

Diagnosis Coding Pro For Home Health

ICD-10 coding and training answers for accurate OASIS, 485 and UB-04 completion to ensure full reimbursement



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FY2022 final codes

Codes to capture post COVID-19 condition, depression NOS, finalized in update

Despite being absent from the codes listed in the April proposed code update, **U09.9** (Post COVID-19 condition, unspecified) was included as part of the 159 new codes finalized to be added to the ICD-10 code set on Oct. 1.

This code — which was proposed for implementation at the March ICD-10 Coordination and Maintenance meeting — will be used to capture post COVID-19 conditions — or cases when a patient continues to have lingering symptoms after the infection is gone.

In addition to the 159 new codes, the final code update also includes 20 revised codes and 32 codes deemed invalid. The update also included several changes to Tabular instructions — the majority of which involved changing Excludes 1 notes to Excludes 2 notes. The change to an Excludes 2 note means it is acceptable to use both the code and the excluded code together, when appropriate.

The FY2022 addenda was posted to the CDC's website June 23.

Coders welcome COVID-19 code

This new code is not to be used in cases that are still presenting with active COVID-19. However, an exception is made in cases of re-infection with COVID-19, occurring with a condition related to prior COVID-19, according to the FY2022 Tabular addenda.

Coders should list U09.9 secondary to specific codes for lingering conditions such as chronic respiratory failure (**J96.1-**), loss of smell (**R43.8**), loss of taste (**R43.8**), multisystem inflammatory syndrome (**M35.81**), pulmonary embolism (**I26.-**) and pulmonary fibrosis (**J84.10**), according to new tabular instructions for the code. The code takes the place of assigning B94.8, Sequela of other infectious and parasitic diseases, to identify residual conditions due to COVID-19.

Coders and industry experts alike expressed excitement over the inclusion of this code.

“So many times patients have residuals from COVID-19 and there was no code to capture this,” says Sherri Parson, HCS-D, post-acute education senior manager with McBee Associates Inc. of Wayne, Pa.

However, home health coders will still need to watch [in instances where] these residuals are the focus of care that the residual is a valid primary diagnosis, advises Parson.

New code for depression, unspecified

A new code to capture depression — **F32.A** (Depression, unspecified) — was included in the proposed codes, and made it into the final codes, piquing the interest of experts.

“I was happy to see the addition of depression NOS, as it is much more clinically accurate rather than assigning these patients a ‘major depressive disorder’ code,” says Parson. “Major depressive disorder has specific clinical criteria and an unspecified depression may not meet those criteria.”

“**F32.9** (major depressive disorder, single episode, unspecified) is what we use now, but it didn’t sound applicable to what we were doing,” says J’non Griffin, HCS-D, owner of Home Health Solutions — a SimiTree Coding Company based in Hamden, Conn. “Depression, unspecified will be a better code.”

Notable tabular update for hypertension

A notable tabular change was finalized involving how to code for the presence of hypertension.

CDC finalized a revision under codes I20-I25 that will delete the current “**use additional code**” note to identify the presence of hypertension and replace it with “**code also** the presence of hypertension (I10-I16).”

Remember, a “code also” note instructs that two codes may be required to fully describe a condition, *but* this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.

Industry experts were happy to see this change.

“I think many of us will see this as a welcome change,” says Parson. “The ‘use additional code’ note that is currently present gives coding sequencing guidance. By changing this to ‘code also’ note, we will move away from sequencing guidance.”

Currently, codes associated with category I20-I25 are directed to follow a sequencing rule requiring any condition included in this range of codes to precede any hypertension diagnosis, explains Nanette Minton, HCS-D, senior clinical coding manager with MAC Legacy in Denton, Texas.

“This is particularly challenging when a patient has — for example — an old MI or both CAD and hypertension or CAD and heart failure,” she says. “You are required to code old MI or CAD prior to the I10-I16 category.”

Social determinants can help

Several new codes to capture various social determinants of health (SDOH) were added in the final update, including Z55.5 (Less than a high school diploma), Z58.6 (Inadequate drinking-water supply) and Z59.00 (Homelessness unspecified).

