The I20 – I25 Issue

- Use additional code to identify presence of hypertension (I10-I16)
- This is sequencing direction.
- This means that if the patient has hypertensive heart failure as the focus of care, but happens to have CAD or an old MI, that has to be coded prior to the hypertensive heart failure.

My email to NCHS and their response

- I submitted a proposal regarding the sequencing convention found at I20-I25 indicating that any code in I20-I25 needed to be coded prior to hypertension. I noted that it was not included in the agenda of last week’s meeting, nor was it included in the draft changes to the tabular list. Please provide an update to its status please. Was the agenda too full? Or was the proposal denied for some other reason?

- In review of inquiries received in this office, it appears there may have been an oversight in response to you regarding your inquiry. Please accept my sincere apologies.

- Over the next few weeks, the ICD-10-CM Classification team will be reviewing this issue along with new issues / proposals that are for consideration for the upcoming September C&M Meeting and possible guideline updates.

- I will update you accordingly.

- Thank you for bringing this to our attention.

Related Issue at I60-I69

- Use additional code to identify presence of:
  - Hypertension (I10-I15)

- Sequencing direction meaning even if hypertension, hypertensive heart failure, etc was the focus of care, the old stroke would have to be coded first.

- This direction, however, is related to the guideline regarding Hypertensive Cerebrovascular Disease. If that is not documented, do we have to code the cerebrovascular disease before the hypertension?
The Resolving Complication without the 7th Character Issue

• Body system complications do not have 7th characters
• Transplant complications
• Amputation complications

• Do we continue to code the complication until healed?
• Or do we switch to aftercare?
• Answer from CC via letter: switch to aftercare.

Based on what guideline?

• 7th character “D” subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
• The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care.
• And if the D is not provided, use aftercare.

For example:

The patient has a bowel obstruction with adhesions post gastric bypass surgery.
• K95.89 Other complications of other bariatric procedures
• K56.52 Bowel obstruction

Now, the surgeon has fixed the problem—but there is not a D to use until the wound, etc heals.

Revert to aftercare...
Z48.815 Aftercare following GI surgery

Diabetes, with

• Skin ulcer NEC
• Arthropathy NEC
• Circulatory NEC

• Do not assume a causal relationship when the diabetic complication is “NEC.”
• Source: AHA Coding Clinic Volume 5 Second Quarter Number 2 2018
Diabetes, with

- Peripheral arteriosclerosis, peripheral vascular disease and peripheral arterial disease in a diabetic patient should be linked and coded as “diabetic peripheral angiopathy.”
- Source: AHA Coding Clinic Volume 5 Second Quarter Number 2 2018

Examples

Diabetic atherosclerosis of the extremities
- E11.51 Diabetes with peripheral angiopathy
- I70.2- Atherosclerosis of the extremities
Diabetic atherosclerosis with gangrene
- E11.52 Diabetes with peripheral angiopathy with gangrene
- I70.2-6 Atherosclerosis with gangrene

Other ‘with’ and ‘in’ issues

- Anemia
- CKD
- Neoplasms
- Chemotherapy
- Arthropathy

Diabetes, Hypertension and CKD

- Diabetes and hypertension are assumed related to CKD.
- What if the physician says ‘diabetic CKD’ or ‘hypertensive CKD’?
- Code them all related.
  - Exception is if the physician specifically says the diabetes or the hypertension is NOT related.
Changes in the Code Set

- Every year effective October 1.
- Changes in the code set made by NCHS with input from us!
- Some limitations because code set is owned by WHO.
- Types of Changes
  1. New codes
  2. Deleted codes
  3. Changes to the tabular list
  4. Changes to the index
  5. Guidelines

Lots of Changes Like This

- Revise from: L98495 Non-pressure chronic ulcer of other sites with muscle involvement without evidence of necrosis
  - Revise to: L98495 Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis
- Revise from: I63219 Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral arteries
  - Revise to: I63219 Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral artery

