ensure that

the physician has confirmed this is the case, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. Cirrhosis is a chronic condition that develops over time and is thus not usually associated with acute liver toxicity occurring as an adverse effect of a prescription drug.

### Scenario: Acute liver toxicity

A 61-year-old man is admitted to home health with a primary diagnosis of acute liver toxicity secondary to high-dose prednisone use which he was prescribed to treat a severe flare of ulcerative colitis with rectal bleeding. He also has a diagnosis of chronic systolic heart failure and COPD, both of which are stable.

**Code the scenario:**

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
<b>M1021a:</b> Toxic liver disease, unspecified	K71.9		
<b>M1023b:</b> Adverse effect of glucocorticoids and synthetic analogues, subsequent encounter	T38.0x5D		
<b>M1023c:</b> Ulcerative colitis, unspecified with rectal bleeding	K51.911		
<b>M1023d:</b> Chronic systolic (congestive) heart failure	I50.22		
<b>M1023e:</b> Chronic obstructive pulmonary disease, unspecified	J44.9		

**Rationale:**

- As the primary diagnosis, the drug-induced liver toxicity is coded in the primary position.
- Because the patient took his medication correctly but still experienced a problem, it is considered an adverse effect (as opposed to a poisoning) and must be coded as such.
- The adverse effect of prednisone code immediately follows the liver disease and the reason for the use of prednisone, the ulcerative colitis with rectal bleeding, comes third, according to coding guidelines. [I.C.19.e.5]
- As important comorbidities that must be watched, his chronic systolic heart failure and COPD are also coded. — *Megan Gustafson (mgustafson@decisionhealth.com)*

## Use caution with alcohol-related non-compliance codes

Do not assign Z91.19 (Patient’s noncompliance with other medical treatment and regimen) simply because you see that a patient with alcoholic liver disease continues to drink alcohol, or you could be risking claims denials.

Rather, a patient’s noncompliance is something that must be confirmed by the physician and the clinician, and for which there needs to be written documentation, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

Furthermore, not all physicians consider continuing to drink with alcoholic liver disease to be noncompliance, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Hasty assignment of noncompliance codes in these cases is risky because Medicare requires that agencies discharge non-compliant patients, Twombly says.

However, there is no firm guideline on when discharges should happen and most agencies take it on a case-by-case basis after reporting the non-compliance to the physician and documenting the physician’s response, she says.

Patients get at least “one strike” before they’re classified as noncompliant at FirstHealth Home Care in West End, N.C., says Regenia Simmons, HCS-D, the agency’s coding and OASIS specialist.

Simmons also says that she does not code noncompliance without a documented pattern of failure to follow the prescribed treatment regimen.

Discharge for noncompliance is usually a last-resort option, such as when a patient has been recertified multiple times for severe and worsening alcoholic cirrhosis but resists rehabilitation options and continues to drink heavily, Twombly says.

A patient who is abusing alcohol after receiving a liver transplant also may be considered noncompliant because patients are required to quit drinking in order to be eligible for transplantation, Whitemyer says. — *Megan Gustafson (mgustafson@decisionhealth.com)*

## Coding Clinic issues guidance on hospice coding, diabetes assumptions

Hospice coders should **not** code “probable,” “suspected,” “likely” or “possible” diagnoses as if they were confirmed diagnoses, according to Q1 2016 Coding Clinic guidance.

This means that hospices **may not** code lung cancer, for example, in a patient who is suspected of having the disease but either refuses to or cannot undergo further diagnostic testing to confirm it.

Hospice coders are required to following the official coding guidelines. The exception mentioned in Section

III, C that allows the coding of unconfirmed diagnosis does not apply to them, according to the Coding Clinic.

That exception is only for **inpatient** admissions to short-term, acute, long-term care and psychiatric hospitals, the Coding Clinic said.

This guidance aligns with the opinion of CMS's ICD-10 ombudsman Dr. William Rogers, M.D., who said last month that coding unconfirmed diagnoses in hospice is hard to justify and that signs, symptoms and other conditions should be coded in these scenarios to help support the patient's medical necessity for the hospice benefit. [CPH, 4/16]

### Diabetic assumptions guidance unclear

Guidance previously issued by the Coding Clinic in Q4 2013, that a relationship between diabetes and osteomyelitis **may not** be assumed in ICD-10 without physician confirmation, was confirmed in Q1 2016 guidance [CPH, 7/14].

"ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such," according to the Q1 2016 Coding Clinic.

Yet for every question that answer settled, several more were raised as additional diabetes guidance in the Q1 2016 update appears to potentially imply that there is an assumed relationship between diabetes and renal, circulatory and neuro manifestations.

DecisionHealth and the Association of Home Care Coding and Compliance (AHCC) are seeking clarification on this guidance, including which, if any, renal, circulatory and neuro conditions may be assumed to be related to diabetes when both conditions are present regardless of whether they've been linked by the physician.

In the interim, coding experts agree that coders **should not** assign any diabetes manifestation code, such as E11.22 (Type 2 diabetes mellitus with diabetic chronic kidney disease), **without confirmed documentation** from the physician linking the chronic kidney disease to the diabetes.

### Additional Coding Clinic guidance

Here are four more notable pieces of guidance from the Q1 2016 update:

- Do not code active sepsis in a patient who comes to home care with diagnosis that reads, "sepsis, resolving," according to Q1 2016 Coding Clinic guidance. Instead, code

the underlying infections that triggered the sepsis, which is now resolving and is no longer an active diagnosis. Coding experts recommend that unless there's active ongoing treatment for sepsis, coders should query the physician about a sepsis diagnosis before coding it as a current condition.

