

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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FY2024 final codes

Codes for osteoporosis w/ pathological fractures part of 395 new ICD-10 codes

Come Oct. 1, coders will have several dozen new codes available for osteoporosis with pathological fractures that specify laterality and healing status, for instance.

These new codes, finalized in the FY2024 ICD-10 code update posted June 16 on CMS' website, deliver a welcome change for experts and coders alike. [See box, p. 2, for sample codes.] The FY2024 guidelines have also been posted and these changes will take effect Oct. 1.

The osteoporosis codes are part of a total of 395 new diagnosis codes that are spread throughout the code set, and they are “the best update of the year,” notes Robbi Funderburk James, BSN, RN, HCS-O, HCS-D, HCS-H, director of coding and OASIS review with Healthcare Provider Solutions in Nashville, Tenn.

Prior to this change, the Alpha Index led to “Osteoporosis with current pathological fracture, femur,” which clinically does not make sense. The femur is a totally different bone than the pelvic girdle bones.

It will also be helpful to have the added specificity for laterality of the pelvic fracture, Funderburk James adds.

“Providers often specify the laterality of pelvic fracture, so it is great that we now have codes to reflect that specificity with osteoporosis with pathological pelvic fractures,” she explains.

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“I like the new detail that these codes provide for osteoporotic fractures,” agrees J’non Griffin, RN, MHA, HCS-D, COS-C, HCS-H, principal at SimiTree Healthcare Consulting based in Hamden, Conn.

The final code update also includes hundreds of Tabular and Alpha Index changes, effective October 1.

Get a closer look at new osteo codes

Here are a few of the new codes for osteoporosis with pathological fractures:

- **M80.0B1A** (Age-related osteoporosis with current pathological fracture, right pelvis, initial encounter for fracture)
- **M80.0B1D** (Age-related osteoporosis with current pathological fracture, right pelvis, subsequent encounter for fracture with routine healing)
- **M80.0B1G** (Age-related osteoporosis with current pathological fracture, right pelvis, subsequent encounter for fracture with delayed healing)
- **M80.0B1K** (Age-related osteoporosis with current pathological fracture, right pelvis, subsequent encounter for fracture with nonunion)
- **M80.0B1P** (Age-related osteoporosis with current pathological fracture, right pelvis, subsequent encounter for fracture with malunion)

New code for capturing COPD

A new code to capture other specified chronic obstructive pulmonary disease (COPD) was also finalized in the update.

The new code, **J44.89** (Other specified chronic obstructive pulmonary disease), would be assigned for chronic asthmatic bronchitis, chronic obstructive asthmatic bronchitis, chronic obstructive bronchitis, chronic emphysematous bronchitis, and chronic bronchitis with airway obstruction.

These conditions currently are classified to **J44.9** (Chronic obstructive pulmonary disease, unspecified), but due to the addition of this new code and related changes in the alphabetic index classification, will be assigned to J44.90 beginning Oct. 1, 2023.

Chronic obstructive bronchitis, chronic asthmatic bronchitis and the other conditions listed above are specific types of chronic obstructive pulmonary disease, notes Ohio-based independent home health and coding expert Brandi Whitemyer.

“These conditions are better classified under J44.89 as they are not unspecified,” she says. “Emphysema, unspecified will continue to be classified to J43.9 and unspecified chronic obstructive pulmonary disease (no mention of bronchitis) will continue to be classified to J44.9.”

Parkinson’s codes cause mixed emotions

The final code update for 2024 also includes five new codes to enhance the tracking and progression of Parkinson’s disease. [See box for list of codes.]

These codes came with mixed feelings, however, notes Nanette Minton, RN, HCS-D, HCS-H, HCS-O,

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DIAGNOSIS CODING PRO TEAM

Maria Tsigas, x6022

Product Director
mtsigas@decisionhealth.com

Marci Geipe, x6022

Senior Manager, product and content
mgeipe@decisionhealth.com

Megan Herr, x4062

Content Specialist
mherr@decisionhealth.com

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senior clinical coding manager with MAC Legacy in Denton, Texas.

