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for Home Health

Special Issue

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Avoid upcoding, claims denials by correctly identifying ostomy complications

Do not assign Z43.5 (Encounter for attention to cystostomy) to capture the care of a complicated cystostomy in ICD-10, or you could face upcoding charges.

The codes in the Z43.- category (Encounter for attention to artificial openings) describe ***routine care*** to an ostomy, or artificial opening. If the ostomy is complicated, its care is not routine, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Instead, assign a code from the N99.5- category (Complications of stoma of urinary tract) to capture the complication, such as infection, hemorrhage or malfunction, of the cystostomy, she says.

*(see **Ostomy complications**, p. 5)*

Keep calm and code hypertension in ICD-10

Coding hypertension — one of the most common and important home health diagnoses — just got easier.

Now, you'll assign the same code — I10 (Essential (primary) hypertension) — regardless of whether a patient's hypertension diagnosis is specified by the doctor as "benign," "malignant" or simply isn't specified at all.

That's because code I10 includes a slew of non-essential modifiers, including "essential," "benign," "malignant" and "idiopathic." A non-essential modifier is a descriptive term attached

*(see **Hypertension**, p. 8)*

Get the ultimate guide to wound coding!

The **ICD-10-CM Wound Coding & OASIS Field Guide, 2016,** is your on-the-go reference to choose the right codes and OASIS answers for the most common home health wounds. It is conveniently separated into chapters devoted to each type of wound commonly seen in home health, and contains real-life wound photographs. You won't find a more detailed, real-life instruction wound book than this on the market! For more information, go to *https://store.decisionhealth.com/Product.aspx?ProductCode=PAB-I10WOUND-16*.

CB Coding Basics

Stay cool when coding burns in ICD-10

By J'non Griffin, RN, MHA, WCC, BCHH-C, HCS-D, COS-C

No longer are all burns lumped together. With ICD-10, you now have the ability to capture each burn by its source – whether thermal (i.e. those from a heat source) or corrosion (i.e. those caused by chemicals).

Most burns are classified as injuries and as such are found in Chapter 19 (Injury, poisoning and certain other consequences of external causes). The injury codes here are grouped together by the body site affected and not by type of injury.

Vital to correctly coding a burn is knowing how badly the burn has penetrated the patient's tissue. This is expressed in terms of degree, and burn codes are further grouped by degree. For example, code T24.332- corresponds to burn of third degree of left lower leg.

Defining degrees of burns

A burn can be first, second or third degree. Here's a brief overview of the differences between the degrees of burns:

- **First degree burns:**
  - Include only the epidermis
  - Usually result in red and painful skin

- Begin to heal within three to five days, epithelium begins to peel away from healthy skin
- **Second degree burns:**
  - Second degree burns can cause partial thickness or full thickness tissue loss
    - **Partial thickness second degree burns:**
      - Involve the entire epidermis and upper layers of the dermis
      - Can present with blisters
      - Cause wounds that are pink or red in color and wet in appearance
      - Should heal in 10 to 21 days without grafting
    - **Full thickness second degree burn**s:
      - Involve destruction of the entire epidermis and most of the dermis
      - Are red or white in appearance, but will appear dry
      - Cause diminished sensation but not total loss of feeling
      - Will most likely need excision and grafting to heal
- **Third degree burns:**
  - Involve destruction of all layers of the skin
  - Extend into the subcutaneous tissue
  - Case wounds that are black in white in color, but appear dry

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Board of Medical Specialty Coding & Compliance

- Can look like leather
- Cause no pain, as the nerves have been destroyed

Nail down the basics of coding burns

Assign separate burn codes for a patient who suffers *multiple burns* to *multiple body sites*. But if a patient has *multiple burns* to the *same body site*, but the burns are of different degrees (for example, second and third degree burns to the left thigh), code only the most severe burns, i.e. the third degree burns. [*I.C.19.d.5*] [*I.C.19.d.2*]

Note that sometimes injuries described with the word "burn" aren't classified as burns that are caused by a heat source or by a corrosive chemical in ICD-10. These include sunburns, friction burns and burns acquired from a tanning bed.

Sunburns and burns from tanning beds (also known as radiodermatitis) are captured with codes from Chapter 12 (Diseases of the skin and subcutaneous tissue). Code sunburns to the L55.- category (Sunburn) and tanning bed burns to the L58.- category (Radiodermatitis).

