ICD-10-CM Coding for Home Health

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Objectives

By the end of this webinar, participants will be able to:

✓ Explain diagnosis coding in the home health setting.
✓ Identify correct coding and sequencing of home health diagnosis codes on the claim form and the Outcome and Assessment Information Set (OASIS).
✓ Apply the general and chapter specific coding guidelines to assign ICD-10-CM codes for common home health diagnoses.
Introduction

The **International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** is used in the United States to code and classify morbidity data in all healthcare settings.

**Home health agencies (HHAs)** report these diagnosis codes on the:

- Home health insurance claim
- Home health plan of care
- Outcome and Assessment Information Set (OASIS)

This one-hour session will review the guidelines, conventions and sequencing instructions for coding home health diagnoses in ICD-10-CM.
ICD-10-CM Coding for Home Health

What is Home Health Care?
What is Home Health Care?

Home health care is:

- a range of medical, therapeutic, and nonmedical services
- provided by a variety of health care professionals in the patient’s home

The National Association for Home Care & Hospice estimates over 12 million patients in the U.S. receive home care for acute illness, long-term health conditions, disability, or terminal illness.

“Home care” and “home health care”

- refer to traditional services as defined by the Centers for Medicare and Medicaid Services (CMS).
Evolution of Home Health Care

Home health care in the United States dates back to colonial times…

- Home care began in the United States in the 1700s
- The 1800s saw the advent of “visiting nurses”
- The 1900s included rapid growth in restorative, rehabilitative, and palliative home care, and the Medicare-Medicaid home health benefit
- In 2000, the OASIS and Home Health Prospective Payment System were implemented
- Currently, home care services have grown rapidly and trends predict increasing use of home health care
What are Home Health Care Services?

Home health professionals provide care to manage the effects of illness, and help patients recuperate or restore health, maximize independence, and remain in their home.

Home health services include:

- Restorative care
- Rehabilitative care
- Palliative care
- End of life (hospice) care

Home health professionals provide restorative, rehabilitative, palliative, and end of life (hospice) care.
Who Receives Home Health Services?

Home health patients often:

- Have multiple chronic illnesses or take multiple medications.
- Are discharged to home care services for continued rehabilitative care.
- Need skilled nursing services, therapy, and/or assistance with activities of daily living (ADLs).
- Require significant support, teaching, and coaching to manage their health and remain in their homes.
- Are over age 65, and Medicare is the largest payer. (Medicaid and other payers also regularly cover home care for children, younger adults, and others).
- May qualify for home care services without preceding hospitalization.
Home Health Care Patients and Services

Common reasons for home health care include:

- Cerebrovascular disease
- Chronic obstructive pulmonary diseases and allied conditions
- Dementia
- Diabetes mellitus
- Heart disease, including heart failure
- Hypertension
- Malignant neoplasm
- Osteoarthritis

Common skilled home health services provided include:

- Wound care (pressure sores or a surgical wound)
- Orthopedic or other surgical aftercare
- Patient and caregiver education
- Injections or intravenous therapy
- Monitoring illness and unstable health status
- Nutrition therapy and dietary counseling
- Hospice care
ICD-10-CM Coding for Home Health

Reporting Home Health Diagnoses
Reporting Home Health Diagnoses

Each home health patient's medical condition and care needs are comprehensively assessed.

Home health clinicians determine the primary and secondary diagnoses as part of care planning.

The clinical documentation must:

- Specify which diagnoses are the focus of care and why a particular diagnosis is pertinent to the plan of care.
- Support the medical necessity of services provided in the patient's home.
Home Health Diagnoses: OASIS Reporting

The **Outcome and Assessment Information Set** data items measure a home health patient's health status, risk factors, and outcomes. The OASIS includes:

- Comprehensive adult patient assessment elements.
- Patient conditions and needs (determines reimbursement).
- Patient outcomes for outcome-based quality improvement (OBQI).
- HHA quality data for public reporting on Home Health Compare.
Home Health OASIS Data

The OASIS data is used for care planning, quality reporting, and reimbursement.