Fixes Like This

- Revise from: R402330 Coma scale, best motor response, abnormal, unspecified time
  - Revise to: R402330 Coma scale, best motor response, abnormal flexion, unspecified time
- Revise from: R402331 Coma scale, best motor response, abnormal, in the field [EMT or ambulance]
  - Revise to: R402331 Coma scale, best motor response, abnormal flexion, in the field [EMT or ambulance]
- Revise from: R402332 Coma scale, best motor response, abnormal, at arrival to emergency department
  - Revise to: R402332 Coma scale, best motor response, abnormal flexion, at arrival to emergency department
- Revise from: R402333 Coma scale, best motor response, abnormal, at hospital admission
  - Revise to: R402333 Coma scale, best motor response, abnormal flexion, at hospital admission
- Revise from: R402334 Coma scale, best motor response, abnormal, 24 hours or more after hospital admission
  - Revise to: R402334 Coma scale, best motor response, abnormal flexion, 24 hours or more after hospital admission

What? You don’t see the change?

Revise from: M5001 Cervical disc disorder with myelopathy, high cervical region
  - Revise to: M5001 Cervical disc disorder with myelopathy, high cervical region
Revise from: M86621 Other chronic osteomyelitis, right humerus
  - Revise to: M86621 Other chronic osteomyelitis, right humerus
And things like this...

- Medial phalanx changed to middle phalanx of the finger
- T43641A Poisoning by ecstasy
- V00821S Fall from babystroller, sequela
- V00821S Fall from baby stroller, sequela
- E671 Hypercarotinemia
- Revise to: E671 Hypercarotenemia

Who knew baby stroller was 2 words?

New Postoperative Infection Codes

- T81.4xxA, T81.4xD, T81.4xS are deleted
- Added (each with a choice of A, D, or S):
  - T81.40X- Infection following a procedure, unspecified
  - T81.41X- Infection following a procedure, superficial incisional surgical site
  - T81.42X- Infection following a procedure, deep incisional surgical site
  - T81.43X- Infection following a procedure, organ and space surgical site
  - T81.44X- Sepsis following a procedure
  - T81.49X- Infection following a procedure, other surgical site

Postoperative Infection Definitions

- These are standardized definitions from the CDC:
- **Superficial incisional infection**
  - Involves only skin & subcutaneous tissue
  - May be indicated by localized signs such as redness, pain, heat or swelling at the site of the incision or by the drainage of pus
- **Deep incisional**
  - Involves deep tissues, such as fascial and muscle layers
  - May be indicated by the presence of pus or an abscess, fever with tenderness of the wound, or separation of incision edges exposing deeper tissues
- **Organ and space**
  - Involves any part of the anatomy in organs and spaces other than the incision, which was opened or manipulated during operation, such as the joint or the peritoneum
  - May be indicated by the drainage of pus or the formation of an abscess detected by histopathological or radiological examination or during re-operation; does not include organ infection.

Tabular Changes

- **T81.41-** (Infection following a procedure, superficial incisional surgical site)
  - Subcutaneous abscess following a procedure
  - Stitch abscess following a procedure
- **T81.42-** (Infection following a procedure, deep incisional surgical site)
  - Intra-muscular abscess following a procedure
- **T81.43-** (Infection following a procedure, organ and space surgical site)
  - Intra-abdominal abscess following a procedure
  - Subphrenic abscess following a procedure
- **T81.44-** (Sepsis following a procedure)
  - Tabular instruction:
    - Code first the post op infection, e.g. T81.42-
    - Use Additional code to identify the sepsis
    - (this is not changed as far as sequencing)
**Tabular & Index Updates**

- Index entries added or revised:
  - “Abscess, intra-abdominal, following procedure” – T81.43
  - “Abscess, intramuscular, following procedure” – T81.42
  - “Abscess, stitch” – T81.41
  - “Cellulitis, drainage site (following operation)” – T81.49
  - “Fever, due to infection” – T81.40
  - “Infection, postoperative” – T81.40
  - “Sepsis, local, in operation wound” – T81.44
  - “Sepsis, postprocedural” – T81.44

**New Neoplasm Codes**

- Current codes specify the eyelid for non-melanoma skin cancer, but not whether the upper or lower is involved.
- 45 new codes:
  - Skin cancers (melanoma, basal cell, squamous cell, sebaceous cell, Merkel cell carcinoma, & unspecified, as well as in situ cancers) affecting the upper and lower eyelid
  - Melanocytic nevi and other benign neoplasms affecting the upper & lower eyelid