- A "code first" note in the tabular is commanding sequencing order, with the underlying condition, or etiology, listed first, followed by the manifestation, the Coding Clinic said. However, the rule only applies if applicable. If the underlying condition is not present, the "code first" note does not apply.

- You may now code systolic heart failure (I50.2-) or diastolic heart failure (I50.3-) based on a physician's diagnosis of "heart failure with preserved ejection fraction" or "heart failure with reduced ejection fraction" respectively, according to the Coding Clinic. The Coding Clinic reconsidered its previous guidance based on updated information from the American College of Cardiology and the Coding Clinic Editorial Advisory Board.

- Assign D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) when a patient is experiencing bleeding, such as hemoptysis, hematuria, hematemesis or hemochezia, as the result of taking an anticoagulant drug, according to the Coding Clinic. Sequencing is dependent on the circumstances of the admission.

Code D68.32 should also be assigned in addition to K26.4 (Chronic or unspecified duodenal ulcer with hemorrhage) and T45.515- (Adverse effects of anticoagulants) to describe a patient who developed a duodenal ulcer with hemorrhage as the result of Coumadin therapy, according to the Coding Clinic. Either D68.32 or K26.4 may be sequenced first depending on the focus of care. — Megan Gustafson ([mgustafson@decisionhealth.com](mailto:mgustafson@decisionhealth.com))

### News brief

- **CMS takes one step closer to finalizing OASIS-C2 form.** CMS has opened the comment period for the OASIS-C2 data set. All comments are due by May 31. The OASIS document has been updated to comply with requirements for the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) and all changes will take effect January 1, 2017, CMS states. The federal Medicare agency announced its request for approval by the Office of Management and Budget on April 1. For more details, visit: *Find supporting documentation for the OASIS-C2 at <http://go.cms.gov/1RXfsuE>.*

## Chapter-By-Chapter Quick View of FY2017 Proposed Code Changes

See below for a quick breakdown of where you can find the proposed new, revised and deleted codes for FY2017.

Chapter	New	Revised	Deleted
1: Certain infectious and parasitic diseases (A00-B99)	0	0	0
2: Neoplasms (C00-D49)	12	56	1
3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	7	2	0
4: Endocrine, nutritional and metabolic diseases (E00-E89)	264	2	41
5: Mental, behavioral and neurodevelopmental disorders (F01-F99)	13	1	4
6: Diseases of the nervous system (G00-G99)	20	2	0
7: Diseases of the eye and adnexa (H00-H59)	92	8	15
8: Diseases of the ear and mastoid process (H60-H95)	12	2	0
9: Diseases of the circulatory system (I00-I99)	81	6	10
10: Diseases of the respiratory system (J00-J99)	4	2	1
11: Diseases of the digestive system (K00-K95)	83	3	17
12: Diseases of the skin and subcutaneous tissue (L00-L99)	4	2	0
13: Diseases of the musculoskeletal system and connective tissue (M00-M99)	152	2	10
14: Diseases of the genitourinary system (N00-N99)	62	15	15
15: Pregnancy, childbirth and the puerperium (O00-O9A)	67	29	8
16: Certain conditions originating in the perinatal period (P00-P96)	2	53	0
17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	21	0	4
18: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	79	0	9
19: Injury, poisoning and certain other consequences of external causes (S00-T88)	885	237	123
20: External causes of morbidity (V00-Y99)	40	0	42
21: Factors influencing health status and contact with health services (Z00-Z99)	43	0	5
<i>Source: CDC</i>			

**Editor's note:** To view the list of proposed code changes, go to [ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Publications/ICD10CM/2017/NewICD10CMCodes\\_FY2017.txt](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/NewICD10CMCodes_FY2017.txt).

## Non-Traumatic CVA Code Quick Reference

Use this tool, created by Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md., to help guide your coding of CVA-related conditions & sequelae.

Term	Physiology of Condition
<b>Subarachnoid hemorrhage:</b> Code sequelae using I69.0- if this specific diagnosis was given for the patient's brain bleed	Extravasation of blood into the subarachnoid space between the pial and arachnoid membranes
<b>Intracerebral hemorrhage:</b> Code sequelae using I69.1- if this specific diagnosis was given for the patient's brain bleed	Bleeding into brain tissue
<b>Intracranial hemorrhage:</b> Code sequelae using I69.2- if this specific diagnosis was given for the patient's brain bleed	Bleeding inside the skull around the brain (not in)
<b>Thrombosis:</b> Code sequelae using I69.3-	Also known as an ischemic stroke; clot obstructs blood to area of brain
<b>Stroke/CVA NOS:</b> Code sequelae using I69.3- (this is the default code for stroke or CVA sequelae)	The etiology or cause of the stroke/CVA was not specified
<b>Cerebral atherosclerosis:</b> Condition codes to I67.2; Code sequelae using I69.8-	Cerebral atherosclerosis doesn't mean there's been a stroke; it means the patient has plaque build-up and is at risk for a stroke <b>(Tip! Home health &amp; hospice should not use I67.2 (Cerebral atherosclerosis) unless it is clear that no CVA has occurred)</b>
<b>TIA:</b> <i>(Note- In ICD-10-CM, cannot code sequela(e) of TIA as the definition indicates that it is a transient condition. Home health and hospice may only code history of TIA, Z86.73)</i>	TIA is short for "Transient Ischemic Attack" – it's temporary/transient. Defined by the World Health Organization (WHO) as symptoms resolving in 30 min to 24 hrs.