Friction burns are considered abrasions, a separate type of injury. Codes for these wounds are found scattered throughout Chapter 19, grouped by body site as with codes for all other types of wounds.

Use the Rule of 9s to accurately code burns

Just like in ICD-9, you'll need to assign a code to indicate the extent of the body surface that was burned, and more specifically, affected by third degree burns.

Codes from the T31.- (Burns classified according to extent of body surface involved) and T32.- (Corrosions classified according to extent of body surface involved) categories indicate burns resulting from heat sources and chemicals, respectively.

Use what's known as the Rule of 9s to determine the total body surface area if this information is not already documented in the record. The Rule of 9s involves dividing up areas of the body in multiples of nine to help estimate total body surface percentages. Here's the breakdown for adults:

- Head and Neck (9%)
- Posterior Trunk (18%)
- Anterior Trunk (18%)
- Each upper extremity (9%)
- Each lower extremity (9%)
- Perineum (1%)

Tip: Don't assign a code from T31.- or T32.- unless the patient has suffered third degree burns or corrosions over 20 percent or more of his or her body.

Understand the role of seventh characters

New to the world of ICD-10 coding is the requirement to assign seventh characters for certain codes, such as injury codes. Burns and corrosions are no exception and thus coders must learn to appropriately assign seventh characters for these conditions.

There are three possible seventh characters to assign on burn and corrosion codes. These are:

- **A** for initial encounter
- **D** for subsequent encounter
- **S** for sequela

The seventh character "A" corresponds to initial treatment for the burn while "D" captures the care that is aimed at continued healing *after* the initial treatment phase has ended.

Uniquely, the seventh character "S" is used when the burn has healed but left behind a residual condition, such as a scar. "D" and "S" are the appropriate seventh characters for home health when coding burns.

When coding a sequela of a burn, code the residual condition (i.e. the scar) first and then the appropriate burn code with the "S" seventh character. Note that only the burn code receives the seventh character; the residual condition code does not.

Tips for coding burns correctly

Here are four more tips to help you get burns right in ICD-10:

- Read and heed all "code first" and "use additional code" notes. For example, T20.5- (corrosion of first degree of head, face, and neck) includes a note that tells the coder to "Code first (T51-T65) to identify the chemical and intent" (such as intentional, unintentional, etc.).

- Never assign a burn or corrosion code that corresponds to an unspecified degree, such as T25.012- (Burn of unspecified degree of left ankle). If you're treating the burn, you should know its degree, or you risk a claim denial.

• Code an infected burn as you would a non-infected burn, but include the code T79.8- (Other early complications of trauma) to indicate the presence of infection, as well as the code for infecting organism, such as B95.61 (Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere) if known. [*I.C.19.d.4*]

• Code a burn described as "non-healing" as an acute burn. For example, a third degree burn to the left forearm that is not healing would be coded with T22.312- (Burn of third degree of left forearm). [*I.C.19.d.3*]

Scenario: Burn from battery acid

A 59-year-old man was working in his machine shop when he accidentally spilled battery acid on his right thigh, causing a third degree burn over 15 percent of his body area. He's admitted to home health for daily wound care to his thigh.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Toxic effect of corrosive acids and acid-like substances, accidental (unintentional), subsequent encounter	T54.2x1D		
M023b: Corrosion of third degree of right thigh, subsequent encounter	T24.711D		

Rationale:

• The burn was caused by a corrosive chemical and should therefore be coded as a corrosion burn.

• The code identifying the chemical that caused the burn, T52.2x1D, must be coded first, according to tabular instruction.

• Because the third degree burns have not affected 20 percent or more of the patient's body, a code from the T32.- category isn't necessary.

Scenario: Scar from burn

A 68-year-old female developed an extensive scar on her left forearm after a second degree burn healed. The scar causes her severe pain and difficulty with mobility and completing ADLs/IADLs. She was admitted to home health for nursing care and occupational therapy. She also has peripheral vascular disease and chronic atrial fibrillation, for which she is on long-term anticoagulant therapy.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Scar conditions and fibrosis of skin	L90.5		
M1023b: Burn of second degree of left forearm, sequela	T22.212S		
M1023c: Peripheral vascular disease, unspecified	I73.9		
M1023d: Chronic atrial fibrillation	I48.2		
M1023e: Long term (current) use of anticoagulants	Z79.01		

Rationale:

• The burn, though healed, left behind a scar that is causing the patient significant distress. Therefore, the burn is coded with a seventh character "S" to indicate that it's healed but has caused a residual condition, or sequela.