“Having these codes will help with tracking these specific SDOH and their effects on patients,” says Parson. Many of these codes represent patients who with have deficiencies nutritionally, as well as the inability to focus on health concerns when their basic needs are not met. These codes help with care planning for those patients.

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“There are changes ranging from an expansion in problems related to education and literacy to problems related to housing and economic circumstances, as well as the separation of categories on lack of adequate food and safe drinking water,” adds Minton. “These changes, along with many others in this chapter, help the industry paint the best picture regarding the specific circumstances affecting each individual patient.”

We know individual social determinants have an effect on goals and outcomes, Minton adds.

“The expansion and addition to these categories will also prepare home care providers for thinking through the social determinant health categories that will be part of the new OASIS-E scheduled for post pandemic,” she says.

Other notable code changes

- Coders will also find 12 new codes that describe poisonings, adverse effects and underdosing for synthetic cannabinoids. For example, **T40.721A** (Poisoning by synthetic cannabinoids, accidental (unintentional), initial encounter) and **T40.725A** (Adverse effect of synthetic cannabinoids, initial encounter). These codes will replace the current codes in category T40.7X- (Poisoning by, adverse effect of and underdosing of cannabis (derivatives)), which are deemed invalid in the FY2022 update.
- The final update also includes eight new codes to further capture irritant contact dermatitis including **L24.A1** (Irritant contact dermatitis due to saliva) and **L24.B0** (Irritant contact dermatitis related to unspecified stoma or fistula).
- Chapter 13 accounts for 20 code changes, including an expansion of the category for Sjogren syndrome (**M35.0-**) and a new series of codes for non-radiographic axial spondyloarthritis (**M45.A-**). The diagnosis code for low back pain (M54.5) has been expanded to distinguish vertebrogenic low back pain (**M54.51**) from other types.

Six new codes to add specificity to coughs (**R05**), including acute (**R05.1**), subacute (**R05.2**), chronic (**R05.3**), cough syncope (**R05.4**), other specified (**R05.8**) and unspecified (**R05.9**).

Notable changes to coding guidelines

Here are some notable changes in the FY2022 coding guidelines for home health — released July 12:

- **Diabetes.** A revision was made to coding guidelines for diabetes mellitus/secondary diabetes mellitus and use of insulin, oral hypoglycemics and injectable non-insulin drugs. The revised guideline states that “if the patient is treated with both oral medications and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.” This will replace the current, long-standing guidance that states to only code the insulin.
- **Unstageable pressure ulcers.** A new guideline was added for unstageable pressure ulcers which states that if during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.
- **Laterality.** A new guideline was added to state that, “when laterality is not documented by the patient’s provider, code assignment for the affected side may be based on medical record documentation from other clinicians.” If the medical record documentation conflicts regarding the affected side, a query should be made to the patient’s attending provider for clarification, the guideline says. The guideline also advises that codes for “unspecified” side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification. — Megan Herr (mherr@decisionhealth.com) ■

Related link: To view the final code update, visit <https://tinyurl.com/2p4c4u53>.

Proposed rule: PDGM changes

CMS proposes changes to comorbidity adjustment and functional impairments for 2022

Agencies could see some changes in the way that CMS determines home health payments in 2022 if proposed changes to the comorbidity adjustment and functional impairment points get finalized.

The number of diagnosis pairings that will lead to a high comorbidity adjustment could jump from the current 31 possible interactions to 85.

And the low comorbidity adjustment interaction subgroups list is proposed to grow from 14 to 20 possible low comorbidity adjustments.

CMS also plans to adjust functional points and functional impairment levels by clinical group for 2022 with the majority of the changes resulting in a slight decrease in the amount of points.

It's likely that the data showed that when these pairs of diagnoses were used together, they required a higher resource use," says Sherri Parson, HCS-D, post-acute education senior manager with McBee Associates Inc. of Wayne, Pa. of the jump in high comorbidity adjustment pairings.

