ICD-10 for Beginners
Four-Part Series

ICD-10

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ICD-10-CM Coding
&
Its Impact on Reimbursement

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**Learning Objectives**

At the conclusion of this program, the participant will be able to:

- Learn how to choose the primary & other diagnoses using ICD-10-CM & OASIS guidelines
- Review OASIS M items that relate to coding including
  - Inpatient diagnosis (M1011)
  - Diagnoses Requiring Change (M1017)
  - Primary diagnosis (M1021)
  - Other diagnoses/ comorbidities (M1023)
- Discuss the proper sequencing of diagnoses
- Gain a basic understanding of case mix diagnoses

**Important Definitions**

- **Outcome and Assessment Information Set (OASIS):**
  - A group of standard data elements which provide a comparative measurement of home health care patient outcomes at two points in time. The OASIS is part of the comprehensive clinical assessment of the patient. The patient’s condition and care needs are comprehensively assessed and OASIS diagnoses are then assigned.

- **Case Mix Diagnosis:**
  - A specific list of diagnoses determined by Center for Medicare & Medicaid Services (CMS) which increase revenues if listed as on the of the first six (6) diagnoses on the OASIS form.
Important Definitions

- **Prospective Payment System (PPS):**
  - The general term for the payment system under which home health is paid for Medicare patients. PPS uses “episodic payment” which is based on the case mix diagnosis and specific OASIS information.

- **Home Health Resource Grouping (HHRG):**
  - The calculated payment category for home health. 153 Payment Groupings where payment is per episode & is based on **18 OASIS data elements**. It includes the cost of the 6 disciplines & NRS.

OASIS Manual

- The OASIS Guidance Manual provides information about the completion of assessment items that require coding.

Selection & Assignment of OASIS Diagnoses

From OASIS Guidance Manual

The assessing clinician is expected to complete the patient’s comprehensive assessment and understand the patient’s overall medical condition and care needs before selecting and assigning diagnoses.

The determination of the patient’s primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.

OASIS Coding Items

- **M1011**
  - Inpatient Diagnosis ICD-10 Code

- **M1016**
  - Diagnoses Requiring Medical or Treatment Change Within 14 days

- **M1021**
  - Primary Diagnosis &
  - Symptom Control Rating
  - 30 Diagnostic Categories

- **M1023**
  - Other Diagnoses
M1011 Inpatient Diagnosis

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):

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>--- '----</td>
</tr>
<tr>
<td>b.</td>
<td>--- '----</td>
</tr>
<tr>
<td>c.</td>
<td>--- '----</td>
</tr>
<tr>
<td>d.</td>
<td>--- '----</td>
</tr>
<tr>
<td>e.</td>
<td>--- '----</td>
</tr>
<tr>
<td>f.</td>
<td>--- '----</td>
</tr>
</tbody>
</table>

Identifies diagnose for which patient was actively receiving treatment in an inpatient facility within the past 14 days.

- This list of diagnoses is intended to include only those diagnoses that required active treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis.
- "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.
- If a diagnosis was not treated during an inpatient admission, it should not be listed. (Example: The patient has a long-standing diagnosis of "osteoarthritis," but was treated during hospitalization only for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)

- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V, W, X, Y, or Z codes. List the underlying diagnosis.
### Comparison

<table>
<thead>
<tr>
<th>Inpatient Diagnosis</th>
<th>Home Health Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Acute CVA I63.9</td>
<td>■ Late Effect CVA with</td>
</tr>
<tr>
<td>■ Hemiplegia, unspecified</td>
<td>Hemiplegia right</td>
</tr>
<tr>
<td>right dominant side G81.91</td>
<td>dominant side I69.351</td>
</tr>
<tr>
<td>■ Two Codes Required</td>
<td>■ One Code Required</td>
</tr>
<tr>
<td>■ Side of hemiplegia specified</td>
<td>■ Combines diagnosis and sequelae</td>
</tr>
<tr>
<td></td>
<td>■ Side of hemiplegia specified</td>
</tr>
</tbody>
</table>

### M1017 Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:

If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)

<table>
<thead>
<tr>
<th>Changed Dx</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

NA = No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
M1017 Conditions Prior to Medical or Treatment Regimen Change

- No surgical codes - list the underlying diagnosis.
- No V, W, X, Y, or Z codes - list the appropriate diagnosis.
- Response to this item may include the same diagnoses as M1011 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.
- Mark "NA" if no medical or treatment regimen changes were made within the past 14 days OR all changes in the medical or treatment regimen were made because a diagnosis improved.