The new codes will help agencies to further describe the symptoms regarding the dyskinesia and fluctuations in a Parkinson's patient that support homebound status and impact the patient's activities of daily living (ADL).

On the flip side, it may take referring providers time to incorporate this into the documentation for coders to capture it.

To help with this, agencies should educate their referral sources — especially those that generate higher volumes of Parkinson's patients such as ALFs and neurologists — on the specificity now needed regarding diagnosing dyskinesia in Parkinson's patients, says Funderburk James.

“You will need that specificity in the documentation to assign these codes,” she adds.

New codes for Parkinson's

- **G20.A1** (Parkinson's disease without dyskinesia, without mention of fluctuations).
- **G20.A2** (Parkinson's disease without dyskinesia, with fluctuations).
- **G20.B1** (Parkinson's disease with dyskinesia, without mention of fluctuations).
- **G20.B2** (Parkinson's disease with dyskinesia, with fluctuations).
- **G20.C** (Parkinsonism, unspecified)

Highlights of the guidelines

- Guidelines for screening for COVID-19 can be found at I.C.1.g.1.f and advise:
 - For screening for COVID-19, including preoperative testing, assign code **Z11.52** (Encounter for screening for COVID-19).
- A change to Myocardial Infarction with Coronary Microvascular Dysfunction is also included at I.C.9.e.6 to state:
 - Coronary microvascular dysfunction (CMD) is a condition that impacts the microvasculature by restricting microvascular flow and increasing microvascular resistance. Code I21.B, Myocardial infarction with coronary microvascular dysfunction, is assigned for myocardial infarction with coronary

microvascular disease, myocardial infarction with coronary microvascular dysfunction, and myocardial infarction with non-obstructive coronary arteries (MINOCA) with microvascular disease.

- Section III. Reporting Additional Diagnoses added the phrase: “clinically significant.” The first paragraph now reads:
 - “For reporting purposes, the definition for “other diagnoses” is interpreted as additional clinically significant conditions that affect patient care in terms of requiring...” ■

Editor's note: For more highlights from the FY2024 final code update, see tool. To view the final codes, visit <https://tinyurl.com/9r4n6fx5>. To view the full guidelines, visit <https://tinyurl.com/hwbxx5c4>.

Coding Basics

Understand multiple sclerosis in order to accurately code for it

Multiple sclerosis, more commonly known as MS, is a disease of the central nervous system that is chronic in nature.

It is thought to be autoimmune in nature, meaning a condition in which the body attacks itself by mistake. The difficult thing about MS is the unpredictability of the disease.

It affects people in different ways. While one person may only have mild weakness, another person may lose their ability to write, see, speak or walk.

As noted in the article from John Hopkins Medicine, this happens when the communication between the brain and other parts of the body becomes disrupted.

There is a layer of fatty tissue known as myelin that serves as a protection around the nerve fibers. In MS, that protective layer is destroyed in multiple areas.

This destruction leaves scar tissue called “sclerosis.”

These areas also may be known as plaques or lesions. The damage to the protection around the nerves does not allow conduction of the electrical impulses to and from the brain to other parts of the body.

Interestingly, the National Library of Medicine reports in an article published in 2016 on the history of myelin enlightens us to the fact that “Antoni van Leeuwenhoek is arguably the first to have observed myelinated fibers in 1717.”

He stated: “Often, and not without pleasure, I have observed the structure of the nerves to be composed of very slender vessels of an indescribable fineness, running lengthwise to form the nerve.”

The actual word *Myelin* was named so by German pathologist Rudolf Ludwig Virchow. He is known to have said: “The necessity exists of being able to identify a word, so I suggest, to prevent any confusion already created by others and avoid more problematic substances, to name the marrow material myelin.”

Myelin derives from the Greek *myelos* after bone marrow color and texture.

Understanding the cause

The cause of MS is unknown, but the possibilities include infections agents, specifically viruses, genetic and/or environmental factors and autoimmune disorders.