"I am glad to see that there is an increase in the possibility of high comorbidity adjustments," notes Nanette Minton, HCS-D, senior clinical coding manager with MAC Legacy in Denton, Texas. "It will give home care agencies a better opportunity for the care they provide to line up with the payment model."

While of course there is no perfect payment model, this change is a step in the right direction in recognizing the complex nature of managing patients with a multitude of comorbid diagnoses, Minton adds.

Coders capturing more complete picture

"I hope this is a reflection of better overall capture of a patient's comorbidities in ICD-10 assignment under PDGM," says Karen Tibbs, HCS-D, quality and education manager with Wayne, Pa.-based McBee Associates.

"In the past, as an industry, we have not done a great job of capturing the entire picture of the patient — concentrating on the "money" codes and leaving off other conditions in our diagnosis sequence," Tibbs explains. "I believe with the PDGM transition, our industry returned to fully coding the patient."

For instance, data are showing conditions like rheumatoid arthritis impacts utilization and outcomes — criteria for conditions on these adjustment tables — whereas before, rheumatoid arthritis may have been completely left off and therefore it's impact wasn't being captured, Tibbs adds.

It also gives agencies more opportunity for patients like cancers with a secondary diagnosis to be included in the comorbidity adjustment, adds J'on Griffin, HCS-D, director of the coding division with SimiTree Healthcare Consulting based in Hamden, Conn.

Low comorbidity adjustments

Despite removing Circulatory 4, Endocrine 2 and Respiratory 10 from the low comorbidity adjustment interaction subgroups list, the list is proposed to grow from 14 to 20 possible low comorbidity adjustments.

The nine added low comorbidity subgroups proposed to be added are:

- Circulatory 7
- Endocrine 4
- Heart 10
- Musculoskeletal 1
- Musculoskeletal 2
- Neoplasms 2
- Neoplasms 18
- Neoplasms 22
- Neurological 11

While experts were excited to see the growth of low comorbidity adjustment opportunities, some were surprised by the few that were removed.

It's unclear why CMS is removing Respiratory 10 when it was just added, says Minton.

"U07.1 (COVID-19) is a Respiratory 10 diagnosis," she adds. "Are we not still seeing this in home care? An end to the pandemic has yet to be declared so this does not make sense to me."

Parson noted that perhaps the numbers weren't there for home health over the period evaluated.

What additions are the 'big wins'?

"I was glad to see that the interaction between Respiratory 5 and Circulatory 10," says Minton.

"As a clinician and a coder, I fully understand and appreciate how much more complex the patient's care becomes with confirmed cardiac and respiratory diagnoses," she explains. "It was also nice to see some interactions that involved the musculoskeletal category and skin/skin."

These diagnoses can prove to be very debilitating and require more care to manage and maintain the care of the patient in the home, Minton adds.

Parson also thought the musculoskeletal associated comorbidity adjustments were big.

“It was good to see comorbidity adjustments associated with some musculoskeletal diagnoses and some more neoplasm subgroups added for adjustment,” says Parson. Previously, there weren’t any low or high comorbidity adjustment for musculoskeletal diagnoses [previously] or any neoplasms other than the oral neoplasms, so I see this as a win for home health.”

Minton agrees.

“I believe the big win is in the addition of multiple new neoplasm categories,” Minton says. “Cancer is very complex in nature and brings with it the need for specialized care.”

Helping cancer patients manage their disease through the use of home care is a service much underutilized as a care plan option, she adds.

“I would like to think the industry may recognize this with the inclusion of these categories for a low comorbidity adjustment,” Minton says.

One thing to keep in mind, however, is the time-frame in which the data was collected.

“I believe we also need to take into account that these changes are based on claims data from 2020 – a year that was far from normal with variables related to the PHE,” says Tibbs. “I fear that these are based on a patient population that is not our typical home health patient.”

Changes to functional impairment levels

Additionally, updates to functional points and functional impairment levels by clinical group are also

proposed with the majority of changes resulting in a slight decrease in the amount of points.

CMS is proposing to use the same methodology that was previously finalized to update these levels using CY 2020 claims data.