M1017 Diagnoses Requiring Medical or Treatment Regimen Change within past 14 days

- Question 4. Please provide clarification and guidance related to M1016 and the Response specific Instructions to "Mark NA if changes in the medical or treatment regimen were made because a diagnosis improved." If we admit a patient following a hospital stay for exacerbation of CHF and at SOC, the patient’s CHF is still a current diagnosis that requires monitoring, evaluation, and/or active treatment by the agency to prevent readmission of the patient to the hospital; can we list CHF in M1017 even though it is “improved”? 
M1017 Diagnoses Requiring Medical or Treatment Regimen Change within past 14 days

- **Answer 4.** M1017 is utilized in the risk adjustment of outcomes. The Ch. 3 Item Intent explains, "The purpose of this question is to help identify the patient’s recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable." The intent of the item is not to identify diagnoses where all medical or treatment regimen changes in the last 14 days were related to improvements in a condition. If at any time in the last 14 days the patient requires a medical or treatment regimen change due to development of a new condition or lack of improvement or worsening of an existing condition, the diagnosis should be reported in M1017, even if the condition also showed improvement or stabilization during that time, or is improved at the time of the SOC.

Home Care Diagnosis

- **List conditions which are identified as impacting the plan of care**
  - Chronic conditions such as diabetes, CHF, CAD, Alzheimer's may be listed as long as there are documented measures
  - Diagnoses listed here are carried over to 485
- **When patient admitted from acute care or rehab – Aftercare may be the appropriate primary diagnosis**
Resolved Conditions

- When a diagnosis is no longer being actively treated or monitored
- These diagnoses may only be listed in:
  - M1011 Inpatient Diagnosis
  - M1017 Diagnoses Requiring Medical or Treatment Regimen Change
  - M1025 Payment Diagnosis
- Examples: Pneumonia, UTI
  - History of Pneumonia Z87.01
  - History of UTI Z87.440
- May be used as Past Medical History

OASIS Coding Items

Home Health Diagnosis

M1021 Primary Diagnosis & Symptom Control Rating
30 Diagnostic Categories

M1023 Other Diagnoses

M1025 Payment Diagnoses (Optional)
### M1021 Primary Diagnosis Selection

**M1021 line a: (Columns 1 & 2) PRIMARY DIAGNOSIS (485 #11)**

**Definition:** the diagnosis most related to current home health plan of care

- The condition established *after study* to be the chief reason for the admission.
- The diagnosis that represents the most acute condition and requires the most intensive services should be entered.
- Specifically, why the agency is treating the patient.
- May be different from hospital diagnosis (M1011).
- Z-Codes may be the appropriate primary diagnosis.

- Example: Attention to Colostomy Z43.3
- Example: Aftercare following surgery of circulatory system dressing Z48.812
Assignment of OASIS Codes

Q44.1.5 Can anyone other than the assessing clinician enter the ICD codes?

A44.1.5. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write-in the medical diagnoses requested in M1011, M1017, and M1021/1023, if applicable. A coding specialist in the agency may enter the actual numeric ICD-10 codes once the assessment is completed.

Assignment of OASIS Codes

Q36: Can we have the SOC Clinician defer to the agency certified coder for all coding in the document? Does this affect the date that the OASIS assessment is completed?