- HHAs collect OASIS data at the start of care, 60-day follow-ups, and on discharge.
- Reimbursed for each 60-day episode
- Rate determined by case-mix methodology, based on OASIS data:
  - OASIS domains are assigned a score
  - Scores determine the case-mix or Home Health Resource Group (HHRG)

OASIS Note:
The current OASIS data set (OASIS-C1/ICD-10) incorporates diagnosis items consistent with ICD-10-CM. Effective January 1, 2017, the OASIS-C2 includes standardized post-acute care measures required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.
Home Health Diagnoses Reporting

- All diagnosis codes reported by the HHA on the home health plan of care, on the OASIS and on the insurance claim must match.

<table>
<thead>
<tr>
<th>OASIS ITEM (M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses (cont’d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
</tr>
<tr>
<td>Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)</td>
</tr>
<tr>
<td>Description</td>
</tr>
<tr>
<td>(M1021) Primary Diagnosis</td>
</tr>
<tr>
<td>a.</td>
</tr>
<tr>
<td>(M1023) Other Diagnoses</td>
</tr>
<tr>
<td>b.</td>
</tr>
<tr>
<td>c.</td>
</tr>
</tbody>
</table>
Coding Home Health Diagnoses

The assessing home health clinician determines and documents the primary and secondary diagnoses but may or may not assign the diagnosis codes.

Home health professionals completing the OASIS data items must report the codes for the reason(s) for home health services in compliance with the official ICD-10-CM coding guidelines.

Accurate coding for home health requires an understanding of the OASIS requirements and the ICD-10-CM coding conventions and guidelines.
ICD-10-CM Coding Guidelines

Home health professionals use the *ICD-10-CM Official Guidelines for Coding and Reporting* to select the correct diagnosis codes. These coding guidelines are used together with the coding and sequencing instructions in the tabular list and alphabetic index of ICD-10-CM, to assign and sequence diagnosis codes.

The CDC’s National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) provide the guidelines for coding with ICD-10-CM.

http://www.cdc.gov/nchs/icd/icd10cm.htm
The **OASIS-C1/ICD-10 Guidance Manual**:  
- Developed by the Centers for Medicare & Medicaid Services  
- Contains OASIS item guidance  
- assists HHAs in accurate selection and assignment of diagnoses on the OASIS.

The current version of the manual includes the ICD-10-CM codes in both the guidance manual and the corresponding OASIS-C1 data set items.

Home Health Diagnosis Coding: General Guidelines

HHAs report each diagnosis for which the patient is receiving home care and its ICD-10-CM code at the level of highest specificity. Diagnoses are listed based on the seriousness of each condition and the services provided. ICD-10-CM sequencing requirements must be followed for all diagnoses.

Primary Diagnosis:
Chief reason for home care services

Secondary Diagnoses:
Actively addressed in POC or affects treatment or rehabilitative prognosis

Sequence diagnoses according to the ICD-10-CM coding guidelines
Home Health Coding Guidelines: Sequencing Diagnoses

**Primary** and **secondary** home health diagnoses must be determined by the assessing clinician based on the findings of the assessment.

The patient’s **primary** home health diagnosis is defined as the:

- Chief reason the patient is receiving home care.
- Diagnosis most related to the current home health plan of care and the services rendered by the HHA.
- Most acute condition requiring the most intensive services (if more than one diagnosis is treated concurrently).

**Coding Note:**

*Primary* and *principal* diagnosis are often used interchangeably. However, “*principal diagnosis*” describes the first code reported for an inpatient case, and “*primary*” or “*first-listed*” describe the sequencing of diagnoses for outpatient cases.
Secondary diagnoses are reported for:

- All coexisting conditions actively addressed in the patient’s Plan of Care
- Any comorbid conditions with the potential to affect the patient’s treatment or rehabilitative prognosis, or impact the skilled services provided by the HHA.

**Coding Note:**
Only current medical diagnoses should be reported. Diagnoses that are resolved or do not potentially impact the skilled services provided should not be reported (e.g., cholecystitis following a cholecystectomy).
Home Health Coding Guidelines: Multiple Coding

When **multiple coding** is required to identify all elements of certain diagnoses, HHAs must follow OASIS guidance and ICD-10-CM coding guidelines (e.g., general coding guidelines Section I.B.7).

