ICD-10 Coding for Home Health and Hospice

A Field Clinician's Guide to Coding

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Objectives

- Identify why coding is important in HH and Hospice
- Define coding guidelines
- Provide guidance to staff regarding what information is must be provided to the QI/coding staff to ensure accurate and specific coding

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Coding Facts

- Coding contributes to the:
  - Patient's Plan of Care
  - Correct Reimbursement
  - Risk adjustment and outcomes
- Establishes Medical Necessity
  - LCD's and NCD's further dictate what should be coded under certain circumstances

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Hospice Coding Issues

- Hospice Item Set (HIS)
- Correctly identifying the terminal illness
- Correctly identifying and coding related diagnoses (also coding unrelated diagnoses)
- Avoidance of prohibited primary diagnoses

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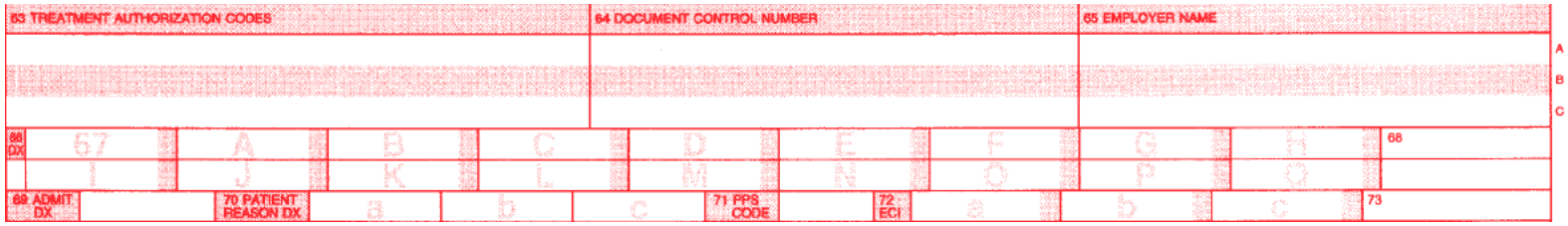
What is coding?

- Coding is assigning a code for a diagnosis
  - CHF I50.9
- Codes are required on the OASIS/HIS, POC and on claims, although only the numbers show on a claim.
  - Electronic claim takes 25 diagnoses but only top 6 determine payment/RA
- Codes have to match on all documents



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Eligibility and Coverage

Home Health

- Primary reason for home care
- All other diagnoses that impact care (any comorbid conditions that have the potential to affect the patient's responsiveness to treatment and rehab prognosis, even if the condition is not the focus of any home health treatment itself). For example, DM and CAD should always be coded.

Hospice

- Terminal diagnosis
- Conditions related to the terminal diagnosis (not all diagnoses the patient has). Generally this aligns with med coverage.
- And the unrelated diagnoses too!

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Payment

Home Health

- Per episode
- Case mix system based partially on diagnoses used- some diagnoses earn us reimbursement while others do not

Hospice

- Per day
- Care for the terminal diagnosis and related diagnoses must be covered by the hospice (visits, meds, treatments, etc.)

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Communication

- Diagnoses must be confirmed by the physician
  - Can be documented in office visits, hospital records, H&P's, confirmed by phone- this information can and should be obtained at the point of intake as much as possible.
- Undocumented diagnoses (for example the patient says they have something, or the clinician deduces based on assessment that the patient has a particular diagnosis) must be verified by the physician prior to being coded
- Assessing clinician must decide order of diagnoses for the POC, based on their completion of the comprehensive assessment and understanding of the patient's overall medical condition. Diagnoses will be assigned to reflect what we will be addressing with the patient. This information is provided to the coder to assign the codes.

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You may need to...

- Following the assessment, you may need to communicate with the physician to clarify diagnoses, or confirm suspected diagnoses.
  - Confirm the specific type of wound- i.e. pressure, arterial, stasis, diabetic, or chronic. With or without complications/infection?
  - Confirm the type and locations of tumors- i.e. primary malignancy vs metastesis and location
  - Verify related conditions (hospice) and secondary diagnoses (home health)
  - Look for documentation to determine if assumed manifestations apply- i.e. is retinopathy or neuropathy related to (a manifestation of) DM

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M1011 Inpatient Diagnosis

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility) ***[Omit "NA" option on SOC, ROC]***

- "Actively treated" should be defined as having something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.
- No surgical codes- list the underlying diagnosis that was surgically treated. For example, if patient had a joint replacement surgery, you should ask to have the underlying OA or DJD coded that was the reason for the surgery.