A36: Regulation does allow for a coding specialist to enter the ICD-10 Codes after the assessment is completed so therefore it does not change the M0090 date.
Symptom Control Rating

Symptom Control Rating is used in conjunction with the diagnoses assigned in M1021-M1023 to rate the symptom control of each diagnosis

- 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

Questions To Ask To Determine Diagnoses

- What diagnosis is driving the plan of care?
- What diagnosis is the most resource intensive?
- Does the diagnosis impact the plan of care? How?
- Is the reason for the admission treatment or aftercare?
- Is this diagnosis a manifestation?
- If Psych diagnosis – are they being treated with psychiatric meds or by psychiatrist?
- Does the diagnosis selected affect progress or rehab potential?
- Is the primary reason for service rehab or nursing?
- Does the diagnosis justify the medical necessity of each discipline?
### How To Choose The Appropriate Other Diagnosis

M1023 lines b-f (Columns 1 & 2) OTHER DIAGNOSES

Home Health Certification and Plan of Care (485) #13

**Definition:** all conditions that coexisted with this primary diagnosis at the time the plan of care was established, or which developed subsequently, or affect the treatment or care of the patient.

- Secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient’s Plan of Care, or that have the potential to affect the patient’s responsiveness to treatment and rehabilitative prognosis.
- The secondary diagnoses may or may not be related to a patient’s recent hospital stay, but must have the potential to impact the skilled services provided by the HHA.

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### Comorbidities Impacting Plan of Care

- Diabetes
- Parkinsonism
- Alzheimer’s
- Dementia
- MS
- Hypertension
- CHF
- Anemia
- Depression
- CAD
- COPD
- Blindness
- Neoplasms
- Obesity *(impacts functional status)*
Questions to Determine Additional Diagnoses

- If patient had a fall, why did patient fall?
- If patient on pain med, what is diagnosis?
- If patient experiencing cognitive decline, what is neuro diagnosis?
- If patient receiving injectable, what is diagnosis?
- If patient is noted to have significant weight loss, how to code?
- Does patient live alone?
- Is patient on continuous O2?

Sequencing Other/Secondary Diagnoses (M1023 lines b - f)

- List the diagnosis that would become the primary diagnosis, after the primary is resolved
- Record the most recent onset/exacerbation date
- Document symptom control rating of diagnosis
- Review diagnoses listed in the plan of treatment (Box 21 on 485)
- Review 485 #10 Medication box for additional diagnoses

Example

- Colace
- Prednisone
- B12 Injection

Diagnosis

- (Not needed)
- Lupus
- Pernicious Anemia
HH PPS Grouper Software Logic
Calculating Case Mix Points

- Not eligible to earn points from the same diagnosis group
- If both primary & secondary diagnoses are from the same diagnostic category then the primary diagnosis score is recognized
- If diagnoses are from different diagnostic groups – points from each different diagnostic group is assigned
  - Up to 6 diagnoses are recognized
- Codes identified as a manifestation must be preceded by underlying etiology to receive points

Understanding the Case Mix Tables

- 30 Case Mix Categories
  - Sequencing continues to be important for three case mix categories
    - Diabetes
    - Neuro 1
    - Skin 1
- 22 Diagnostic Groups for Code Capture
  - Decimal point after third character is included in updated tables/lists
  - Specific 7th character(s) is included in listing
Case Mix Categories - 30

1. Blindness/low vision
2. Blood
3. CA
4. Diabetes – Primary
5. Diabetes – Other Diagnosis
6. Dysphagia & Neuro 3-Stroke
7. Dysphagia & M1030 Therapies
8. GI
9. GI & Ostomy
10. GI & Neuro 1, 2, 3

Case Mix Categories

11. Heart disease or HTN
12. Neuro 1 Brain Disorders
13. Neuro 1 Brain Disorders & M1840 Toilet Transferring
14. Neuro 1 or Neuro 2 & M1810/M1820 Dressing
15. Neuro 3 Stroke
16. Neuro 3 Stroke & M1810/M1820 Dressing
17. Neuro 3 Stroke & M1860 Ambulation
18. Neuro 4 MS & M1830-M1860 Bathing, Toileting, Transferring, Ambulation
19. Ortho 1 & M1324 Stage of Most Problematic PU
20. Ortho 1 or Ortho 2 & M1030 Therapies
Case Mix Categories