For conditions with an underlying cause (**etiology**) and **manifestations**:  
- ICD-10-CM mandatory coding convention: underlying condition sequenced first, followed by manifestation code  
- Denoted by brackets in the alphabetic index or a notation in the tabular list.  
- An instructional note to "Use additional code" is sometimes present.

For example, the diagnosis **"oral phase dysphagia following cerebral infarction"** is coded as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I69.391</td>
<td>Dysphagia following cerebral infarction</td>
</tr>
<tr>
<td>R13.12</td>
<td>Dysphagia, oral phase</td>
</tr>
</tbody>
</table>
The **OASIS Optional Diagnoses** item (M1025):

- May be completed in a multiple coding situations (e.g., an etiology/manifestation pair)
- The etiology code for the underlying disease must be sequenced before the code for the related manifestation.
- Report the ICD-10-CM code for the underlying condition in Column 3
- Report the code for the manifestation in Column 4

**OASIS Note:**
Diagnoses reported in the OASIS Optional Diagnoses item (M1025) will not impact payment.
Home Health Coding Guidelines: 7th Characters

ICD-10-CM codes are 3-7 characters. Many codes require a 7th character extension describing the episode of care.

**7TH CHARACTER EXTENSIONS:**

- A Initial encounter
- D Subsequent encounter
- S Sequela

**Initial and subsequent encounters are:**

- Not based on chronology of care or whether the patient is seeing a new provider.
- Based on whether or not the patient is still receiving active treatment.

HHAs report 7th character “A” for initial encounter or “D” for subsequent encounter based on whether the care provided is active treatment (A) or routine care during healing and recovery (D).

**Active treatment**: Surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a new provider for the same condition.

**Subsequent care**: Medication adjustment, aftercare, and follow up visits following treatment of the injury or condition.
Patient is admitted to home health for ongoing IV antibiotics for a surgical wound infection.

T81.4xxA, Infection following a procedure, initial encounter

 Assign 7th character “A” for initial encounter for active treatment of the surgical wound infection.

Patient is admitted to home health for routine dressing changes and care of a healing postoperative wound infection.

T81.4xxD, Infection following a procedure, subsequent encounter

 Assign 7th character “D” for subsequent encounter for routine care during the healing and recovery phase.
ICD-10-CM Coding for Home Health

Common Home Health Diagnoses
Common Home Health Diagnoses

The primary and secondary home health diagnoses are determined based on the patient’s status and treatment plan at the time of the assessment.

Home health encounters may:
- Occur after active treatment
- Provide routine care during the healing or recovery phase
- Have post-acute care diagnoses (e.g., orthopedic aftercare)

Home health services may be directed at:
- Current, acute conditions (e.g., malignancy, wound infection)
- Acute exacerbations of chronic conditions (e.g., COPD, diabetes, hypertension, heart disease).

HHAs may treat two or more concurrent conditions. For example, symptoms may be treated concurrently with an existing primary or secondary, or a symptom may be a primary diagnosis (e.g., postoperative patients receiving pain management services).
Common Home Health Diagnoses: Cerebrovascular disease

Cerebrovascular accident (CVA), commonly referred to as stroke, is a leading cause of long-term disability in the United States. Patients with stroke and other cerebrovascular diseases have a broad range of symptoms and many are living with residual conditions or "sequelae".

Cerebrovascular disease and the late effects (sequela) of cerebrovascular conditions are common diagnoses in home health care patients. Patients discharged from the hospital following cerebral infarction may be admitted to home health for an acute diagnosis or a residual condition.

The code block I60-I69, Cerebrovascular Diseases, in Chapter 9, "Diseases of the Circulatory System" (I00-I99), includes nontraumatic cerebral hemorrhage, cerebral infarctions, occlusion or stenosis without an infarction, and sequelae of cerebrovascular disease (Category I69).