While some functional impairment scores remained the same, others received minor changes.

For example, responses to OASIS item M1800 (Grooming) showing a 2 or 3 are proposed to receive three points versus the current five points.

A difference in some of the points has also been proposed for OASIS items M1830 (Bathing), M1860 (Ambulation and Locomotion) and M1033 (Risk of hospitalization).

Point adjustments are also proposed for the thresholds for functional impairment level by clinical group.

For example, points for a clinical group of behavioral health with a low functional impairment level is proposed to change from 0 to 36 points to 0 to 32 points.

It looks like “CMS is trying to get back to their projection of a lower high functional impairment level,” says Parson. “We exceeded their projections so they may be trying to regain the percentages the initial aimed to have each impairment level to fall into.” ■

Related content: To view the full list of proposed functional impairment scoring and thresholds for functional impairment level by clinical group, see insert. To view the CY 2022 Home Health Prospective Payment System proposed rule, visit <https://tinyurl.com/33h5tjan>.

Other highlights from the 2022 proposed rule

- **HHVBP Model.** CMS announced plans for national expansion of the Home Health Value-Based Purchasing (HHVBP) model beginning Jan. 1, 2022. Under the proposed rule, the first year for payment adjustments would be calendar year 2024, with a maximum adjustment upward or downward of 5%. Instead of comparing performance on a state level, CMS will compare performance to peers nationwide, with larger- and smaller-volume cohorts based on beneficiary count in the previous calendar year.
- **Payment rates.** Medicare payments to HHAs in calendar year 2022 would increase in the aggregate by 1.7%, or \$310 million, based on the proposed policies. This increase reflects the effects of the proposed 1.8% home health payment update percentage (\$330 million increase) and a 0.1% decrease in payments due to reductions made in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018 for 2022 (\$20 million decrease).
- **No-pay RAP with Notice of Admission.** CMS is replacing the no-pay RAP with a Notice of Admission (NOA) at the start of care. CMS has been promoting this change for months, with expectations that agencies and technology vendors will have to adjust some processes to conform with the slimmed-down NOA requirements.
- **OT LUPA add-on factor.** CMS proposed to use the “physical therapy LUPA add-on factor to establish the occupational therapy add-on factor for the LUPA add-on payment.” This change is due to another permanent change in the proposed rule: CMS will permit an occupational therapist to conduct the initial assessment visit and complete the comprehensive assessment under the Medicare program when occupational therapy is on the home health plan of care with either physical therapy or speech therapy and skilled nursing services are not initially on the plan of care.



Advanced Coding Corner

Scenario: Home care was ordered for wound care on a 68-year-old male. He presents with a worsening laceration to the left lower calf which the provider now documents as a diabetic ulceration secondary to the laceration. The clinician indicates that the wound is full thickness with fat layer exposed. The patient also has documented venous insufficiency and peripheral neuropathy to bilateral lower extremities. Other confirmed diagnoses include depression with anxiety and moderate asthma. The patient takes insulin and an oral hypoglycemic agent to manage his diabetes along with prescribed inhaled albuterol, “as needed” for control of asthma symptoms.

Answer: E11.622 (Type 2 diabetes mellitus with other skin ulcer) would be the primary code to capture the fact that the provider has indicated that this wound initially started as a traumatic wound in the form of a laceration but has now evolved into an ulcer.

An ulcer requires different treatment protocols, so it is important that the etiology of the wound be coded as clearly identified in the medical record.

The wound is now considered to be considered a sequela of the laceration. Guidance from Q1 2021 Coding Clinic indicates that in this type of case, the ulcer is a sequela of the laceration, and codes for both the diabetic ulcer and the laceration should be assigned, with the diabetic ulcer first listed, followed by the laceration.

Therefore, L97.222 (non-pressure chronic ulcer of the left calf with fat layer exposed) is coded next to capture the specificity of the wound. Next S81.812S, Laceration without foreign body, left lower leg, sequela should be added to further explain that the ulcer is a late effect or consequence of the original laceration.