• The residual condition, the scar, is coded prior to the injury that caused it, in accordance with coding guidelines.

• As comorbidities that will impact her ability to heal, her peripheral vascular disease and use of anticoagulants are coded as well.

Scenario: Staph sepsis from infected burns

A 54-year-old man is admitted to home health for continued treatment with IV antibiotics and wound care after he developed staph sepsis from infected second and third degree burns covering his entire back. He sustained the burns in a brush fire.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Sepsis due to unspecified staphylococcus	A41.2		
M1023b: Burn of third degree upper back, subsequent encounter	T21.33xD		
M1023c: Burn of third degree lower back, subsequent encounter	T21.34xD		
M1023d: Other early complications of trauma, subsequent encounter	T79.8xxD		
M1023e: Long term (current) use of antibiotics	Z79.2		
M1023f: Encounter for adjustment and management of vascular access device	Z45.2		

Additional diagnoses: X01.0xxD (Exposure to flames in uncontrolled fire, not in building or structure, subsequent encounter)

Rationale:

• As the focus of care, the sepsis caused by the infected burns is coded first.

• There is no code that captures that a patient's entire back has been burned. Therefore, two codes, one for upper back and one for lower back, are assigned to cover both areas.

• Though he sustained both second and third degree burns on his back, the most severe burns are coded when different degrees of burns affect the same body part.

• The burns became infected, which is a complication, and then caused sepsis. Therefore, code T79.8- should be assigned to capture the complication of trauma.

About the author: *J'non Griffin, RN, MHA, WCC, HCS-D, COS-C, BCHHC is the owner of Home Health Solutions, LLC, a full-service consulting firm. She is a 26-year veteran of home health and hospice, and has clinical specialties in wound and mental health nursing, in addition to coding and OASIS review expertise.*

? **Ask the Expert**

Code esophageal dysmotility and shingles nerve pain accurately

Question: A patient has a diagnosis of esophageal dysmotility. What is this and how do I correctly code it in ICD-10?

Answer: Code esophageal dysmotility with K22.4 (Dyskinesia of esophagus).

In ICD-10, esophageal dysmotility is classified under dyskinesia. To find this code, first look in the alphabetic index under "dyskinesia," then scroll to "esophagus." That will bring you to K22.4.

To understand the condition, it's important to have a basic knowledge of anatomy and physiology. First, the esophagus delivers food from the mouth to the stomach where the process of digestion begins.

To do this, the esophagus requires muscles to propel food from the esophagus into the stomach. Esophageal dysmotility occurs when the esophagus loses the ability to squeeze the food down to the stomach.

Question: My patient has severe nerve pain from having shingles. However, the shingles has been resolved for a while now. Is there a way to capture this condition in ICD-10?

Answer: In ICD-10, this condition is coded with B02.29 (Other post-herpetic nervous system involvement).

Neuralgia is the medical term for nerve pain and when it results from a shingles infection that has resolved, it is referred to as "post-herpetic neuralgia." Understand that shingles is a form of the herpes virus, hence the term "post-herpetic."

To find the correct code, first search the index under "neuralgia" and then to "post-herpetic NEC," which will lead you to B02.29.

Note that there's another code option, B02.22, under the term "trigeminal." However, that refers to a specific nerve and your description does not specify a particular nerve. Therefore, B02.29 is the correct code.

Post-herpetic neuralgia can last for months or even years after shingles resolves.

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.

Ostomy complications

For example, for the care of a cystostomy that is complicated by infection, first assign N99.511 (Cystostomy infection) and then a code to specify the infection, such as B95.61 (Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere), according to tabular instruction. .

Furthermore, take note that Z43.5 carries case-mix points, while codes from the N99.5- category do not. Thus, wrongly assigning an "attention to" code when you should be assigning a complication code could get you reimbursement to which you're not entitled.

Understanding ostomy complications and coding them correctly is imperative if you want to ensure that your records stay out of the hands of auditors, particularly as wound coding gets complicated and demands more detail and documentation in ICD-10.

Learn where complications are classified to find right code

Don't look for a complication of a colostomy code in Chapter 19 (Injury, poisoning and certain other consequences of external causes) or you'll come up empty-handed.