Coding Note:
Sequelae of an injury or condition can occur at any time—soon after acute injury or condition, or years later. Two codes may be needed: the code for the condition or nature of the sequela, followed by the sequela code.
**Diagnosis:** Residual facial weakness due to previous non-ruptured cerebral aneurysm

**Weak, weakening, weakness (generalized) R53.1**
- arches (acquired) — see also Deformity, limb, flat foot
- bladder (sphincter) R32
- facial R29.810
- following
  - cerebrovascular disease I69.992
  - cerebral infarction I69.392
  - intracerebral hemorrhage I69.192
  - nontraumatic intracranial hemorrhage NEC I69.292
  - specified disease NEC I69.892
  - stroke I69.392
  - subarachnoid hemorrhage I69.092
**Diagnosis:** Residual facial weakness due to previous non-ruptured cerebral aneurysm

**Coding:**

- Reference the index main term *Weakness*, and subterms *facial, following, cerebrovascular disease, specified disease NEC*.

- I69.892, Facial weakness following other cerebrovascular disease
Diagnosis: Bilateral locked-in syndrome due to a previous nontraumatic subarachnoid hemorrhage

Coding: Reference the index main term
- Sequelae
  - subterms:
    - Hemorrhage
      - Subarachnoid
        - Paralytic syndrome
Diagnosis: Bilateral locked-in syndrome due to a previous nontraumatic subarachnoid hemorrhage

Coding: See main term Sequelae, subterms: hemorrhage, subarachnoid, paralytic syndrome (I69.06-)

→ Use additional code to identify type of paralytic syndrome (locked-in state G83.5)

Assign: I69.065, Other paralytic syndrome following nontraumatic subarachnoid hemorrhage bilateral

G83.5, Locked-in state

Home Health Coding Practice: Cerebrovascular Disease
ICD-10-CM Coding for Home Health

Skin Ulcers
Common Home Health Diagnoses: Skin Ulcers

**Skin ulcers** (lesions that erode the skin) are very common among home health patients. Skin ulcers are classified in two main categories:

1) **Pressure ulcers** result from extended periods of continued pressure on the skin and subcutaneous tissue, muscles and bones. Pressure ulcer development is a home health quality of care indicator and a publicly reported quality measure.

2) **Non-pressure ulcers** are chronic, non-pressure wounds that are caused by venous insufficiency, occlusive diseases, and diabetes.

**OASIS Note**
Several OASIS data items in the Integumentary Status domain related to stasis ulcers, surgical wounds, and skin lesions or open wounds. To report these items accurately, it is essential to differentiate between the types of skin lesions and ulcers.
Coding Home Health Diagnoses: Skin Ulcers

Codes for both pressure ulcers and non-pressure ulcers are combination codes that specify the site of the ulcer and the ulcer severity.

- **Category L89, Pressure Ulcers**, includes the terms bed sore, decubitus ulcer, plaster ulcer, pressure area, and pressure sore. An Excludes2 Note references diabetic ulcers, non-pressure chronic ulcers of the skin, and varicose ulcers. An instructional note directs the home health coder to “code first any associated gangrene”.

- **Category L97, Non-Pressure Chronic Ulcer of Lower Limb, Not Elsewhere Classified**, includes conditions such as chronic skin ulcer of skin of lower limb, nonhealing ulcer of skin, trophic ulcer NOS, tropical ulcer NOS, and ulcer of skin not otherwise specified.

- **Subcategory L98.4, Non-Pressure Chronic Ulcer of Skin, Not Elsewhere Classified**, includes chronic ulcer of skin, topical ulcer, and ulcer of the skin not otherwise specified, of the buttock, back and chronic skin ulcers of other sites.
ICD-10-CM classifies **pressure ulcer stages** based on severity, designated by **stages 1-4**, **unspecified** stage and **unstageable**.

- Code assignment for the depth of non-pressure chronic ulcers and pressure ulcer stage codes, may be based on medical record documentation from clinicians who are not the patient’s physician, (e.g., nurses often document the pressure ulcer stages).
ICD-10-CM classifies pressure ulcer stages based on severity. Pressure ulcer stages are designated as stages 1, 2, 3 and 4, unspecified stage, and unstageable.