There is a greater predisposition for women to be diagnosed with the disease. Again, the reasons are ambiguous but could be related to stress, higher body fat and hormones.

The first symptom of MS is likely to be a visual issue. This could include blurred or double vision along with red-green color distortion.

This is due to optic neuritis. Trouble walking and abnormal paresthesia also are common first symptoms.

This can progress to severe weakness, trouble with coordination, fatigue, sensation deficit, tremor and potentially speech problems among other issues.

Depression due to the progression of the disease also is common. The article in John Hopkins Medicine as referenced above states that: “About 50% of all people with MS have thinking (cognitive) problems linked to the disease.”

Diagnosing MS

There is no specific test to diagnose multiple sclerosis. The process begins with ruling out all other differential diagnoses.

These two things must be true in order for an official diagnosis to be made:

- There must have been two attacks that occur one month or more apart (an attack is the sudden development of symptoms or worsening of symptoms for a minimum of 24 hours).
- There must be more than one area of damaging to the central nervous system myelin that is not caused by any other disease.

Currently, there is no known cure for MS.

Depending on the age of the patient and other health issues treatment is aimed at changing the course of the disease through management of symptoms, treating exacerbations and improving mobility. Medications, durable medical equipment and rehabilitation activities play a big part in disease management.

When coding MS under the home health benefit guided by PDGM, G35 (Multiple sclerosis) is used.

This code can be used as primary and belongs to the Neuro Rehabilitation primary diagnosis clinical group.

It also falls into the Neurological5 comorbidity group and qualifies for a low comorbid adjustment alone or a high comorbid adjustment with another contributing high comorbidity diagnosis combination.

Coding guidance tells us that G35 should be listed primary when the patient is being seen for more than one aspect of the disease. Code associated symptoms of MS from Chapter 18 after code G35 (MS), but only if those symptoms are not routinely associated with MS. Conditions associated with MS, such as neuropathy, are not symptom codes and should be coded in addition to MS.

Scenario: MS, neurogenic bladder

A 51-year-old female was diagnosed with multiple sclerosis 15 years ago. She has some impaired mobility, decreased vision, and issues with fine motor control. These issues have been stable for the last 4 months. She has been referred to home health due to a history of multiple urinary tract infections and issues related to her neurogenic bladder which is causing incontinence without sensory awareness. The incontinence is managed with a foley catheter. Skilled nursing is needed for observation and assessment and teaching on the neurogenic bladder as well as foley catheter instruction/management.

Code the scenario:

Code	Diagnosis description
M1021a: N31.9	Neuromuscular dysfunction of bladder, unspecified
M1023b: G35	Multiple Sclerosis
M1023c: N39.42	Incontinence without sensory awareness
M1023d: Z46.6	Encounter for fitting and adjustment of urinary device
M1023e: Z87.440	Personal history of urinary (tract) infections

Rationale:

- The patient is not being seen for more than one aspect of MS, therefore N31.9 Neuromuscular dysfunction of bladder, unspecified should be listed as primary as it is the focus of care.
- G35 Multiple sclerosis is added next to capture the disease process causing the neurogenic bladder.
- N39.42 Incontinence without sensory awareness should be added to capture the specific type of incontinence.
- Z46.6 Encounter for fitting and adjustment of urinary device is coded to capture the presence of and management of the indwelling foley catheter.
- Z87.440 Personal history of urinary (tract) infections should also be added to capture the patient’s history of urinary tract infections. ■

About the author: *Nanette Minton, RN, HCS-D, HCS-H, HCS-O, is the senior clinical coding manager with MAC Legacy.*

Proposed rule

CMS proposes new measure for COVID-19, OASIS-E item updates

Agencies will have a new OASIS item in 2025 to track patients’ COVID-19 vaccination status if proposed changes are finalized later this year.

The new proposed OASIS item will appear in OASIS section O and will measure whether a patient’s COVID-19 vaccination is up to date, CMS stated in a June notice on its website.