Even though many kinds of complications, such as surgical wound dehiscence, are classified to Chapter 19, ostomy complications are found in their individual body system chapters.

All colostomy, gastrostomy, enterostomy and esophagostomy complications are coded to category K94.- (Complications of artificial openings of the digestive system). This includes excoriation and denuding of the skin surrounding the ostomy, infection of the ostomy site, hemorrhage of the ostomy site, and other complications. The K94.- codes are found in Chapter 11 (Diseases of the digestive system).

No additional code should be used when coding skin complications unless an infection is present, in which case, an additional code should be used to specify the infection, according to tabular instructions.

Codes that specifically capture colostomy complications are found in the K94.0- subcategory. Other types of complications of ostomies of the digestive system include enterostomy (K94.1-), gastrostomy (K94.2-) and esophagostomy (K94.3).

Excoriation or denuding of the skin around the site of the colostomy is an example of a malfunction that would be coded to K94.03 (Colostomy malfunction), says Lisa Selman-Holman, HCS-D, principal of Selman-Holman & Associates and the coding service CoDR – Coding Done Right, in Denton, Texas.

Further, colostomies, enterostomies, gastrostomies and esophagostomies that are complicated by the presence of cellulitis should be captured first with the code for infection of the ostomy (such as K94.12, Enterostomy infection) followed by the code for the cellulitis, such as L03.311 (Cellulitis of abdominal wall), says Selman-Holman.

In an exception to the classification system, codes that describe mechanical malfunctions of a cystostomy device are captured with codes from Chapter 19, from the T83.0- category (Mechanical complication of urinary (indwelling) catheter).

Note that these codes are for complications involving the ostomy device, such as the tubing, and not the actual ostomy or opening into the body, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. An example might be suprapubic catheter (another term for a cystostomy) that keeps falling out of place.

Tip: Look to the documentation to determine which code category to assign for a patient's cystostomy complication, Twombly says. The description of the diagnosis should indicate whether the complication involves the opening or the device.

When to assign 'attention to' vs. status Z codes

When providing routine care to an ostomy, you'll need to assign a Z code to capture that care.

Don't assign a code from the Z43.- category (Encounter for attention to artificial openings) unless your agency is actively providing care to a patient's ostomy. On the other hand, if the patient has an ostomy but cares for it independently, a code from Z93.- (Artificial opening status) should be assigned.

You should be wary of assigning a Z43.- code for more than one episode. If the agency still is teaching on the care of the ostomy after the initial episode of care it may send a red flag to the Medicare Administrative Contactors (MACs). CMS does not consider ongoing routine care to an uncomplicated ostomy, beyond the initial observation and assessment period, a reimbursable skill, says Whitemyer.

With few exceptions, the patient and/or the patient's caregiver(s) should be able to take over the care of the ostomy fairly quickly, Whitemyer says. However, a status code from Z93.- may be used in subsequent episodes of care. (*See the Tool of the Month for more information on ostomy coding*)

More tips to get ostomy complication coding right

Here are four more tips to help guide your coding of ostomy complications and avoid upcoding and claims denials:

• **Don't assign a complication code and a status or 'attention to' Z code for the same ostomy on the same claim**, says Michelle Mantel, HCS-D, manager of system integration and coding analytics for Kindred at Home in Atlanta. A patient can have more than one type of ostomy (such as a gastrostomy for nutrition and a colostomy for elimination) but the care of the same ostomy can't be both complicated and routine at the same time.

• **Watch for inconsistences in how an ostomy is described in the documentation and how it is coded**.

For example, coder Pallavi Sheth, HCS-D, clinical coding coordinator for the VNA of Englewood, N.J., noticed that a clinician had coded a patient's ostomy as an ileostomy but described the waste products in the pouch as "malformed." Stool removed from an ileostomy, due to the placement of the ostomy in the body's digestive process, is usually liquid and thus describing it as "malformed" doesn't make sense; the stool wouldn't be "formed" at all. Thus, it's probable that the clinician meant to code it as a colostomy but simply mixed up the terms.

• **Don't code a complicated ostomy as a post-operative infection or a non-healing surgical wound**. Coding conventions stipulate that you must capture a diagnosis with the most specific code possible. Since there are unique codes for ostomy complications, you must assign those specific codes, Mantel says. [*I.A.2, 3*]

• **Never code an ostomy complication or the care of an ostomy with a code for an open wound**. Open wound codes refer only to trauma wounds, never to surgical wounds or ostomy openings, Mantel says. And, since open wound codes are eligible for such a high level of reimbursement, the misuse of them can easily lead to financial penalties.