21. Psych 1
22. Psych 2
23. Pulmonary Disorders
24. Pulmonary Disorders & M1860 Ambulation
25. Skin 1 – Primary
26. Skin 1 – Other Diagnosis
27. Skin 1 or Skin 2 & M1030 Therapies
28. Skin 2
29. Tracheostomy
30. Urostomy/Cystostomy

22 Diagnostic Groups (DG) 2016

1. Blindness & Low vision 12. Neuro 3 Stroke
2. Blood Disorders 13. Neuro 4 MS
3. Cancer 14. Ortho 1 Leg Disorders
4. Diabetes 15. Ortho 2 Other Ortho Disorders
5. Dysphagia 16. Psych 1
6. Gait 17. Psych 2
7. GI Disorders 18. Pulmonary
8. Heart Disease 19. Skin 1
9. Hypertension 20. Skin 2
11. Neuro 2 Peripheral 22. Urostomy
Reminder

- No points given

- DG01 Blindness & Low Vision
- DG16 Psych 1
- DG17 Psych 2
- DG18 Pulmonary

Breakdown of Diagnostic Groups

- Heart Disease DG08
- Hypertension DG09

<table>
<thead>
<tr>
<th>DG08</th>
<th>DG09</th>
</tr>
</thead>
<tbody>
<tr>
<td>I25.10</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I25.110</td>
<td>Hypertensive heart disease without heart failure</td>
</tr>
<tr>
<td>I25.111</td>
<td>Hypertensive chronic kidney disease w/stg 5 chr kidney disease or ESRD</td>
</tr>
<tr>
<td>I25.118</td>
<td>Hypertensive chronic kidney disease w/stg 1-4/unspl chr kdny</td>
</tr>
<tr>
<td>I25.119</td>
<td>Hypertensive heart disease w/unsp ang pts</td>
</tr>
</tbody>
</table>

| 130.0 | Hypertensive heart disease with heart failure |
| 130.1 | Hypertensive heart disease without heart failure |
| 130.2 | Hypertensive chronic kidney disease w/stg 5 chr kidney disease or ESRD |
| 130.3 | Hypertensive chronic kidney disease w/stg 1-4/unspl chr kdny |
| 130.4 | Hypertensive heart disease w/unsp ang pts |

- Must follow Coding Guidelines
- Must be sequenced properly
# Diabetes 2016

## Four Equation Model

### Table 12: Case-Mix Adjustment Variables and Scores

<table>
<thead>
<tr>
<th>Episode number within sequence of adjacent episodes</th>
<th>1 or 2</th>
<th>1 or 2</th>
<th>3+</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy visits</td>
<td>0-13</td>
<td>14+</td>
<td>0-13</td>
<td>14+</td>
</tr>
<tr>
<td>EQUATION</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Clinical Dimension

<table>
<thead>
<tr>
<th></th>
<th>4 Primary Diagnosis = Diabetes</th>
<th>5 Other Diagnosis = Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

19. Primary or Other Diagnosis = Ortho 1 - Leg Disorders or Gait Disorders AND M1324 (most problematic pressure ulcer stage)= 1,2,3 or 4

20. Primary or Other Diagnosis = Ortho 1 - Leg OR Ortho 2 - Other orthopedic disorders AND M1030(Therapy at home)= 1 (IV/Infusion) or 2(Parenteral)
What is a HHRG?