<table>
<thead>
<tr>
<th>Ulcer Stage</th>
<th>Clinical</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Skin has no breaks or tears but is red and tender</td>
<td>Skin changes limited to persistent focal edema</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Skin has an open sore or ulceration that is painful</td>
<td>Abrasion, blister, partial-thickness skin loss involving epidermis and/or dermis</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Ulceration extends beneath skin surface, forming a crater. Nerve damage may result, so pain may not be felt at this stage</td>
<td>Full-thickness skin loss involving damage or necrosis of subcutaneous tissue</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Ulcerated area open to the level of muscles, tendons, or bones (most severe stage)</td>
<td>Necrosis of soft tissues through to underlying muscle, tendon, or bone</td>
</tr>
<tr>
<td>Unstageable</td>
<td>The stage cannot be clinically determined</td>
<td>Do not confuse with “unspecified” stage (L89.--9)</td>
</tr>
</tbody>
</table>
The codes in category L97, Non-pressure Chronic Ulcer of Lower Limb, NEC are specific for site and laterality. In addition, the codes are differentiated by severity of the ulcer. Non-pressure ulcers do not have stage numbers as pressure ulcers do, but they are described much the same way.

Severity levels for non-pressure ulcers include:

- Limited to breakdown of skin
- With fat layer exposed
- With necrosis of muscle
- With necrosis of bone
- With unspecified severity

Coding Note:
Underlying conditions (e.g., atherosclerosis of the lower extremities, chronic venous hypertension, diabetic ulcers, postphlebitic syndrome, postthrombotic syndrome, or varicose ulcer) and any associated gangrene (I96) should be coded first.
ICD-10-CM Coding for Home Health

Coding Practice: Skin Ulcers
Case:

Home health skilled nursing services are ordered for a type 2 diabetic with a chronic diabetic ulcer on the heel of the right foot with muscle necrosis. The focus of the plan of care is ulcer management.
**Case:** Home health admission for a type 2 diabetic with a chronic diabetic ulcer on the heel of the right foot with muscle necrosis.

**Coding:**
- E11.621  Type 2 diabetes mellitus with foot ulcer
- L97.413  Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

**Rationale:**
Assign the associated underlying condition as the primary diagnosis followed by the code for the non-pressure, chronic ulcer of the right heel. Use additional code to identify site of ulcer (L97.4-, L97.5-). Note: conditions in diabetic patients are not necessarily complications of the diabetes and should be coded as such only when the physician identifies it as a diabetic complication.
A patient is discharged from the hospital following treatment for acute osteomyelitis due to a stage IV decubitus ulcer on the right heel. During hospitalization, the patient developed a stage II pressure ulcer on the right buttock. Home health skilled nursing is ordered for wound care of the ulcers and continued long-term antibiotic therapy for the osteomyelitis.

How is this case coded?
Home Health Coding Practice: Skin Ulcers

HOME HEALTH CODING ANSWER:

Coding:
- M86.171  Other acute osteomyelitis, right ankle and foot
- L89.614  Pressure ulcer of right heel, stage 4
- L89.312  Pressure ulcer of right buttock, stage 2

Rationale:
Osteomyelitis is the primary diagnosis because it is still being treated with antibiotics. It is also the most acute diagnosis and requires the most intensive skilled services. Assign as many pressure ulcer codes as needed to identify all the patient’s pressure ulcers.
ICD-10-CM Coding for Home Health

“Z” Codes
Common Home Health Diagnoses: Z Codes

The codes in *Chapter 21, Factors Influencing Health Status and Contact With Health Services (Z00-Z99)*, represent reasons for encounters other than a disease, injury or external cause.

The “Z” codes are used:

- In any healthcare setting.
- As either a primary or secondary code (certain Z codes may only be first-listed diagnosis).
- When a circumstance or health status is present which may affect the patient’s course of treatment and outcome.