Scenario: Colostomy, cellulitis

An 81-year-old woman was recently diagnosed with cellulitis around her colostomy site. She has had the colostomy for 10 years, following surgery for colon cancer, which was completely eradicated. She will receive wound care and medication management. She also has hypertension.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Colostomy infection	K94.02		
M1023b: Cellulitis of abdominal wall	L03.311		
M1023c: Essential (primary) hypertension	I10		
M1023d: Personal history of other malignant neoplasm of large intestine	Z85.038		

Rationale:

• The patient's colostomy is complicated and therefore a Z code for attention to or status is not appropriate. Rather, the code for a colostomy infection is assigned in the primary position.

• Because there is cellulitis at the site of the ostomy, code L03.311 is assigned immediately after the colostomy infection code.

• The patient has the colostomy as a result of colon cancer, which was eradicated. Therefore, the code for personal history of colon cancer is assigned.

Scenario: Mechanical complication of cystostomy, congestive heart failure

A 76-year-old man has a cystostomy as a result of a neurogenic bladder due to multiple sclerosis. However, the indwelling suprapubic catheter has been malfunctioning and keeps falling out. Skilled nursing is ordered to assess the catheter and assist with fitting. He also has acute systolic congestive heart failure.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Displacement of cystostomy catheter, subsequent encounter	T83.020D		
M102b: Other neuromuscular dysfunction of bladder	N31.8		
M1023c: Multiple sclerosis	G35		
M1023d: Acute systolic (congestive) heart failure	I50.21		

Rationale:

• The patient is experiencing a mechanical complication of the urinary device, versus a complication at the stoma site. Therefore, T83.020- is the most appropriate code.

• Code T83.020- requires a seventh character; "D" is appropriate for a home health admission.

• The neurogenic bladder is the condition necessitating the cystostomy and therefore it is coded immediately following the complication.

• As the condition causing the neurogenic bladder, as well as a complicating comorbidity, multiple sclerosis (G35) is coded as well.

• As a relevant comorbidity, 150.21 is assigned to capture the patient's acute systolic congestive heart failure. Note that the non-essential modifier "(congestive)" means that the code also captures the congestive element of the patient's heart failure; no additional code is required.

— *Megan Gustafson (mgustafson@decisionhealth.com)*

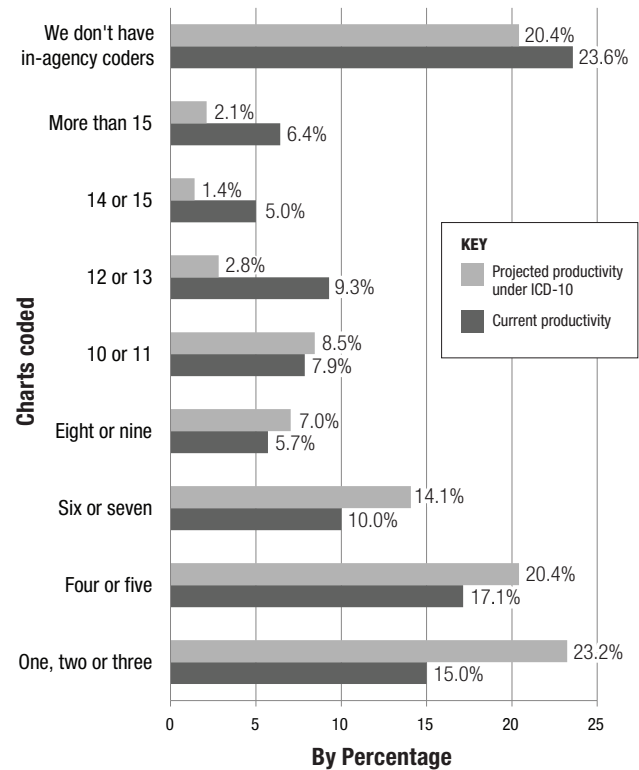# Hypertension

(continued from p. 1)

to a code that is shown in parentheses, and may be listed in the code title or in the Includes notes attached to the code.