**Types of Skin Cancer & Benign Skin Neoplasms**

- Melanoma – begins in melanocytes cells; the least common but most serious type of skin cancer
- Basal cell carcinoma – abnormal, uncontrolled growths or lesions in the skin’s basal cells, the deepest layer of the epidermis
- Squamous cell carcinoma – uncontrolled growth in the skin’s squamous cells, skin’s outermost layers; second-most common skin cancer
- Sebaceous cell carcinoma – rare skin cancer that mostly begins on the eyelid
- Merkel cell carcinoma – rare type of skin cancer that usually appears as a flesh-colored or bluish-red nodule, often on your face, head or neck
- Melanocytic nevi – Moles made up of skin cells that produce melanin
- Other benign skin neoplasms – other non-cancerous skin lesions

**Examples of New Neoplasm Codes**

- C43.111 (Malignant melanoma of right upper eyelid, including canthus)
- C43.112 (Malignant melanoma of right lower eyelid, including canthus)
- C43.121 (Malignant melanoma of left upper eyelid, including canthus)
- C43.122 (Malignant melanoma of left lower eyelid, including canthus)

**Note:** C43.11 & C43.12 will both be invalid codes in FY2019
- You’ll need to know whether the melanoma is affecting the upper or lower eyelid!

Sources: American Cancer Society, Skin Cancer Foundation, American Academy of Dermatology, Mayo Clinic
But watch out for those crazy C44 codes

- C44.1121 Basal cell carcinoma of skin of right upper eyelid, including canthus
- C44.1122 Basal cell carcinoma of skin of right lower eyelid, including canthus
- C44.1191 Basal cell carcinoma of skin of left upper eyelid, including canthus
- C44.1192 Basal cell carcinoma of skin of left lower eyelid, including canthus

G71.0 Muscular dystrophy

- G71.00 Muscular dystrophy, unspecified
- G71.01 Duchenne or Becker muscular dystrophy
  - genetic disorder characterized by progressive muscle degeneration and weakness. Starts as early as 3yo
- G71.02 Facioscapulohumeral muscular dystrophy
  - muscles of the face, shoulder blades and upper arms are among the most affected. By the age of 20
- G71.09 Other specified muscular dystrophies

CADASIL

- I67.850 Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy
- What is it?
  - Inherited disorder that causes strokes, brain lesions, and other impairments
  - Frequently begins with migraines & mood disorders in 20s & 30s, followed by strokes in 40s & 50s
  - Epilepsy can occur
  - Multiple strokes generally leads to vascular dementia
  - Death 10 to 20 years after strokes & dementia begin

Source: ICD-10 Coordination & Maintenance Committee March 2017 proposal
For example:
- The patient has a diagnosis of CADASIL with vascular dementia and a recent stroke resulting in monoplegia of the right leg.
- I67.850 CADASIL
- F01.50 Vascular dementia
- I69.341 (I69.841) monoplegia following cerebral infarction affecting right dominant side

Urethral Stricture
- According to the proposal:
  - The etiology (i.e. post-traumatic, post-infective, etc.) of a patient’s urethral stricture is often unknown or unspecified
  - Current codes don’t allow for the specification of the location of the stricture if the etiology isn’t known
  - Nor do current codes allow for the capture of strictures involving overlapping sites

Source: ICD-10 Coordination & Maintenance Committee March 2017 proposal
- Site
- Male, female
- Cause
- N35 has 16 new codes plus another in N99

Anal and Rectal Abscesses
- K61.- category (Abscess of anal and rectal regions)
  - K61.0 Anal abscess
  - K61.1 Rectal abscess
  - K61.2 Anorectal abscess
  - K61.3 Ischiorectal abscess
    - K61.31 Horseshoe Abscess
    - K61.39 Other ischiorectal abscess
  - K61.4 Intrasphincteric abscess
  - K61.5 Supralevator abscess