The most common Z codes in home health include: **Aftercare, History, and Status**.

| Z00-Z13 | Persons encountering health services for examinations |
| Z14-Z15 | Genetic carrier and genetic susceptibility to disease |
| Z16     | Resistance to antimicrobial drugs |
| Z17     | Estrogen receptor status |
| Z18     | Retained foreign body fragments |
| Z20-Z29 | Persons with potential health hazards related to communicable diseases |
| Z30-Z39 | Persons encountering health services in circumstances related to reproduction |
| Z40-Z53 | Encounters for other specific health care |
| Z55-Z65 | Persons with potential health hazards related to socioeconomic and psychosocial circumstances |
| Z60     | Do not resuscitate status |
| Z67     | Blood type |
| Z68     | Body mass index (BMI) |
| Z69-Z76 | Persons encountering health services in other circumstances |
| Z77-Z99 | Persons with potential health hazards related to family and personal history and certain conditions influencing health status |
Common Home Health Diagnoses: Status and History Z Codes

Z codes are often used in home health to identify patients with certain conditions influencing health status and potential health hazards related to family and personal history.

Status Z codes used in home health include:

- Dependence on wheelchair (Z99.3)
- Bed confinement status (Z74.01)
- Colostomy status (Z93.3)
- Tracheostomy status (Z93.0)
- Dependence on respirator [ventilator] status (Z99.11)
- Do not resuscitate status (Z66)
- Long-term current drug therapy (Z79)

Coding Note:

Category Z79 codes report continuous use of a prescribed drug for long-term treatment or prophylactic use. Do not assign Z79.- for medication administered for a brief period of time to treat an acute illness (such as a course of antibiotics to treat acute bronchitis).
Common Home Health Diagnoses: History Z Codes

A history code indicates the patient no longer has the condition. **History codes** (categories **Z80-Z87**) may be used as **secondary** codes if the historical condition has an impact on current care or influences treatment. There are two types of history Z codes:

- **Personal history** codes explain a past medical condition, that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and may require monitoring.

- **Family history** codes are used when a family member(s) has/had a particular disease causing the patient to be at higher risk for the disease.

- History of falling (Z91.81)
- Personal history of stroke without residual deficits (Z86.73)
- Personal history of antineoplastic chemotherapy (Z92.21)
- Personal history (Z85) or Family history (Z80) of malignant neoplasm

**Note**: Do not code history of a surgical procedure unless the postoperative status affects current patient care.
Aftercare describes cases in which the initial treatment has been completed and the patient is receiving continued care after the acute phase has ended.

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequela. For others, the condition is included in the code title.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z43</td>
<td>Encounter for attention to artificial openings</td>
</tr>
<tr>
<td>Z44</td>
<td>Encounter for fitting and adjustment of external prosthetic device</td>
</tr>
<tr>
<td>Z45</td>
<td>Encounter for adjustment and management of implanted device</td>
</tr>
<tr>
<td>Z46</td>
<td>Encounter for fitting and adjustment of other devices</td>
</tr>
<tr>
<td>Z47</td>
<td>Orthopedic aftercare</td>
</tr>
<tr>
<td>Z48</td>
<td>Encounter for other postprocedural aftercare</td>
</tr>
<tr>
<td>Z51</td>
<td>Encounter for other aftercare</td>
</tr>
</tbody>
</table>

Encounters for aftercare are among the most common in the home healthcare setting such as:

**Coding Note:**
Do not confuse follow-up encounters with aftercare or subsequent care. Follow-up Z codes indicate continuing surveillance following completed treatment of a disease, condition, or injury that no longer exists. Encounters for follow-up care would not occur in the home healthcare setting.
Aftercare codes are located in the alphabetic index under the main term:

- **Aftercare**
- **Attention (to)**
- **Admission (for)** -see also Encounter (for)

The aftercare codes are generally first-listed to explain the specific reason for the encounter. The aftercare Z code is **not** used:

- If treatment is directed at a current, acute disease (use the diagnosis code instead).
- For aftercare for injuries (use the acute injury code with the appropriate 7th character).
Coding Home Health Diagnoses: Surgical Aftercare

In most home health cases, the patient is admitted for continued care (e.g., surgical aftercare). For postoperative home care patients, first **identify the focus of the home care**.

For example, does the patient require:
- Aftercare for joint replacement?
- Routine postsurgical wound care or infected wound care?
- Physical therapy for an associated gait abnormality?

When a patient is admitted to home health for surgical aftercare, only report the related medical diagnosis if it is still applicable. HHAs do not code conditions that were previously treated and no longer exist.