A non-essential modifier refers to any of the terms in parentheses that can be, but don't have to be, part of the diagnosis captured by the code in order for the code to be assigned. [*I.A.7*]

In short, because of these non-essential modifiers, code I10 covers all three hypertension codes that were available in ICD-9 (401.0, Essential hypertension, malignant, 401.1, Essential hypertension, benign and 401.9, Essential hypertension, unspecified).

Number of charts coders complete in a day expected to plummet in ICD-10

Nearly 10% of home health agencies' coders complete between 12 and 13 charts a day currently. But, less than 3% of agencies expect their coders to be able to complete that many after the implementation of ICD-10, according to the 142 respondents on DecisionHealth's 2015 Productivity Survey.

KEY
Projected productivity under ICD-10
Current productivity

Charts coded	Projected productivity under ICD-10	Current productivity
We don't have in-agency coders	20.4%	23.6%
More than 15	2.1%	6.4%
14 or 15	1.4%	5.0%
12 or 13	2.8%	9.3%
10 or 11	8.5%	7.9%
Eight or nine	7.0%	5.7%
Six or seven	14.1%	10.0%
Four or five	20.4%	17.1%
One, two or three	23.2%	15.0%

By Percentage

Source: DecisionHealth's 2015 Productivity Survey

These changes likely occurred because benign, malignant and unspecified hypertension are all forms of "essential hypertension" for which the cause is largely unknown and the treatment is pretty much the same, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

Coders no longer have to worry about whether they have a specific diagnosis of benign or malignant hypertension as those are now outdated terms that no longer apply, says Brandi Whitemyer, HCS-D, product specialist for DecisionHealth in Gaithersburg, Md.

Coding hypertensive conditions: When to assume a relationship

Hypertension and conditions caused by hypertension are captured by codes found in Chapter 9 (Diseases of the

circulatory system) in the Hypertensive diseases category. Here you'll find the all-encompassing hypertension (I10), hypertensive heart disease (I11.-), hypertensive chronic kidney disease (I12.-), hypertensive heart and chronic kidney disease (I13.-) and secondary hypertension (I15.-). (*See the Tool of the Month for a hypertension crosswalk*)

You'll need physician confirmation to code a patient with heart disease and hypertension as having hypertensive heart disease, according to coding guidelines. If a connection is not stated, code the conditions separately. This rule mirrors the guidelines of ICD-9. [*I.C.9.a.1*]

If a patient has a heart condition classified either to the I50.- category (Heart failure) or to a code between I51.4 (Myocarditis, unspecified) and I51.9 (Heart disease, unspecified) along with a diagnosis of hypertension and **the physician explicitly specifies a causal relationship between the two**, they can be captured with a combination code from the I11.- (Hypertensive heart disease) category, according to coding guidelines. [*I.C.9.a.1*]

Look for phrases in the documentation such as "hypertensive heart disease" or "heart disease due to hypertension" as clues that it's appropriate to assign a code from I11.-, says Jean Bird, HCS-D, utilization review supervisor for the Mid-Atlantic region at Gentiva in Fall River, Mass.

Conversely, a patient with diagnoses of hypertension and chronic kidney disease (CKD) should be coded as having hypertensive chronic kidney disease (I12) regardless of whether the physician has specifically stated that a causal relationship exists; the conditions can be assumed to be connected, according to coding guidelines. This assumption also existed in ICD-9. [*I.C.9.a.2*]

You need to assign an additional code from category N18.- (Chronic kidney disease) to identify the stage of the CKD, according to coding guidelines. For example, a patient with a diagnosis of stage 3 hypertensive chronic kidney disease would be coded first with I12.9 (Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease) and then with N18.3 (Chronic kidney disease, stage 3 (moderate)). [*I.C.9.a.2*]

If a patient is described as having hypertensive heart **and** chronic kidney disease, assign a code from category I13.- (Hypertensive heart and chronic kidney disease), followed by a code from the N18.- category to identify the stage of the CKD. If a patient has documented hypertensive heart disease and chronic kidney disease, you may assume a connection and code

Agencies using GEMs to code breast cancer could lose $40 per episode

Agencies planning to rely upon the general equivalency mappings (GEMs) could wind up costing themselves a lot of money in ICD-10.