Cannabis Withdrawal
- Common among those with cannabis dependence
  - those with cannabis dependence make up a substantial percentage of treatment admission for substance use disorders
  - Symptoms (develop within a week of ceasing heavy, prolonged cannabis use) include
    - irritability, anger, or aggression
    - nervousness or anxiety
    - sleep difficulty
    - decreased appetite or weight loss
    - restlessness
    - depressed mood
    - physical symptoms such as abdominal pain, shakiness/tremors, sweating, fever, chills, or headache
Cannabis Use, Dependence & Withdrawal

- 2 new codes added to 2 subcategories within F12.- (Cannabis related disorders):
  - Within F12.2- (Cannabis dependence)
    - F12.23 (Cannabis dependence with withdrawal)
    - For cases of cannabis withdrawal in the context of dependence
  - Within F12.9- (Cannabis use, unspecified)
    - F12.93 (Cannabis use, unspecified, with withdrawal)
    - For cases of cannabis withdrawal in contexts other than dependence

Remember this:

- The Official Guidelines for Coding and Reporting, Psychoactive Substance (I.C.5.b.3.) state, “As with all other diagnoses, the codes for psychoactive substance use (F10.9-, F11.9- F12.9-, F13.9-, F14.9-, F15.9-, F16.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). The codes are to be used only when the psychoactive substance use is associated with a physical, mental or behavioral disorder, and such a relationship is documented by the provider.”

Guideline Changes

Sepsis

- For infections following a procedure, a code from T81.40, to T81.43 Infection following a procedure, ...that identifies the site of the infection should be coded first, if known. Assign an additional code for sepsis following a procedure (T81.44). Use an additional code to identify the infectious agent (A40 or A41).
Post-procedural Septic Shock

• If a postprocedural infection has resulted in postprocedural septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock.

• Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.

Index

2019 Change

• List of heart conditions excludes I51.81

• Takotsubo Syndrome is not related to hypertension. It is related to stress, so it was omitted from the list of conditions assumed caused by hypertension.

Hypertension

• Hypertension with heart conditions classified to I50.- or I51.4- I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease.

• Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

• The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has specifically documented a different cause.

• New language: if the provider has documented they are unrelated to the hypertension.

Hypertensive Chronic Kidney Disease

• The classification assumes a relationship between hypertension and chronic kidney disease.

• CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.

• Code to I12.-
  • Stage 5 or ESRD with hypertension I12.0
  • Stage 1-4 or unspecified CKD with hypertension I12.9
  • Specific sequencing required with CKD
Documentation by Clinicians Other than the Patient's Provider

- Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).
- There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale).

Documentation by Clinicians Other than the Patient's Provider

- However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider.
- BMI codes should only be assigned when the associated diagnosis (such as overweight or obesity) meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses).

Other Changes

- 2 MIs of 2 different types (Type 1 and Type 2) in the same 4 week period
  - MI due to ischemia I21.A1
  - AMI I21.9
  - Do not use I22 for the subsequent MI in this case.
Other Changes

- Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer’s instruction. **Discontinuing the use of a prescribed medication on the patient’s own initiative (not directed by the patient’s provider) is also classified as an underdosing.** For underdosing, assign the code from categories T36-T50 (fifth or sixth character “6”).

Underdosing

- Guideline: Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.
- Noncompliance or complications of care codes are to be used with an underdosing code to indicate intent, if known.

- C—Condition
- T—T code for underdosing of the drug
- Z—Z code for Underdosing reason (or sometimes Y)

Underdosing Example

- Patient with diagnosis of Hypertension continued to experience elevated blood pressure while taking blood pressure meds. Upon patient interview, it was found the patient was taking medication once daily instead of twice daily because of the cost of the drug.

- I10 Essential (primary) hypertension
- T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

Changes to the OASIS!!!!
How OASIS Changes Affect Coding

Effective Now (as of August 2017)

• Extension of the one clinician rule
  • First clinician may not complete the assessment and wait for someone else to complete (team assessments)
  • May collaborate more on assessment findings
  • Skin assessment is biggest impact

How OASIS Changes Affect Coding

• Only items that cannot be updated in the 5 day timeframe for SOC
  • Pressure Ulcers
  • When did the skin assessment occur?

Example

1. RN says that patient wouldn’t allow him to look at her bottom when he did skin assessment. Female nurse visits on day 3 and documents pressure ulcer on coccyx.
   • Pressure ulcer marked in M1300 items?
   • Should it still be coded (considering physician verified)?
   • Can the care still be added to the POC?