The proposed response options would then be either:

- “0- No, patient is not up to date”
- “1- Yes, patient is up to date”

“I think the tracking of the COVID-19 vaccination status will become commonplace like the influenza vaccine status,” says Lisa McClammy, senior clinical education consultant with MAC Legacy in Denton, Texas. “We have seen so many changes in our practice related to the COVID-9 pandemic, and tracking vaccination status may help identify trends in COVID-19 cases.”

The information can be helpful in identifying vulnerable individuals and encouraging those individuals to keep their vaccination current, she adds.

“This will also be useful for the agency to track any COVID-19 cases and trends,” McClammy says.

Get ready for new OASIS item

While this COVID-19 vaccination item does not yet exist on the OASIS instrument, the item would be added to the OASIS and collected at the transfer, discharge and death at home to capture this information across all Medicare-certified home health agencies.

Agencies would be able to use all sources of information available to obtain the vaccination data, such as patient interviews, medical records, proxy response, and vaccination cards provided by the patient/caregivers.

With new OASIS item comes new measure

Data from the new OASIS item would feed the proposed new measure, COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date” (Patient/Resident COVID-19 Vaccine), the 2024 proposed home health rule states.

If finalized this measure would be added to the home health quality reporting program (HH QRP) in CY2025.

According to the rule, the new measure would be displayed on Care Compare beginning with the January 2026 refresh or as soon as technically feasible.

The new COVID-19 vaccine measure would report the percentage of home health quality episodes in which patients were up to date with their COVID-19 vaccinations as defined by Centers for Disease Control and Prevention (CDC) guidelines on current vaccination.

(continued on p. 7)



Advanced Coding Corner

Hospice scenario: A patient was admitted to hospice due to metastatic clear cell renal carcinoma of the right kidney. Documentation includes metastasis to the right and left lung, right adrenal gland, as well as into other parts of the retroperitoneum. Lytic metastasis in the left superior pubic rami are also noted. Pain is associated with the neoplasm. Patient continues to have anemia and some residual issues from recent hospital stay due to a malignant pleural effusion. The patient has refused further chemo and radiation, instead electing hospice. Other confirmed diagnoses include anxiety, PE, Embolism of left renal vein and a chronic duodenal ulcer.

Answer: C64.1 (Malignant neoplasm of right kidney, except renal pelvis) should be added first to capture the primary terminal diagnosis.

The medical record indicates that the patient has clear cell renal cell carcinoma, however, there is no ICD-10 code that breaks this cancer down to that level of cell specificity, therefore C64.1 is the best option. Clear renal cell carcinoma is named as such due to the cancer cells look like clear bubbles under a microscope.

The metastatic (secondary) sites of cancer should be added next. The sequencing can vary but best practice is to place the secondary sites in order of priority according to what issues they are causing the patient. In this scenario, we do not have that information so they may be placed in any order.

C78.01 (Secondary malignant neoplasm of right lung) and **C78.02** (Secondary malignant neoplasm of left lung) are added to capture the bilateral lung metastasis. There is no combination code.

C79.71 (Secondary malignant neoplasm of right adrenal gland) is coded for the confirmed metastasis to the right adrenal gland.

C78.6 (Secondary malignant neoplasm of retroperitoneum and peritoneum) is coded to reflect the metastasis into the retroperitoneum.

Lytic metastasis are noted in the left superior pubic rami and should be included in the coding. Lytic metastasis mean that there are areas of the bone that have been destroyed by the cancer, leaving a hole in the bone. **C79.51** (Secondary malignant neoplasm of bone) is added to reflect this confirmed diagnosis. There is no code for the specific site (pubic rami) of secondary bone cancer.

G89.3 (Neoplasm related pain (acute) (chronic)) confirmed by the provider should be added to support the terminal diagnosis and medical necessity for hospice.

D63.9 (Anemia in neoplastic disease) is coded to capture the anemia. While there was recent advice from the Coding Clinic recently in the 2nd Quarter edition for 2023 that “with” is not interchangeable with “due to”, the term “neoplastic disease” appears below the subterms “due to” and “in” within the alphabetic index. The “with” convention for presuming diagnoses as associated does include conditions that appear under the subterm “in” within the alpha index and these should be presumed to be associated in the absence of provider documentation of any other underlying cause.