For example, the GEMs map the ICD-9 code for breast cancer, 174.9 (Malignant neoplasm of breast (female), unspecified) to the non-specific C50.919 (Malignant neoplasm of unspecified site of unspecified female breast). That doesn't carry case-mix points. But more appropriate codes in the same category that specify right or left breast, C50.911 (Malignant neoplasm of unspecified site of right female breast) and C50.912 (Malignant neoplasm of unspecified site of left female breast), do and would lead your agency to receive $39.61 more in reimbursement per episode, according to Seattle-based National Research Corporation.

The data are based on 6,378 standard episodes in 2014 that had ICD-9 code 174.9 as a primary, other or payment diagnosis.

	Mapped to non-specific breast cancer code (C50.919), no points received	Mapped to specific breast cancer codes (C50.911, C50.912) points received	Difference
Case weight per episode	0.9514	0.9655	0.0141
Reimbursement per episode	$2,799.15	$2,838.76	$39.61

Source: National Research Corporation, Seattle

it as hypertensive heart and chronic kidney disease, according to coding guidelines. [*I.C.9.a.3*]

Focus of care guides secondary HTN sequencing

Sequence the condition causing a patient's secondary hypertension before the secondary hypertension code if the causal condition is the focus of care. Do the opposite if the secondary hypertension is the focus of care, according to coding guidelines. [*I.C.9.6*]

Secondary hypertension is hypertension that's been caused by an underlying disease process. There are five unique codes for various forms of secondary hypertension, including renovascular hypertension (I15.0), hypertension secondary to endocrine disorders (I15.2) and unspecified secondary hypertension (I15.9).

Renal artery stenosis is usually the underlying cause of the secondary hypertension that Vonnie Blevins sees. Brain cancer is another possible underlying condition, says Blevins, HCS-D, coding and billing manager for Excellence Healthcare in Houston.

Note that two codes are required to fully capture secondary hypertension: the code for the underlying

OASIS Q&A: ICD-10 does not change rules governing secondary diagnoses

Assign in M1023 secondary diagnoses that are actively being addressed in the plan of care as well as diagnoses that will affect how patients will react to treatment and their prospects for recovery, *even if* the conditions are not the focus of home care, according to CMS' July 2015 OASIS Q&As.

The guidance governing how to assign secondary diagnosis codes in ICD-10 is not new, it's precisely what was contained in the old Appendix D which retired with ICD-9, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md.

While a document called Appendix D is contained in the OASIS-C1/ICD-10 guidance manual, which takes effect Oct. 1, it's currently blank, save for a statement saying it's being saved for future expansion. All relevant coding guidance is now included in the coding items, according to the guidance manual.

This guidance likely prompted the question of how to approach secondary diagnoses in an ICD-10 environment, Twombly says.

Additionally, the OASIS-C1/ICD-10 guidance manual instruction on M1025 (Additional diagnoses) confirms that coding resolved conditions there directly across from Z codes assigned in M1021/M1023 is *optional* and at the agency's discretion but does not impact payment or risk adjustment.

Editor's note: You may view the July 2015 OASIS Q&As at http://www.oasisanswers.com/aboutoas_links.htm#qAndA.

diseases and the code for the secondary hypertension, according to coding guidelines. [*I.C.9.6*]

For example, secondary hypertension caused by renal artery stenosis, in which the secondary hypertension is focus of care, would be coded first with I15.0 (Renovascular hypertension) and then with I70.1 (Atherosclerosis of renal artery).

Tips for getting hypertension coding right

Here are three more tips for ensuring that your hypertension coding is in compliance in ICD-10:

Tip: Don't use I10 with a code from N18.- for a patient documented as having hypertension and chronic kidney disease, says Blevins. The hypertension in this case must be captured with I12.- and then followed with the appropriate N18.- code.

Tip: Sequence I12.- (Hypertensive chronic kidney disease) first, and then assign the appropriate code from N18.- (Chronic kidney disease), according to coding guidelines. Some coders think that the sequencing to these conditions is dependent on the focus of care, but that's not true, Twombly says. Guidelines stipulate that the hypertension must always be coded first. [*I.C.9.2*]

Tip: Don't underestimate the importance of coding a diagnosis of hypertension; it should always be coded if physician documentation supports it. Blood pressure is an important vital sign that is measured at every patient visit. When it's too high, it can affect many body systems and organs including the cardiovascular system, the kidneys and eyes, potentially leading to many serious diseases such as kidney failure, retinopathy and cardiomyopathy, Bird says.