- Home Health Resource Grouping (HHRG) is the calculated payment category
- 153 Payment Groupings
- Payment is per episode & is based on 18 OASIS data elements
- Includes the cost of the 6 disciplines & NRS
- What is a Health Insurance Prospective Payment System (HIPPS)?
  - A 5 digit alphanumeric code used on the Medicare claim form.
  - The first letter represents episode timing; the second position represents the clinical domain (A-D); the third position the functional domain (E-I); the fourth position service domain (J-M); and the fifth represents a severity group for Non-routine supplies based on the scoring for NRS
Understanding HHRG Case Mix

- A patient is assigned into four equations:
  - 1st or 2nd episode* low therapy
  - 1st or 2nd episode* high therapy
  - 3rd + episode* low therapy
  - 3rd + episode* high therapy

* From M0110 Episode Timing

- Therapy thresholds at 6, 14, 20 visits
  - Threshold of 20+ is captured separately as the fifth item (equation) in the four equation model.

### Table 12: Case-Mix Adjustment Variables and Scores

<table>
<thead>
<tr>
<th>Episode number within sequence of adjacent episodes</th>
<th>1 or 2</th>
<th>1 or 2</th>
<th>3+</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy visits</td>
<td>0-13</td>
<td>14+</td>
<td>0-13</td>
<td>14+</td>
</tr>
<tr>
<td>EQUATION:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**CLINICAL DIMENSION**

| 6 Primary or Other Diagnosis = Dysphagia AND Primary or Other Diagnosis = Neuro 3 -Stroke | 3 | 16 | 1 | 9 |
| 7 Primary or Other Diagnosis Dysphagia AND Primary or Other Diagnosis = M1030 (Therapy at Home) = 3 Enteral | 1 | 10 | 1 | 10 |
HHRG C1F1S1

- Clinical is the first level of the decision tree and is composed of 11 M items.
- Functional is the second level of the decision tree and is composed of 6 M items.
- Service level dimension is based on 1 item: M2200 Therapy Services

18 Items Used to Calculate HHRG

Clinical
- M1021 Primary Diagnosis
- M1023 Other Diagnoses
- M1030 Therapies (IV, parenteral)
- M1242 Frequency of Pain
- M1308 Multiple Pressure Ulcer
- M1324 Most Problematic Pressure Ulcer
- M1334 Stasis Ulcer
- M1342 Surgical Wound
- M1400 Shortness of Breath
- M1620 Bowel Incontinence
- M1630 Ostomy for Bowel Elimination

Functional
- M1810 Ability to Dress Upper Body
- M1820 Ability to Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation/Locomotion

Service
- M2200 Therapy Visits
### Breakdown of Points

**Table 4—CY 2016 Clinical and Functional Thresholds**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1st and 2nd Episodes</th>
<th>3rd+ Episodes</th>
<th>All episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 13 therapy visits</td>
<td>14 to 19 therapy visits</td>
<td>0 to 13 therapy visits</td>
</tr>
<tr>
<td>Grouping Step:</td>
<td>1</td>
<td>2.1</td>
<td>3</td>
</tr>
<tr>
<td>Equation(s) used to calculate points: (see Table 3)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Severity Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>C1</td>
<td>0 to 1</td>
<td>0 to 1</td>
</tr>
<tr>
<td></td>
<td>C2</td>
<td>2 to 3</td>
<td>2 to 7</td>
</tr>
<tr>
<td></td>
<td>C3</td>
<td>4+</td>
<td>8+</td>
</tr>
<tr>
<td>Functional</td>
<td>F1</td>
<td>0 to 14</td>
<td>0 to 6</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>15</td>
<td>7 to 13</td>
</tr>
<tr>
<td></td>
<td>F3</td>
<td>15+</td>
<td>14+</td>
</tr>
</tbody>
</table>