J91.0 (Malignant pleural effusion), **F41.9** (Anxiety disorder, unspecified), **I26.99** (Other pulmonary embolism without acute cor pulmonale), **I82.3** (Embolism and thrombosis of renal vein) and **K26.7** (Chronic duodenal ulcer without hemorrhage or perforation) are all added to reflect these confirmed diagnoses.

Z92.21 (Personal history of antineoplastic chemotherapy) can be added to indicate that the patient has undergone chemotherapy.

Z92.3 (Personal history of irradiation) can be added to reflect the personal history of exposure to therapeutic radiation.

Z51.5 (Encounter for palliative care) is added as a best practice measure indicating palliative care. While this code is not required, it may be added to provide additional information.

Primary and Secondary Diagnoses	
M1021a: Malignant neoplasm of right kidney, except renal pelvis	C64.1
M1023b: Secondary malignant neoplasm of right lung	C78.01
M1023c: Secondary malignant neoplasm of left lung	C78.02
M1023d: Secondary malignant neoplasm of right adrenal gland	C79.71
M1023e: Secondary malignant neoplasm of retroperitoneum and peritoneum	C78.6
M1023f: Secondary malignant neoplasm of bone	C79.51

Additional diagnoses: **G89.3** (Neoplasm related pain (acute) (chronic)), **D63.0** (Anemia in neoplastic disease), **J91.0** (Malignant pleural effusion), **F41.9** (Anxiety disorder, unspecified), **I26.99** (Other pulmonary embolism without acute cor pulmonale), **I82.3** (Embolism and thrombosis of renal vein), **K26.7** (Chronic duodenal ulcer without hemorrhage or perforation), **Z92.21** (Personal history of antineoplastic chemotherapy), **Z92.3** (Personal history of irradiation) and **Z51.5** (Encounter for palliative care)

Here's a scenario to work on for next month: A 74-year-old male is referred to home health care for SN to perform skilled observation and assessment and PT for strengthening related to recent hospitalization and diagnosis of Rhabdomyolysis from being on the floor of his home for several hours after a minor fall. The patient has resolving acute kidney injury and suffers from chronic hyponatremia. The patient's medical history also indicates chronic diastolic heart failure, hypertension and chronic kidney disease stage IV. The confirmed records uploaded to the electronic medical record also reflects confirmation of HIV related dementia as well as a history of CVA with right sided deficits.

Editor's note: This scenario was provided by Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy. To submit a scenario for the Advanced Coding Corner, email it to mherr@decisionhealth.com.

(continued from p. 5)

Note: The definition of “up to date” on COVID-19 vaccines may change based on the CDC’s latest guidance.

The measure would require the collection of COVID-19 vaccination data at the end of each quality episode. This would include OASIS collection when a patient is transferred to an inpatient facility, with or without discharge (M0100 RFA 6 or 7), when a patient experiences a death at home (M0100 RFA 8) and when a patient is discharged from agency – not to an inpatient facility (M0100 RFA 9).

Data would be collected using a standardized item harmonized across the post-acute care settings as collected on the OASIS for home health patients, the IRF-PAI for IRF patients, the LCDS for LTCH patients, and the MDS for SNF residents.

The measure would use information from the OASIS to obtain raw rates of the number of home health quality episodes in which patients were up to date with their COVID-19 vaccination.

The measure would be reported using one quarter of data and updated quarterly. — Megan Herr (mherr@decisionhealth.com) ■

Editor’s note: View CMS’ COVID vaccine measure specifications at <https://tinyurl.com/38hswmnc>.

Proposed rule: OASIS

CMS plans to remove episode timing, therapy needs items

CMS also proposes to remove two OASIS items, **M0110** (Episode timing) and **M2200** (Therapy Needs), effective Jan. 1, 2025.

Industry experts were happy to see the proposed changes for M0110 and M2200 as neither of those items have contributed to payment since PDGM took effect.