The medical record also indicates that the patient has venous insufficiency. Venous insufficiency is considered to be peripheral angiopathy and is assumed related to diabetes. We do not have the type of diabetes documented. Without absence of any specific documentation as to the type of diabetes we are to assume it is Type 2. Therefore, E11.51 (Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene) is coded followed by the code to describe the type of angiopathy more accurately, I87.2 (Venous insufficiency).

The record also indicates that the patient has bilateral neuropathy to the lower extremities. Neuropathy without another stated cause is assumed to be related to diabetes, therefore, E11.42, Type 2 diabetes mellitus with diabetic polyneuropathy should be added to capture this comorbidity.

F32.9, is added to capture Major depressive disorder, single episode, unspecified because this code is used when no further clarification is evident to capture the depression, as noted in clarifying terms, Depression NOS.

F41.9 (Anxiety disorder, unspecified) is coded to capture the confirmed anxiety diagnosis.

Even though the record states that the patient has depression with anxiety, F41.8 is not used because according to coding tips — “There is no assumed relationship between depression and anxiety. Do not assume that because the physician or NPP documented depression with anxiety that the two are related. Depression and anxiety should only be coded with F41.8 if the physician or NPP had indicated a relationship or has documented anxiety depression or mixed anxiety and depressive disorder or MADD.” [Q1 2021 Coding Clinic]

J45.909 (Unspecified asthma, uncomplicated) should be added next. Although moderate asthma is documented the record does not further clarify that the asthma is moderate persistent so we cannot assume this and to code that would need to query the provider.

The patient takes insulin and an oral hypoglycemic agent. According to coding guidelines for E11-- An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned. Z79.4 (Long term (current) use of insulin) is added to reflect this in the coding.

Code the scenario:

Primary and Secondary Diagnoses

M1021a: Type 2 diabetes mellitus with other skin ulcer	E11.622
M1023b: Non-pressure chronic ulcer of left calf with fat layer exposed	L97.222
M1023c: Laceration without foreign body, left lower leg, sequela	S81.812S
M1023d: Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51
M1023e: Venous insufficiency (chronic) (peripheral)	I87.2
M1023f: Type 2 diabetes mellitus with diabetic polyneuropathy	E11.42

Additional diagnoses: F32.9 (Major depressive disorder, single episode, unspecified), F41.9 (Anxiety disorder, unspecified), J45.909 (Unspecified asthma, uncomplicated), Z79.4 (Long term (current) use of insulin)

Here’s a scenario to work on for next month: Hospice was consulted to admit a patient for cervical cancer with liver metastasis. The patient is having neoplasm related pain and her TNM score is noted as T4N3M1 as authenticated by the staging physician. The patient also has developed a sacral deep tissue injury (DTI). After surgical debridement prior to hospice admission, the pressure ulcer was been identified as a stage 4 pressure ulcer of the sacrum. The patient is no longer eating and requires Oxygen at night. She is also now incontinent of bowel and bladder due to the physician documented neoplasm related weakness and remains wheelchairbound.

Editor’s note: This scenario provided by Nanette Minton, RN, CHPCA, HCS-D, HCS-H with MAC Legacy. To submit a scenario for the Advanced Coding Corner, email it to mherr@decisionhealth.com.

Coding Basics

Determine etiology of cerebral accident when coding for sequelae of CVA

When we refer to sequelae of CVA, we are referring to the late effects or residuals persisting after the initial onset of conditions classified to categories I60-I67.

Cerebral vascular conditions classified to these categories would include nontraumatic hemorrhages of the brain, cerebral occlusion, cerebral infarction, cerebral ischemia, and other cerebral conditions.

When discussing assignment of codes related to sequelae of CVA, it is imperative that you know the underlying etiology of the cerebral accident before code assignment, since sequelae of CVA will be non-traumatic in origin.

Though nontraumatic hemorrhages and traumatic cerebral injuries often produces similar residuals and symptoms, the codes are assigned to different categories, based on the underlying cause of the symptoms and effects.