### Case Mix Weights

**Table 6: Final CY 2016 Case-Mix Payment Weights**

<table>
<thead>
<tr>
<th>Payment group</th>
<th>Step (episode and/or therapy visit ranges)</th>
<th>Clinical and functional levels (1 = Low; 3 = Medium; 3+ High)</th>
<th>Final CY 2016 case-mix weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>10111</td>
<td>1st and 2nd Episodes, 0 to 5 Therapy Visits</td>
<td>CIF1S1</td>
<td>0.5006</td>
</tr>
<tr>
<td>10112</td>
<td>1st and 2nd Episodes, 6 Therapy Visits</td>
<td>CIF1S2</td>
<td>0.7987</td>
</tr>
<tr>
<td>10113</td>
<td>1st and 2nd Episodes, 7 to 9 Therapy Visits</td>
<td>CIF1S3</td>
<td>0.6485</td>
</tr>
<tr>
<td>10114</td>
<td>1st and 2nd Episodes, 10 Therapy Visits</td>
<td>CIF1S4</td>
<td>0.9774</td>
</tr>
<tr>
<td>10115</td>
<td>1st and 2nd Episodes, 11 to 13 Therapy Visits</td>
<td>CIF1S5</td>
<td>1.1063</td>
</tr>
<tr>
<td>10121</td>
<td>1st and 2nd Episodes, 0 to 5 Therapy Visits</td>
<td>CIF2S1</td>
<td>0.7062</td>
</tr>
<tr>
<td>10122</td>
<td>1st and 2nd Episodes, 6 Therapy Visits</td>
<td>CIF2S2</td>
<td>0.8517</td>
</tr>
<tr>
<td>10123</td>
<td>1st and 2nd Episodes, 7 to 9 Therapy Visits</td>
<td>CIF2S3</td>
<td>0.9373</td>
</tr>
<tr>
<td>10124</td>
<td>1st and 2nd Episodes, 10 Therapy Visits</td>
<td>CIF2S4</td>
<td>1.0527</td>
</tr>
<tr>
<td>10125</td>
<td>1st and 2nd Episodes, 11 to 13 Therapy Visits</td>
<td>CIF2S5</td>
<td>1.1681</td>
</tr>
<tr>
<td>10131</td>
<td>1st and 2nd Episodes, 0 to 5 Therapy Visits</td>
<td>CIF3S1</td>
<td>0.7643</td>
</tr>
<tr>
<td>10132</td>
<td>1st and 2nd Episodes, 6 Therapy Visits</td>
<td>CIF3S2</td>
<td>0.6832</td>
</tr>
<tr>
<td>10133</td>
<td>1st and 2nd Episodes, 7 to 9 Therapy Visits</td>
<td>CIF3S3</td>
<td>0.9021</td>
</tr>
<tr>
<td>10134</td>
<td>1st and 2nd Episodes, 10 Therapy Visits</td>
<td>CIF3S4</td>
<td>1.1310</td>
</tr>
<tr>
<td>10135</td>
<td>1st and 2nd Episodes, 11 to 13 Therapy Visits</td>
<td>CIF3S5</td>
<td>1.2389</td>
</tr>
</tbody>
</table>
Test Your Knowledge
Late Effects CVA

- Patient is discharged from hospital s/p CVA with hemiplegia left dominant side and dysphagia. Patient also has HTN and is legally blind.

- Total of 5 diagnoses
- How should diagnoses be sequenced?

<table>
<thead>
<tr>
<th>Acute CVA</th>
<th>Late Effects CVA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Diagnoses</strong></td>
<td><strong>Home Health Diagnoses</strong></td>
</tr>
<tr>
<td>Acute CVA</td>
<td></td>
</tr>
<tr>
<td>Hemiplegia, left Dysphagia (Dominant Side)</td>
<td>with Hemiplegia (Left Dominant Side)</td>
</tr>
<tr>
<td>L63.9</td>
<td>I69.352</td>
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<tr>
<td>G81.92</td>
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<tr>
<td>R13.10</td>
<td>I69.391</td>
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<tr>
<td>M1011a</td>
<td></td>
</tr>
<tr>
<td>M1011b</td>
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<td>M1011c</td>
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<tr>
<td>HTN</td>
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<tr>
<td>I10</td>
<td>R13.10</td>
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<td>Legally Blind</td>
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<tr>
<td>H54.8</td>
<td>I10</td>
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<td>H54.8</td>
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</table>
Late Effect CVA with Dysphagia 1st episode
17 therapy visits CY 2016 Weights