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M1011 Inpatient Diagnoses

- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption/Follow-Up (M0090) date assessment completed.
- The assessment date is day 0 and the day immediately prior is day 1

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M1017 Changed Diagnoses

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

- M1011 and M1017 will be the same when the conditions in M1011 are:
  - New or exacerbated
  - Required changes to the treatment regimen

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M1017 Changed Diagnoses

- Identifies if any changes have occurred to the patient's treatment regimen, health care services or meds in the last 14 days.
  - New, changed, or exacerbated diagnoses
  - New, changed medications
  - New, changed treatments
  - If we cannot answer the questions "what has changed with the patient in the last 14 days that they now need home care?" the patient may not be appropriate for services.

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M1021/1023/1025 Diagnoses

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)

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M1021/1023/1025 Diagnoses

- M1021 Primary Diagnosis
  - Chief reason the patient is receiving home care and the diagnosis most related to the current home health POC
- M1023 Other Diagnoses
  - Comorbid conditions that exist at the time of the assessment that are actively addressed in the patient's POC, or that have the potential to affect the patient's responsiveness to treatment and rehab prognosis, even if the condition is not the focus of home health treatment itself

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M1025 Optional Diagnoses

- M1025 Optional Diagnoses- used to provide the agency with the option of documenting a resolved underlying condition in columns 3 and 4 if a Z code is reported as a primary or secondary diagnosis in columns 1 and 2
  - For example, patient had a hip replacement and after care of joint replacement surgery is coded primary in column 1 (a Z code)- the OA, DJD, fracture, etc. the caused the replacement could be coded in M1025
- NOT for payment
- CMS says it *may* be used for RA, but not currently being used

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M1021/1023

- Only current diagnoses should be reported
- Diagnoses should not be reported if they are resolved or do not have the potential to impact the skilled services provided by the HHA
  - Cholecystitis is resolved after having a cholecystectomy- would not be coded
  - Hypothyroidism controlled by meds x10 years probably will not impact patient's HH services
- Diagnoses may change during the course of the patient's home health episode, however they should reflect the patient's current medical conditions *at the time of the assessment*.

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M1021/M1023 Symptom Control

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

- Assessing degree of symptom control includes:
  - Review of the presenting s/s
  - Type and number of meds
  - Frequency of treatment adjustments
  - Frequency of contact with health provider/inpatient stays
- Primary diagnosis should never be listed as "0" or "1"- what are we seeing the patient for if they are asymptomatic or well-controlled?

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Coding Guidelines

- Specific rules and guidelines approved by the AHA, AHIMA, CMS and NCHS exist that dictate coding at times ("coding conventions and guidelines")
- Some codes are not appropriate for the home health/hospice settings (acute codes, initial encounters)
- Some diagnoses require that additional things must be coded (i.e. if a patient is diabetic and insulin dependent)
- Some diagnoses illustrate a "cause and effect relationship", where we muse code the etiology (cause) first, and the manifestation (effect) second, even if we are focusing on the manifestation

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Unspecified

- "Unspecified" codes are used when the information in the medical record is insufficient to assign a more specific code
- If more specific information is available, unspecified or NOS (not otherwise specified) codes should not be used.
- Sometimes, by using the more specific code we get additional reimbursement.

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Laterality

- For anything that your body has two of, you must specify laterality (or if bilateral)
  - M16.ø Bilateral primary OA of hip
  - M16.11 Unilateral primary OA, right hip
  - Z90.11 Acquired absence of right breast

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Sequencing

- Primary reason for home care (using conventions and guidelines)
- Other diagnoses in order of importance to the POC
- Z codes can be used first if primary purpose of care. If not primary, push to the bottom of the list.

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Sequencing in Hospice

- Terminal Illness (using conventions and guidelines)
  - May take more than one diagnosis to code
- Related conditions in order of importance to POC
- Unrelated diagnoses
- Z codes never primary

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Sequencing

- F02.80 dementia in other disease classified elsewhere..
- Coding guidance tells you code the underlying physiological condition first, such as Alzheimer's or Parkinson's
- So… this would be coded as:
  - Alzheimer's dementia G30.9 ← *Underlying Cause*
  - Dementia in other diseases classified elsewhere F02.80
- Another example:
  - Type 2 DM with foot ulcer E11.621 ← *Underlying Cause*
  - Non-pressure ulcer of left heel and midfoot limited to breakdown of the skin L97.421

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Sequencing

- Two codes are also normally used for infectious diseases
  - Infectious disease coded first (UTI, pneumonia, bacteremia, acute cystitis, etc.)
  - Organism coded second (MRSA, E Colia, Streptococcus, etc.)