Scenario: CABG, hypertension

A 79-year-old man underwent a triple bypass procedure to treat a diagnosis of coronary artery disease (CAD). He'd never had bypass surgery before. His recovery is going well and he was admitted to home health for routine surgical aftercare. He also has a diagnosis of hypertension.

Code the scenario:

Primary and Secondary Diagnoses		M1025 Additional diagnoses	
M1021a: Encounter for surgical aftercare following surgery on the circulatory system	Z48.812		
M1023b: Atherosclerotic heart disease of native coronary artery without angina pectoris	I25.10		
M1023c: Essential (primary) hypertension	I10		
M0123d: Presence of aortocoronary bypass graft	Z95.1		

Rationale:

• An admission to home health for routine surgical aftercare following a CABG procedure is captured with Z48.812. As the focus of care, it's coded in M1021.

• The surgery was performed to manage the CAD, but did not resolve it. Therefore, it is coded as an active condition. Because he'd never had a bypass before, the CAD is affecting his native arteries and it thus captured with I25.10 as there's also no mention of angina.

• The patient has a diagnosis of hypertension that has the potential to impact his recovery and plan of care. Thus it is coded as well.

• The status code Z95.1 is added to capture the presence of the bypass graft.

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

Ostomy Coding Tool

Use this straightforward coding tree to help you accurately code scenarios involving ostomies.

```
                        ┌─────────────────────┐
                        │  Coding of Ostomies │
                        └─────────────────────┘
                                   │
        ┌──────────────────────────┼──────────────────────────┐
┌───────────────┐         ┌───────────────┐          ┌───────────────┐
│Current treatment│        │  Complication │          │  Status (post)│
└───────────────┘         └───────────────┘          └───────────────┘
        │                          │                           │
```

Current treatment	Complication	Status (post)
Reference *Attention to* and assign code for correct type of ostomy for current care/ instruction to ostomy. Skilled services caring for an ostomy means coding from the Z43.- category.	Reference *Complication* or type of complication (i.e. infection) in the Index and choose correct ostomy. Assign the code. Do not assign a Z code!	Reference *Status (post)* and assign a code from category Z93.- for presence of ostomy that requires no attention or care by skilled services.

- Only use Z43.- when skilled services are working with the ostomy.

- As a general rule, do not use Z codes with complications. Do not use the Z93.- category or the Z43.- category when coding a complication, including an infection to an ostomy.

- Status of ostomy means the agency isn't providing care. If the patient or caregiver, but NOT the agency, is taking care of the ostomy, Z93.- is the proper category.

Source: Originally created by Rita McNasby, CCS, HCS-D, manager of medical records for Virtua Home Care in Mount Laurel, N.J. Used with permission.

Hypertension ICD-10 Crosswalk

Use this crosswalk to help guide you understanding how hypertension coding has changed from ICD-9 to ICD-10.

ICD-9	ICD-10
401 Essential HTN	I10 – Essential (primary) hypertension includes: high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
401.0 Malignant HTN	
401.1 Benign HTN	
401.9 HTN, unspecified	

Hypertensive Heart and Chronic Kidney Disease

Description	ICD-9	ICD-10
Malignant without heart failure and with chronic kidney disease stage I through IV, or unspecified	404.00	I13.10
Malignant with heart failure and with chronic kidney disease stage I through IV, or unspecified	404.01	I13.0
Malignant without heart failure and with chronic kidney disease stage V or end stage renal disease	404.02	I13.11
Malignant with heart failure and chronic kidney disease stage V or end stage renal disease.	404.03	I13.2
Benign without heart failure and with chronic kidney disease stage I through IV, or unspecified	404.10	I13.10
Benign with heart failure and with chronic kidney disease stage I through IV, or unspecified	404.11	I13.0
Benign without heart failure and with chronic kidney disease stage V or end stage renal disease	404.12	I13.11
Benign with heart failure and chronic kidney disease stage V or end stage renal disease.	404.13	I13.2
Unspecified without heart failure and with chronic kidney disease stage I through IV, or unspecified	404.90	I13.10
Unspecified with heart failure and with chronic kidney disease stage I through IV, or unspecified	404.91	I13.0
Unspecified without heart failure and with chronic kidney disease stage V or end stage renal disease	404.92	I13.11
Unspecified with heart failure and chronic kidney disease stage V or end stage renal disease.	404.93	I13.2