<table>
<thead>
<tr>
<th>Calculation</th>
<th>Correct ICD-10 Coding</th>
<th>Incorrect ICD-10 Coding</th>
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<tbody>
<tr>
<td>M1021 Primary Diagnosis M1023 Other Diagnosis</td>
<td>Sequelae CVA with Dysphagia - 9 points Dysphagia -16 points I69.391; R13.10</td>
<td>Sequelae CVA with Dysphagia - 0 points I69.991</td>
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<tr>
<td>Category Name</td>
<td>Neuro 3 – Stroke; Dysphagia</td>
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<tr>
<td>Category # providing point</td>
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<tr>
<td>Total Clinical Points</td>
<td>9,16 (C3 = 8+ points)</td>
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<td>HHRG Assignment</td>
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<td>C1F1S2</td>
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<td>Case mix weight</td>
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<td>0.7197</td>
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<tr>
<td>National Rate</td>
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<td>$2961.38</td>
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<tr>
<td>Final Reimbursement</td>
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<td>$2131.31</td>
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<tr>
<td>Difference</td>
<td>-$2874.01</td>
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</tr>
</tbody>
</table>

Criteria for OASIS Diagnosis Reporting

DO......

- Comply with ICD-10-CM Guidelines
- Code only unresolved diagnoses in M1021-M1023
- Code only relevant diagnoses which have a potential to impact the plan of care
- Code diagnoses supported by medical record information
- Follow sequencing requirements
- Follow manifestation requirements
**Coding Success**

- Include all appropriate comorbidities
- Be sure manifestations have two codes designated
- Check the OASIS M items for any appropriate diagnoses
- Query the clinician as needed
- Audit...Audit...Audit
  - Check the integrity of the coding & documentation

---

**Exhaustion from Coding**

R53.83

If due to excessive exertion

T73.3xxD
Questions????

Next Session
Understanding Common Diagnostic Areas - Where Coding Mistakes Occur: Part 1
Class Companion: Rapid Reference Guide

- Available for beginners & for quick reference.
- Allows for easy look-up of home health codes. Pages are organized how clinicians think and by medical abbreviation. Book includes coding updates for 2016.
- Cost is for Webinar participants only is $74 (5% discount) including s/h. Offer valid until September 15, 2016.
- To download order blank, go to www.jluhealth.com Use discount code NH.

Resources

Coding

- Coding Guidelines http://www.cdc.gov/nchs/icd/icd10cm.htm

OASIS

- Home Health Agency Center https://www.cms.gov/center/provide r-Type/home-Health-Agency-HHA-Center.html
ABOUT THE SPEAKER:
JOAN L. USHER, BS, RHIA, ACE, President, JLU Health Record Systems, Pembroke, MA

- Degree in Health Information Management
- Certified OASIS and Coding Specialist over 9 years
- AHIMA Approved ICD-10-CM Trainer
- Author, Online ICD Coding Courses in partnership with Libman Education 2012-2016 [http://www.libmaneducation.com/healthcare-education-training/home-health-coding/]
- Author/Editor Online E-Learning Coding Courses: Home Health Diagnostic Coding; Home Health Reimbursement Methods, Home Health Documentation & Health Record Requirements AHIMA [www.ahimastore.org] © 2011
- Contributing editor, Schraffenberger/Keuhn, Effective Mgmt of Coding Services, AHIMA, © 2009
- Massachusetts Health Information Management Association (MaHIMA), BOD 2004-2011
  - President, 2006, under her leadership, MA received 4 national awards from AHIMA in Continuing Education Programs, Support for Accredited HIM Education Programs, Legislative Advocacy and Electronic Communications
  - Co-Chair ICD-10 Task Force 2013-2015
- Professional Achievement Award Recipient, MaHIMA, 2008
- American Health Information Management Association (AHIMA) delegate 2002-2006
- Taught ICD coding for over 20 years and has educated over 17,000 people nationwide
- Home Care Alliance of MA, Board of Director 2012-2017, member QI Committee, Facilitator ICD-10 Group 2013-2015
- Hospice & Palliative Care Federation MA, Board of Director 2008-2017