Example

2. RN says that the patient wouldn’t allow him to assess her bottom and so he did not complete the skin assessment. Female nurse visits on day 3 and completes skin assessment and documents pressure ulcer on the coccyx.
   • Pressure ulcer marked in M1300 items?
   • Should it still be coded (considering physician verified)?
   • Can the care still be added to the POC?
How OASIS Changes Affect Coding

Effective January 1
- M1011
- M1017
- M1025
- PDGM – up to 25 diagnoses

But also items like: M1350
- Tracking down the etiology of wounds
- Should still be there

BAM!
They’re gone!

Conventions—Relational Terms
- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list (e.g., C34 Malignant neoplasm of bronchus and lung)

- The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, (either under a main term or subterm) or an instructional note in the Tabular List.

Diabetes & Hypertension

With
The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).
“With” or “in”

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.

If the condition is not specifically listed under with or in, then it cannot be linked without the physician’s say-so. Does a guideline say it requires physician documentation?

Examples of ‘With’

- Reference diabetes in the index AS AN EXAMPLE
- Diabetes with
  - amyotrophy
  - arthropathy NEC
  - autonomic (poly) neuropathy
  - cataract (yes, even cataracts)
  - Charcot’s joints
  - And so on...
- Not limited to diabetes...see dementia, with...
  - Dementia, with, Parkinson’s
  - Anemia in...
  - Arthropathy in...

Diabetic Manifestations (and Others)

- It’s not the coder that assumes—the classification assumes a cause and effect relationship between diabetes and the listed manifestations
- The only time you do not code those manifestations specifically listed, as diabetic is if the physician has documented a different cause. It is unrelated.
  - It is imperative that all documentation be reviewed for indications that there is another cause before assigning the manifestation to diabetes.

Examples

- The physician documents foot ulcer on a diabetic patient.
- The physician documents pressure ulcer on the right buttock on a diabetic patient.
- The patient has diabetes and also has polyneuropathy.
- The patient has diabetes and also has alcoholic polyneuropathy documented.
- The diabetic has a gangrenous pressure ulcer.
Examples

• The diabetic patient has PVD
• The diabetic patient has arterial ulcers.
• The diabetic has an ulcer on his lower leg associated with stasis dermatitis with hemosiderin staining and a beefy wet appearance.
  • Know when you should really ask

Arthropathy NEC
• Circulatory complication NEC
• Complication, specified NEC
• Kidney complications NEC
• Neurologic complication NEC
• Oral complication NEC
• Skin complication NEC
• Skin ulcer NEC

CC Q4 2017 Do NOT link conditions not specifically listed!

• For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

E -- Endocrine, Metabolic and Nutritional

• The patient has diabetes and OA. Do we code that as diabetic arthropathy?
• What about if the physician documents arthropathy?
• The patient has diabetes and CAD. Is that diabetic CAD? No, but...
  • (If diabetic CAD is documented: E11.59, I25.10)
Diabetes Categories

E08 DM due to underlying condition
- Code first underlying condition (e.g., pancreatitis, pancreatic cancer, injury to pancreas, cystic fibrosis, malnutrition, Cushing's)
- Use additional code for insulin (Z79.4) or oral antiglycemics (Z79.84)

E09 DM due to drug or chemical
- Sequencing depends on adverse effect or poisoning (Adverse Effect—e.g., steroids, pentamidine; E09.-, then T code for drug) (Poisoning—e.g., Dioxin, arsenic; T code for drug or chemical, then E09.-)
- Use additional code for insulin (Z79.4) or oral antiglycemics (Z79.84)

E10 DM Type I
- Brittle, ketosis prone
- Use additional code for insulin (Z79.4) or oral antiglycemics (Z79.84)
- Includes unspecified diabetes

E11 DM Type II
- Use additional code for insulin (Z79.4) or oral antiglycemics (Z79.84)
- Special sequencing when caused by removal of pancreas (E89.1, E13.-, Z90.41-, Z79.4 or Z79.84)

E13 Other specified DM
- Secondary diabetes NEC
- Special sequencing when caused by removal of pancreas (E89.1, E13.-, Z90.41-, Z79.4 or Z79.84)

E08 DM due to underlying condition
- Any condition that impacts the pancreas function
- Cystic fibrosis- Cystic fibrosis produces abnormally thick mucus, which blocks the pancreas.
- Pancreatic cancer, Pancreatitis, and trauma can all harm the pancreatic beta cells or impair insulin production, thus causing diabetes.
- Malnutrition
- Cushing’s syndrome—induces insulin resistance. Cushing’s syndrome is marked by excessive production of cortisol—sometimes called the “stress hormone.”