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Combination Codes

- A single code used to classify
  - Two or more diagnoses *or*
  - A diagnosis with an associated secondary process *or*
  - A diagnosis with an associated complication
- Examples:
  - I69.351 hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
  - I12 Hypertensive kidney disease
  - N18.6 ESRD

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Infectious/Parasitic Diseases

- Only appropriate to code if patient has current infection (s/s infection, on antibiotics)
- What information does the coder need?
  - Location of infection
  - Infectious organism (if known)
  - Drug resistance
  - Related pain, fractures or anemia?
- Examples:
  - T81.4xxA Postoperative wound infection
  - B95.61 Staph aureus
  - N39.0 UTI, site unspecified
  - B96.20 E.Coli unspecified
  - J15.212 Pneumonia due to MRSA

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Neoplasms and Blood Disorders

- Tips
  - Still code neoplasm after surgery to remove cancer unless confirmed that all was removed
  - May need to code history of cancer if it was recent and has the potential to impact current home health care
  - A mass is not a neoplasm
- What information does the coder need?
  - Location of cancer, including laterality if applicable
  - If neoplasm is benign, potentially malignant (pre-cancer), or malignant (cancer)
  - Primary and secondary sites; primary site can be gone and the patient can continue to have cancer in secondary sites (code secondary site and history of primary site)
- Example:
  - C34.31 CA of right lower lobe of lung
  - C77.1 Mets to intrathoracic lymph nodes
  - C79.31 Mets to brain
  - C79.51 Mets to bone

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Endocrine, Metabolic and Nutritional

- What does the coder need to know?
  - Diabetes category- d/t underlying condition, d/t drug or chemical, type I, type II, other specified DM (absence of pancreas, pancreatic CA, etc.)
  - Complications- renal, ophthalmic, neurological, circulatory, other (arthropathy, skin, oral, hypoglycemia, hyperglycemia and other)
  - Insulin use must be coded!

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Endocrine, Metabolic and Nutritional

- Examples:
  - E09 Diabetes as an adverse effect of steroids with hyperglycemia
  - E11.621 Diabetic foot ulcer on toes (right foot)
  - L97.519 Non-pressure chronic ulcer
  - C25.9 Pancreatic CA
  - E89.1 Postprocedural hypoinsulinemia
  - E13.9 Other specified diabetes
  - Z90.410 Absence of pancreas
  - Z79.4 LTU Insulin

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Mental and Behavioral

- Tips
  - Cannot use vascular dementia in HH or hospice as it occurs as a result of infarction of the brain d/t vascular disease. Code the underlying condition first! (see example below)
- What does the coder need to know?
  - Use and/or abuse and/or dependence
  - Dementia type- senile (Alzheimer's, Vascular, Parkinson's, Lewy Body), presenile
  - Behavior changes
- Examples
  - G30.0 Early onset Alzheimer's
  - F02.81 Dementia in other diseases classified elsewhere with behavior changes
  - Z91.83 Wandering

  - I69.31 Cognitive deficits following cerebral infarction
  - F01.50 Vascular dementia

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Nervous System

- Tips
  - Cannot code acute stroke- the acute event has resolved by the time the patient is home. HH/Hospice code the "late effects" of the event.
- What does the coder need to know?
  - Late effects
  - Laterality/upper vs. lower limb
  - Dominant side vs. non dominant side
  - Was stroke thrombotic or hemorrhagic?
- Example:
  - I69.351 hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
  - I69.391 Dysphagia following cerebral infarction

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Circulatory System

- Tips
  - Be specific! (Congestive, systolic, diastolic, left, right, specify valve)
  - Two different codes used depending on if MI was within the last 4 weeks or if it has been greater than 4 weeks. Specify date of MI.
  - Are all arteries native, or has the patient had a graft in the past?
- Examples:
  - I11.0 Hypertensive heart disease with heart failure
  - I50.32 Chronic diastolic (congestive) heart failure
  - I12.0 Hypertensive CKD with ESRD
  - N18.6 ESRD
  - Z99.2 Dialysis status
  - I50.1 L ventricular failure