Coding for CVA sequelae

Codes from category I60-I63 will usually not be used in home health since these codes represent a continued cerebral bleed. If documentation does not indicate a continued bleed, then codes from the I69 category will be assigned if the patient continues to have residual effects from the cerebral event.

If there are no residuals then Z86.73 will be assigned for personal history of transient ischemic attack (TIA), and cerebral infarction without residuals. Category I65 and I66 may be used in home health to indicate occlusion or stenosis that does not result in an infarction.

Codes classifiable to category I69 will be the codes assigned for sequelae of CVA. The fourth digit of these codes indicates the underlying cause of the nontraumatic cerebral event.

Keep in mind that most home health CVA sequelae coding defaults to I69.3- since the “3” in the fourth spot is the default for “stroke NOS” and “cerebral infarction.” When specific areas of cerebral hemorrhage are provided from the physician then the corresponding fourth digit codes will be assigned.

Tip: There are no codes for sequelae of transient ischemic attack (TIA) since TIA’s are transient in nature

there should not be residuals. If residuals are present query physician as to whether patient had an infarction or stroke.

Usually, G45.9 (Transient cerebral ischemic attack, unspecified) is not coded in home health but it may be assigned if physician/NPP confirms presence of TIA. If patient is diagnosed with a TIA and there are no residuals, assign code Z86.73 (Personal history of transient ischemic attack and cerebral infarction without residuals).

When assigning codes for hemiplegia, hemiparesis or monoplegia, code selection includes identifying the patient’s dominant or non-dominant side. If the patient’s dominant side is not specified a default is built into the classification. If the patient is ambidextrous the default is dominant. If the left side is affected, code assignment will default to nondominant and when the right side is affected it will default to dominant.

Many of the sequelae codes for CVA are combination codes, however, some sequelae codes for CVA will require additional code assignment. For example: I69.391 Dysphagia following cerebral infarction, R13.1- will be added to specify the type of dysphagia per the additional code note in the tabular.

Tip: Be careful that the connection to the residual and the CVA are confirmed by the physician. For example, if the patient has monoplegia and has had a stroke do not make the leap that the monoplegia is due to the stroke unless the connection is confirmed.

Scenario: Oropharyngeal dysphagia, hemiparesis

A patient is referred to home health for oropharyngeal phase dysphagia due to the stroke the patient had two weeks ago. Patient also is noted to have hemiparesis of the left side due to the stroke, physician has ordered nursing, PT, OT and SLP to treat CVA residuals and medication and disease process management. Dysphagia is the focus of care. Patient also has diet controlled diabetes, HTN and weight loss due to dysphagia with a BMI of 19.

Code the scenario:

Code	Description
M1021a: I69.391	Dysphagia following a cerebral infarction
M1023b: R13.12	Dysphagia, oropharyngeal phase
M1023c: I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
M1023d: E11.9	Type 2 diabetes mellitus without complications
M1023e: I10	Essential primary hypertension
M1023f: R63.4	Abnormal weight loss

Additional diagnoses: Z68.1 (Body Mass Index (BMI) 19.9 or less adult)

Rationale:

- Dysphagia is the focus of care in this scenario. The Dysphagia is caused from a CVA, and the documentation gives no other specifics as to the cause of the CVA, so you would assign codes from I69.3-.
- When you look at the combination code for dysphagia and CVA, I69.391, you see a “use additional code” note to add the specific type of dysphagia. You know from the documentation it is oropharyngeal dysphagia.
- The patient also had hemiparesis due to the CVA. You have that the stroke is on the left side and since you have no other information about the patient’s dominant side, you know that the classification defaults to “nondominant side.”
- Since the documentation only states “diabetes”, the classification defaults to type 2 so E11.9 is assigned.
- Codes for HTN (I10) and Abnormal weight loss (R63.4) were also assigned. Since there is a supporting diagnosis the code for the BMI is also assigned.

Scenario: Atrial fibrillation, personal history of TIA

A patient was opened to home health following an inpatient stay for a stroke. Physician confirms patient has no residuals from the CVA due to prompt administration of thrombolytic medications. Patient has a new medication regimen including coumadin and Amiodarone for a new diagnosis of Atrial Fibrillation. The physician feels the atrial fibrillation is the underlying problem that caused the CVA. Patient also has a longstanding diagnosis of HTN.