E09 Drug or chemical induced DM
Adverse Effect
- Some medications, such as nicotinic acid and certain types of diuretics, anti-seizure drugs, psychiatric drugs, and drugs to treat HIV, can impair beta cells or disrupt insulin action. Pentamidine, a drug prescribed to treat a type of pneumonia, can increase the risk of pancreatitis, beta cell damage, and diabetes. Also, glucocorticoids—steroid hormones that are chemically similar to naturally produced cortisol—may impair insulin action. Glucocorticoids are used to treat inflammatory illnesses such as rheumatoid arthritis, asthma, lupus, and ulcerative colitis.

E09 Drug or chemical induced DM
Poisoning
- Many chemical toxins can damage or destroy beta cells in animals, but only a few have been linked to diabetes in humans. For example, dioxin—a contaminant of the herbicide Agent Orange, used during the Vietnam War—may be linked to the development of type 2 diabetes. In 2000, based on a report from the Institute of Medicine, the U.S. Department of Veterans Affairs (VA) added diabetes to the list of conditions for which Vietnam veterans are eligible for disability compensation. Also, a chemical in a rat poison no longer in use has been shown to cause diabetes if ingested. Some studies suggest a high intake of nitrogen-containing chemicals such as nitrates and nitrites might increase the risk of diabetes. Arsenic has also been studied for possible links to diabetes.
Examples

• The patient has steroid induced diabetes from taking corticosteroids for an upper respiratory infection last year.
  • E09.9 Drug or chemical induced diabetes
  • T38.0x5S Adverse effect of glucocorticoids, sequela

• The patient has diabetes from exposure to Agent Orange during the Vietnam conflict.
  • T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela
  • E09.9 Drug or chemical induced diabetes

Coding Clinic

• How do you code a patient with chronic respiratory failure due to a valium overdose 3 months ago?
  • Chronic respiratory failure
  • Poisoning by valium, sequela

• Wait! Isn’t this a poisoning? Shouldn’t this be coded:
  • Poisoning by valium, sequela
  • Chronic respiratory failure
Response: Code it as a sequela (without explanation).

Compare

Poisoning Guideline

T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela

E09.9 Drug or chemical induced diabetes

Sequela Guideline (option)

E09.9 Drug or chemical induced diabetes

T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela

E09.9 Drug or chemical induced diabetes

E10 Type 1 DM

• Type 1 diabetes is caused by a lack of insulin due to the destruction of insulin-producing beta cells in the pancreas. In type 1 diabetes—an autoimmune disease—the body’s immune system attacks and destroys the beta cells.
• Genetic susceptibility
**E11 Type II DM**

- Caused by a combination of factors, including insulin resistance, a condition in which the body’s muscle, fat, and liver cells do not use insulin effectively. Type 2 diabetes develops when the body can no longer produce enough insulin to compensate for the impaired ability to use insulin.
- The role of genes is suggested by the high rate of type 2 diabetes in families and identical twins and wide variations in diabetes prevalence by ethnicity. Type 2 diabetes occurs more frequently in African Americans, Alaska Natives, American Indians, Hispanics/Latinos, and some Asian Americans, Native Hawaiians, and Pacific Islander Americans than it does in non-Hispanic whites.