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Circulatory System

- Examples, cont.
  - I25.10 Atherosclerotic heart disease of native coronary artery without angina
  - I25.2 Old healed MI (>4wks)
  - I25.110 AHD with unstable angina
  - I21.19 MI other coronary artery inferior wall (within 4 wks)
  - I22.0 MI of anterior wall
  - Z79.899 Other LT (current) drug therapy (on new cardiac meds)

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Respiratory System

- What does the coder need to know?
  - With or without exacerbation
  - With or without respiratory infection (if *with* infection, identify organism)
- Examples:
  - J44.0 COPD with lower respiratory infection
  - J18.9 Pneumonia
  - (organism if specified)
  - J44.1 COPD with (acute) exacerbation
  - J44.9 Emphysema with chronic (obstructive) bronchitis (no exac.)

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Skin and Subcutaneous

- Tips
  - You are assessing the wound, so it is not acceptable to not have the following info! If unable to assess the wound at SOC d/t ordered wound care, the same clinician should go back to assess the wound within the 5 day window.
- What does the coder need to know?
  - Type, specific location (including laterality) and severity/stage of wound
    - Pressure ulcer stage
    - Non PU severity (skin breakdown, fat layer exposed, necrosis of muscle, necrosis of bone)
    - Burn degree
  - Infected?
  - Is this a complication of a surgical wound?

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Skin and Subcutaneous

- Examples:
  - I96 Gangrenous cellulitis
  - L89.623 Pressure ulcer of left heel, stage 3
  - L89.612 Pressure ulcer of right heel, stage 2
  - I70.242 Atherosclerosis of native arteries of left leg with ulceration to calf
  - L97.221 Non pressure ulcer of left calf limited to skin

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Musculoskeletal

- Tips
  - Do not code condition (arthritis, DJD, etc.) if removed by joint replacement and patient does not have elsewhere
- What does the coder need to know?
  - Traumatic or Pathologic
  - Closed, displaced, or open
  - Location (be specific!)
  - Routine or delayed healing
  - Corrected by surgery? If so- underlying condition that caused surgery

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Musculoskeletal

- Examples:
  - M80.08xD Age related osteoporosis with current pathological fracture, vertebra
  - S72.001D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing
  - W05.0xxD Fall from wheelchair
  - Z47.1 Aftercare following joint replacement surgery
  - (reason for joint replacement [fracture or OA/DJD] would be coded only as an inpatient diagnosis, unless patient has OA in other body parts
  - Z96.641 Presence of right artificial hip joint

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S&S, Abnormal Clinical/Lab Findings

- Tips
  - Do NOT code when the symptom is routinely associated with the condition (i.e. don't code dyspnea when COPD has already been coded)
  - Code it when the patient has a symptom not commonly associated with a condition (i.e. hemoptysis with PNA)
  - Can be used when a definitive diagnosis is not confirmed yet, however, this does not always support the need for home care if we cannot address the etiology!

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S&S, Abnormal Clinical/Lab Findings

- Examples:
  - R29.6 Repeated falls (the reason for the fall is being investigated)
  - Z91.81 History of falling (for use when a patient has fallen in the past and is at risk for future falls)
  - R42 Dizziness
  - N40.1 BPH with LUTS
  - R31 Hematuria
  - R33 Retention of urine
  - R26.9 Unspecified abnormalities of gait

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Other things we need to know…

- Ostomy
- Trach

HHA required to provide supplies

- IV
- Specific meds
  - Chemo, Insulin, IV Antibiotics, Anticoagulants
- Dependence on oxygen
- Absence of organ or limbs
- Vision loss (legally blind)
- Hearing loss

Both can impair patient's ability to reach goals

- Foley

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Other things we need to know…

- Type of arthritis
- Dysphagia phase
- Head injuries- did patient lose consciousness? For how long?
- GI bleed is an acute condition that should not be coded
- Specific location, location, location!

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Potential Impact

Wrong	Right
I10 Essential (primary) HTN	I12.0 Hypertensive CKD with Stage IV CKD $$$
N15.8 CKD, Stage 5	N18.5 CKD, Stage 5

Wrong	Right
E11.9 Type 2 Diabetes without complications $$$	E11.43 Diabetes mellitus with diabetic polyneuropathy $$$
C62.9 Polyneuropathy, unspecified	E11.621 Type 2 Diabetes mellitus with foot ulcer $$$
L97.401 Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin	L97.411 Non-pressure ulcer of right heel and midfoot limited to breakdown of skin $$$
	Z79.4 LTU Insulin

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Questions?

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