Code the scenario:

Code	Description
M1021a: I48.91	Unspecified atrial fibrillation
M1023b: I10	Hypertension
M1023c: Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
M1023d: Z79.01	Long term (current) use of anticoagulants
M1023e: Z79.899	Other long term (current) drug therapy

Rationale:

- The patient has a new diagnosis of Atrial fibrillation with new medications. Afib is the cause of the CVA and the focus of the health episode.
- Since the CVA has resolved and there are not resid-

uals, the code assigned will be the personal history code Z86.73 for the TIA.

- I48.91 is assigned for the atrial fibrillation since there is no other specifics given as to the type of atrial fibrillation and this is the default code.
- Also assigned is the I10 for hypertension, the long-term use of anticoagulants and Z79.899.
- Even though there is not a specific long-term use code for the Amiodarone, the the coder may optionally assign Z79.899 to capture this medication due to many of the adverse side effects related to its long-term use.

Scenario: Carotid stenosis bilaterally

A 96-year old patient is opened to home health for severe dizziness related to carotid stenosis bilaterally. Patient is not a surgical candidate. PT and OT are ordered to help with ADL’s and safety. Nursing is also ordered for teaching on the management of disease process and treatment regime. Patient also has diabetes type 2, CKD stage 4 and HTN. Patient has been on Xarelto for years.

Code the scenario:

Code	Description
M1021a: I65.23	Occlusion and stenosis of bilateral carotid arteries
M1023b: E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease.
M1023c: I12.9	Hypertensive chronic kidney disease with stage1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
M1023d: N18.4	Chronic kidney disease, stage 4 (severe)
M1023e: Z79.01	Long term (current) use of anticoagulants

Rationale:

- Many patients experience carotid stenosis that either has not currently resulted in a CVA, has not been resolved through a surgical intervention (such as in this case, since the patient is not a surgical candidate), or due to chronic recurrence of disease following a prior surgical intervention. In this case, the patient’s carotid stenosis is symptomatic and the patient requires both therapy and nursing care, so this is coded as primary. The patient also has chronic kidney disease, HTN and diabetes. There is a combination code for HTN and CKD, I12.9, and there is a use additional code note to assign the specific stage of the CKD.
- There is also a connection with diabetes and CKD per the alpha index and the “with” convention.

- Diabetes is captured with E11.22 to represent both the diabetes and the CKD. Z79.01 is also assigned for the long-term use of Xarelto. ■

About the author: Sherri Parson RN, HCS-D, HCS-O, HCS-H, BCHH-C, COS-C is the post-acute education senior manager with McBee Associates.

OASIS

How to resolve disputes about correct OASIS answers

What does your agency do if the assessing clinician disagrees with the clinical reviewer about the response to an OASIS item?

You need a process in place. If not resolved, these disagreements can lead to clinician dissatisfaction and ultimately cost you qualified staff. There are ways to overcome these disputes and keep the clinicians happy throughout the process.

“The bottom line is that what the assessing clinician says goes,” says Sharon Litwin, RN, MHA, HCS-D, senior manager, coding & clinical consultant at Healthcare Provider Solutions in Nashville, Tenn. CMS has clearly stated that the clinician who actually sees the patient is the person whose assessment should be submitted in the OASIS.

Qualities to look for in a reviewer

One of the ways to keep clinicians happy is to be sure that the person who reviews their charts has the right personality.

The job of reviewer isn't for every personality type. When hiring a reviewer, agencies should look for the following in a candidate, according to Litwin:

- **Flexibility** — The role of reviewer is an important one, but there will be many times that corrections in their review will be discarded in favor of the assessing clinician's documentation. For this reason, a hardheaded person might not be optimal for this job. Instead, agencies should look for someone who is flexible, and willing to bend when the assessing clinicians are firm on their word.
- **Cooperation** — The role of reviewer isn't a solo job. When they log their corrections, they will then need to discuss with the assessing clinician and work together to decide how to code the patient. Your reviewer should be ready to cooperate with both the assessing clinician, and anyone else who gets involved with the coding process.