“It makes sense to eliminate M0110 since the data from this item is no longer used in payment and many folks still remain confused with the changes in guidance between OASIS D1 and OASIS E,” notes Ohio-based independent home health and coding expert Brandi Whitemyer. “The OASIS E manual is very clear that this item is **not** used in the PDGM payment model and to reference the payer’s guidelines for determination of payment episodes for when responding to the item as early/late determinations for PDGM claim payment are only taken from claims.

M2200 (Therapy need) is also no longer used to affect payment with PDGM, and the current guidance allows for the agency to code this item as not applicable, notes McClammy, adding that she hopes the removal will help clear up any confusion.

“M2200 is almost impossible to get correct as it basically boils down to a guess and relies on best intentions,” says Anna Powers, vice president of clinical services at HealthRev Partners in Ozark, Mo. “A patient’s disease process or rehabilitation almost never follows the textbook, so it is hard to determine what their need will be. All we can do is make an educated guess.”

CMS is proposing the removal of items from OASIS-E from the specific time points during a home health episode as outlined in the table below:

Item	SOC	ROC	FU
M0110 (Episode timing)	1	1	1
M2200 (Therapy need)	1	1	
Total	2	2	1

“These items are no longer used in the calculation of quality measures already adopted in the HH QRP, nor are they being used currently for previously established purposes unrelated to the HH QRP, including payment, survey, the HH VBP Model or care planning,” CMS states in the 2024 proposed home health rule. — Megan Herr (mherr@decisionhealth.com) ■

Editor’s note: To view the CY2024 Home Health Prospective Payment System proposed rule, visit <https://tinyurl.com/bdzczcce>.

 **Ask the Expert**

Total parenteral nutrition (TPN) & noncompliance codes

Question: Total parenteral nutrition (TPN) is captured with K0520A. Would it also be captured under O0110 H1 (Other IV medications)?

Answer: Yes, TPN would be captured in K0520A (Parenteral IV Feeding) and O0110 H1 (IV medications) as well as the type of access in O011001. (IV access)

Question: There is some confusion on non-compliance codes and M1033 (Risk for hospitalization). We have a built in coding scrubber and we’re getting alerts that the clinician has documented response “6 - Reported or observed history of difficulty complying with any medical

instructions (for example, medications, diet, exercise) in the past 3 months” under M1033 confirming a medical non-compliance history. Is it (Patient noncompliance with dietary regimen) Z91.110 (Patient’s noncompliance with dietary regimen due to financial hardship) – Z91.199 (Patient’s noncompliance with other medical treatment and regimen due to unspecified reason) be assigned based solely on the clinician’s response 6 on M1033? I was under the impression that non-compliance MUST be confirmed and documented by the MD or qualified practitioner, that coders cannot code non-compliance based on a clinician’s response alone.

Answer: Keep in mind that when using the scrubber for your EMR, the scrubber is simply providing suggestions, not requirements. These suggestions may or may not have any applicability to the patient’s specific case. When a software scrubber makes a suggestion, each recommendation should be considered individually to see if it should be accepted and incorporated. ICD-10-CM codes for *non-compliance* are not considered social determinants of health codes (SDoH) and do require provider confirmation to assign these codes to the chart. If the provider has confirmed non-compliance and addressing this is part of the home health plan of care, an appropriate ICD-10-CM code could be added. Provider confirmation of non-compliance is not necessary when responding to M1033. ■

Editor’s note: Do you have a question for one of our coding experts? If so, email your question to mherr@decisionhealth.com.

Hospice coding

Submit a query to determine cause of unspecified dementia for hospice

Determining an appropriate referral diagnosis for a patient when the provider just states “dementia” is an ongoing challenge for hospice coders.

“I still see many hospice referral/intake documents referring hospice patients for dementia with no other stated cause,” notes Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy in Denton, Texas.

“But I can understand why,” she adds. “Providers often see the symptoms before really knowing the cause of the disease and some patients do not want to undergo testing for determination of the cause.”