**Coding Note**
Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare unless the aftercare code indicates the type of status (such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status).
ICD-10-CM Coding for Home Health

Coding Practice: Aftercare
A patient is admitted to home health for rehabilitative services following acute care treatment for a traumatic intertrochanteric fracture of the right femur. The patient is receiving skilled nursing care and physical therapy for this fracture with routine healing.

How is this case coded and sequenced?
Home Health Coding Practice: Aftercare

**HOME HEALTH CODING ANSWER:**

**Coding:**  S72.141D  Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing

**Rationale:**

The home health services are for aftercare for a healing traumatic fracture. Assign the fracture code with a 7th character for subsequent care of the closed fracture with routine healing.

Fractures not specified as open or closed and displaced or nondisplaced, are coded to closed and displaced according to the instructional note at category S72 and the coding guidelines.

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**S72  Fracture of femur**

**Note:** A fracture not indicated as displaced or nondisplaced should be coded to displaced.

A fracture not indicated as open or closed should be coded to closed.

The open fracture designations are based on the Gustilo open fracture classification.
A patient with a personal history of a malignant neoplasm of the right breast, underwent a partial lobectomy for a metastasis to the right lung. She is discharged from the hospital with orders for home health skilled nursing for management of the surgical wound including dressing changes and monitoring for signs of infection.

How is this case coded and sequenced?
Home Health Coding Practice: Aftercare

**Home Health Coding Answer:**

**Coding:**

- Z48.3 Aftercare following surgery for neoplasm
- C78.01 Secondary malignant neoplasm of right lung
- Z48.01 Encounter for change or removal of surgical wound dressing
- Z85.3 Personal history of malignant melanoma of breast

**Rationale:**

- The home health services are for aftercare following surgery for the malignant neoplasm. An additional code is used to identify the specific neoplasm (secondary site of the right lung).

- The dressing changes are also coded as a secondary diagnosis. Refer to the index main term Change, subterms dressing, surgical (Z48.01).

- The breast cancer is coded as personal history. Refer to the index main term History, subterms personal, malignant neoplasm, breast (Z85.3).
A patient is discharged from the hospital following a total left hip replacement to treat osteoarthritis in the hip. The patient developed a postoperative wound infection and is discharged on IV antibiotics. The patient’s physician ordered home health skilled nursing services for orthopedic aftercare and to continue IV antibiotic therapy to treat the infected surgical wound.

How is this case coded and sequenced?
Home Health Coding Practice: Aftercare

**HOME HEALTH CODING ANSWER:**

**Coding:**
- T81.4XXA  Infection following a procedure, initial encounter
- Z47.1  Aftercare following joint replacement surgery
- Z96.642  Presence of left artificial hip joint

**Rationale:**
- Infection following a procedure (T81.4-) is assigned as the primary diagnosis with 7th character “A” (initial encounter) for active treatment of the surgical wound infection.
- Assign Z47.1, Aftercare following joint replacement, as a secondary diagnosis. Although this patient is receiving aftercare following a joint replacement, the surgical wound infection represents the most acute condition and requires the most intensive skilled service.
- Assign an additional Z code to identify the affected joint (Z96.642)
- The osteoarthritis is not coded because it is resolved.
Summary

Home health diagnosis codes indicating the reasons for services must be reported in compliance with the official ICD-10-CM coding guidelines and the OASIS reporting requirements.

To be a proficient home health coder, it is important to become familiar with the official ICD-10-CM conventions.

It is essential for home health professionals to understand the importance of accurate and complete diagnosis coding on the home health claim form, on the plan of care, and on the OASIS for reimbursement, care planning, performance improvement, and quality reporting.
References


You are invited to stay for a short overview on Elsevier’s education solutions for Home Health

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Elsevier’s Home Health Solution

A comprehensive online, continuing education course that helps home healthcare professionals provide care to patients in their homes, appropriately document and accurately and compliantly assign diagnosis codes on the home health claim form, care plan and on the OASIS form.
Our Mosby’s Orientation to Home Health Care Education:

Mosby’s Orientation to Home Health Care

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Provides 24 lessons on practical home health care information and evidence-based guidance

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✓ Scenarios and questions specific to home health
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