- **Knowledge of OASIS** — Clinicians won't necessarily have a mastery of the OASIS, but it is important that the reviewer is well trained and up-to-date with the latest guidance and can establish an effective way to check codes when reviewing documentation.

When interviewing a candidate, hiring managers should observe the candidate's mannerisms. Managers should consider candidates who exhibit great communication skills during the interview.

Case study

The following is a scenario in which the assessing clinician changes the patient's score after consulting with the reviewer, as laid out by Litwin:

The RN doing the SOC/OASIS admission visit asks the patient how she is doing with bathing. The patient says she gets into the shower and onto the bench in the shower two to three times per week and doesn't need help. The RN has the patient walk to the bathroom so that she can see the setup. The patient occasionally grabs onto furniture or the wall while walking to the bathroom. Once there, she holds onto the shower frame and steps in before sitting on the bench.

The RN documents that the answer to M1830 (Bathing) is a “1 — With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower” on the OASIS.

The OASIS reviewer notes that the patient does not seem to be able to safely shower independently as evidence by the patient supporting herself by touching walls while walking to the bathroom, and while getting in and out of the shower. The reviewer concludes the patient could be a fall risk and recommends a response of “2” indicating that the patient requires the intermittent assistance of another person to bathe safely.

The OASIS reviewer will compare responses to M1830 (Bathing) with the patient's scores on the other M items (Ambulation and transferring) and the GG items that ask about bathing to ensure consistency.

The reviewer then sends these recommendations to the RN, who is the assessing clinician, for the OASIS, and includes the PT as he also assessed the patient directly. If they all agree with the recommendation of a “2” for M1830 (Bathing), the RN who conducted the assessment will make the change in the OASIS.

In the event that the assessing clinician does not agree with the reviewer, the reviewer should probe the

clinician to determine why they are not on the same page. The clinician can then explain that she understands the guidance on the item, but the score is based on how she saw the patient perform, so the score is different than what the reviewer recorded. Perhaps the clinician determined that when the patient touched walls, it was out of habit, and not to support herself, so a score of “1” for M1830 (Bathing) seems appropriate to the clinician.

The reviewer needs to acknowledge that she/he provides support for the clinician but cannot make the final decision. The reviewer can go to the manager or clinical director for advice, but in the end the assessing clinician gets the final say. There is no leeway there.

Call in a third party when needed

When a dispute arises between a clinician and a reviewer, the clinical manager or clinical director will step in, as in the example above. Even though the documenting clinician’s word is what should always be accepted, sometimes a third party needs to step in to ensure that relationship doesn’t sour, explains Diane Link, owner of Link Healthcare Advantage, in Littlestown, Pa.

When the manager or director steps in, all involved parties should look to the OASIS manual, as well as all scores given to the patient to ensure consistency. In the

end though, it is the nurse who saw the patient in person that has the final say, Litwin says.

Making corrections

Sometimes clinicians don’t get it right. They look back over the patient’s scores and notice inconsistencies. The reviewer might even have pointed these inconsistencies out, but the assessing clinician didn’t change the scores. In the event this happens, there are ways to go back and change the scores, Link says. “The clinical documentation must be amended per agency policy and must also be reflected in the OASIS database maintained by the agency. If data submission has already occurred, a correction must be transmitted to CMS,” Link explains.

When a disagreement takes place, ideally the OASIS discrepancies should be discussed between the reviewer and assessing clinician. The reviewer should then document the discrepancies discussed into the medical record when amending a patient’s score, Link says.

Best practice is to avoid the need for corrections in the first place. “I recommend 100% review of all admissions by a reviewer in order to catch mistakes prior to submission,” Link says. When the OASIS is reopened, it is recorded by CMS, and surveyors can use this data to identify trends when conducting an audit, she says. — Sarah Schock (sschock@decisionhealth.com) ■

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