Testing can be limited and much of the diagnosis of the cause is somewhat of a guessing game, Minton adds.

The Alzheimer’s Association states that, “dementia is not a single disease, it’s an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer’s disease.”

“The cause is not always easily recognizable or easy to determine so when you need an underlying cause, it may not always be present,” explains Minton.

Navigating these instances

For hospice, unspecified dementia cannot be primary — or the referral diagnosis, Minton says.

Therefore, the best practice would be to make contact with the provider to determine the cause.

Find out whether the patient has a neurologist that might be able to provide more insight rather than the referring physician, she adds.

A professional query providing education to the provider while requesting additional information is the best method, Minton explains.

Tip: Know the referral source — do they prefer a fax, HIPAA compliant email, or phone call for clarification? One query does not fit all.

“Kindly explain that while the patient does qualify for hospice for dementia, Medicare no longer allows the unspecified dementia code as primary as they see it as a symptom and want the cause to be listed,” says Minton.

Educating yourself before sending a query can be beneficial.

“Understanding the diagnoses and history that you are aware of might help to promote a more meaningful conversation to uncover the most likely cause of the dementia,” says Minton.

And always be specific when submitting a query.

Ask: Does the patient have dementia of the Alzheimer’s type or as a result of multiple strokes/cerebrovascular disease — or is there another cause that we can list as primary?

“If there is no other option and an underlying cause cannot be determined — and the patient meets eligibility criteria for hospice — then work with the attending physician and medical director to determine the most appropriate course of action,” Minton advises.

In instances where the cause cannot be determined, consider:

- Is senile degeneration of the brain (G31.1) the closest substitute?
- Does the patient fall under hospice criteria for another issue such as severe protein calorie malnutrition
- Does the patient have another disease such as Parkinson's in which you will assume the dementia is related and code that cause as primary?

Documenting the process

It's always a good idea to document this process as well.

“Ensuring that the communication on the determination of the diagnosis is well-documented is key,” says Minton.

As a best practice measure, this should be in the EMR, she adds, preferably captured with an order signed by the medical director.

Consider this scenario from Minton:

A 78-year-old male referred to hospice with a primary terminal diagnosis of “dementia” of unspecified severity. The patient has become bedbound in the last two weeks, is no longer eating but 25% of meals and has had two urinary tract infections and pneumonia within the last six weeks. His BMI is less than 19 and he is now fully incontinent of bowel and bladder. He has increased confusion with periods of delirium and has increased in sleeping to 16-18 hours a day over the last week.

Determining a valid referral diagnosis:

- The agency knows they cannot use dementia as primary. The family stated that the patient had gone to see a neurologist two years ago when his memory was getting worse. The agency contacts the neurologist, but they do not have any further information. However, they did state the patient has a history of multiple strokes which was not in his other records.
- After discussing this issue with the medical director, in coordination with the neurologist, the medical director advised that the primary diagnosis needed to be **I69.318** (Other symptoms and signs involving cognitive functions following cerebral infarction) followed by **F01.50** (Vascular dementia, unspecified severity, without behavioral disturbance, psychotic

disturbance, mood disturbance, and anxiety) to document the cause and type of dementia. — *Megan Herr* (mherr@decisionhealth.com) ■

OASIS-E

Educate on responses for J0510 to ensure accurate assessment

Educate staff on how to properly assess and respond to **J0510** (Pain interfering with sleep) to ensure clinicians are not confusing the response options with those of the previous OASIS-D's **M1242** (Frequency of pain interfering with patient's activity or movement).

“We are seeing some confusion due to lack of training and reinforcement of training on the new OASIS-E items, one of them being J0510,” notes Jennifer Osburn, RN, HCS-D, COS-C, senior manager of clinical consulting for SimiTree Healthcare Consulting based in Hamden, Conn.

An incorrect answer to J0510 could lead to a lack of interventions on the plan of care to control, monitor or help improve pain, says Powers.

“Pain can have a significant impact on wellness, rehab potential and quality of life, so identifying it is vital,” she adds.

Proper identification of pain also can help paint a picture of why skilled, medically necessary therapy and/or nursing is needed to assist the patient who is having acute or chronic pain — especially when this pain keeps the patient from sleeping or performing activities.

There are painful differences

One of the major differences between the old and the new pain items is the timeline for the assessment.

For M1242, the timeline for assessment defaulted to the “day of assessment” definition, Osburn adds. When assessing J0510, clinicians are asked to look at “the past five days.” It is important to also remember that the five-day lookback for this item starts with counting back from the day of assessment as day 0.

M1242's response “0 — Patient has no pain” meant that in the last 24 hours, the patient had no pain, Osburn explains.

For J0510, however, response “0 — Does not apply — I have not had any pain or hurting in the past five days” means the patient has had no pain or hurting **at all** in the past five-day period, Osburn says.

Note: Marking “0” results in skipping over J0520 (Pain interference with activity) and J0530 (Pain interference with day-to-day activities), so it is important to accurately answer J0510.

Response “1 — Rarely or none at all” means that the patient **has had some level of pain** or hurt in the last five days, but this pain **did not interfere with sleeping** at night.

“If pain did not interfere with the patient’s sleep at all, then **J0520** (Pain interference with therapy activities) and **J0530** (Pain interference with day-to-day activities) are answered to help identify what activities the pain experienced in the last five days did impact,” explains Anna Powers, BSN, RN, BCHH-C, director of coding and OASIS operations with HealthRev Partners in Ozark, Mo.

Be consistent at SOC and beyond

There appears to be a disconnect between pain assessment at SOC versus subsequent clinical notes, says Adriana Molina, HCS-D, coding and OASIS educator for Trilogy Home Health, based in Florida.

Some clinicians are marking “1 — rarely/none at all” for J0510 at the SOC assessment and in subsequent notes they are stating the patient has pain day and night, she explains. “Since OASIS guidelines state to assess for pain in the five-day look back period, I then need to call them and inquire about pain in sleep, frequency and acuity.”

“The patient’s entire documentation should be consistent and make sense, so the responses in the J0510 — J0530 items should not contradict other documentation within that same time period of assessment,” Osburn adds.

Educate, educate, educate

The best thing you can do is continue to educate your staff on how to properly answer the new OASIS-E items.

Remind your staff to make sure the patient understands the question, says Powers.

Ask them when they last took a pain pill or had to use a heating pad and inquire about when they last avoided an activity due to pain, she adds.

Frequent review of the item’s intent and item-specific guidance would also be helpful, says Osburn.

“One class or one review of new material is not enough for most adults to learn a new concept,” she says. “It takes repetition up to seven times to commit new information to memory.”

Presenting in different ways can also prove beneficial, Osburn says.

Try using scenarios, role play and videos as well as printed material or lecture-only training to ensure that all types of learners’ needs are being met. — *Megan Herr* (mherr@decisionhealth.com) ■



Featured benchmark

Top 10 questionable encounter codes

These 10 questionable encounters accounted for nearly 28% of the 687 questionable encounter codes listed as primary in the month of December 2022, according to the Strategic Healthcare Programs’ (SHP) National Client Database. While several of the top 10 codes have remained on the list for years, there were a few newcomers — such as N18.6 (End stage renal disease) and C34.90 (Malignant neoplasm of unspecified part of unspecified bronchus or lung). For a full story, see the June 2023 issue of *Diagnosis Coding Pro*.

ICD code	Description	Periods count
M62.81	Muscle weakness (generalized)	43
R53.1	Weakness	28
R26.9	Unspecified abnormalities of gait and mobility	20
R26.89	Other abnormalities of gait or mobility	19
R29.6	Repeated falls	17
R55.	Syncope and collapse	14
N18.6	End stage renal disease	13
M19.90	Unspecified osteoarthritis, unspecified site	13
M54.50	Low back pain, unspecified	12
C34.90	Malignant neoplasm of unsp part of unsp bronchus or lungs	12

Source: Strategic Healthcare Program’s National Client Database