**E13 Other Specified Diabetes**

- Genetic defects of beta cell function or insulin action
- Postpancreatectomy/post procedural DM
- Secondary DM, NEC
- Specific guideline postpancreatectomy DM
  - E89.1 Postprocedural hypoinsulinemia
  - E13 code(s)
  - Z90.41- Acquired absence of pancreas
  - Z79.4 insulin or Z79.84 anti-glycemics

**Type 1.5 LADA**

- Latent autoimmune diabetes in adults (LADA) is a slow progressing form of autoimmune diabetes. Like type 1 diabetes, LADA occurs because your pancreas stops producing adequate insulin, most likely from some "insult" that slowly damages the insulin-producing cells in the pancreas.
- Unlike type 1 diabetes, with LADA, insulin will not be needed for several months up to years after diagnosis.
- Code? E13

**Type 3 Alzheimers Disease**

- Pronounced insulin resistance in the brain
- Code? E13 Other specified diabetes
Diabetes Categories

- Diabetes
- Diabetes as an adverse effect of steroids with hyperglycemia
- Diabetes as a result of cystic fibrosis
- Diabetes after a pancreatectomy
- Ketosis prone diabetes
- Diabetes as a result of arsenic poisoning
- Type II DM with hyperglycemia due to taking steroids

Diabetes Categories

- Diabetes
- Diabetes as an adverse effect of steroids with hyperglycemia
- Diabetes as a result of cystic fibrosis
- Diabetes after a pancreatectomy
- Ketosis prone diabetes
- Diabetes as a result of arsenic poisoning
- Type II DM with hyperglycemia due to taking steroids

Which one is it?

- Steroid induced diabetes E09
- The patient did not have diabetes prior to taking the medication impacting the pancreatic beta cells.
- Hyperglycemia with taking the medication may be temporary—before coding the patient as diabetic, ask the physician!!

Which one is it?

- Diabetes as a result of pancreatitis, pancreatic cancer of other injury to the pancreatic beta cells (E08)
- Diabetes as a result of removing the pancreas (E13)
**Guidelines**

- The diabetes mellitus codes are combination codes that include:
  - the type of diabetes mellitus (E08-E13),
  - the body system affected, (4th character) and
  - the complications affecting that body system (5th, 6th characters).
- Diabetes codes should be sequenced based on the reason for a particular encounter.
- Assign as many codes from the appropriate category (E08 –E13) as needed to identify all of the associated conditions that the patient has. (MANY Assumptions)

**Guidelines**

- If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.
- Old policy:
  - If the documentation in a medical record does not indicate the type of diabetes, code E11, Type 2 diabetes mellitus, should be assigned.
  - (Type 2 is the DEFAULT—do NOT code Type I just because the patient takes insulin)
  - Physician says insulin dependent diabetes mellitus—code type 2

**Now code these...**

- Secondary Diabetes
- Diabetes as an adverse effect of steroids with hyperglycemia
- Diabetes as a result of cystic fibrosis and CKD
- Diabetes after a pancreatectomy taking insulin
- Ketosis prone diabetes
- Diabetes as a result of arsenic poisoning years ago and chronic osteomyelitis of the 5th lumbar vertebrae (patient had post op infection after laminectomy 5 years ago) NEED to QUERY
- Type II DM with hyperglycemia due to taking steroids

**Now code these...answers**

- Secondary Diabetes
  - E13.9
- Diabetes as an adverse effect of steroids with hyperglycemia
  - E09.65, T38.0x5D
- Diabetes as a result of cystic fibrosis and CKD
  - E84.8, E08.22, N18.9
- Diabetes after a pancreatectomy taking insulin
  - E89.1, E13.9, Z90.410, Z79.4
- Ketosis prone diabetes
  - E10.9
- Diabetes as a result of arsenic poisoning years ago and chronic osteomyelitis of the 5th lumbar vertebrae
  - T57.0x15, E09.9, M46.26
- Type II DM with hyperglycemia due to taking steroids
  - E11.65, T38.0x5D
Diabetes 4th characters 0 and 1

- Diabetes with hyperosmolarity
  - Does not occur with Type 1 DM
    - No choice in Type 1 diabetics (no E10.0-)
- Diabetes with ketoacidosis
  - Occurs rarely with Type 2 diabetics
    - New choice in Type 2 diabetics (E11.1-)
- Type 2 DM with ketoacidosis E11.10
- Do not code hyperglycemia with ketoacidosis.
- If the type of diabetes is unspecified but documented with ketoacidosis, do not code Type 2. Query physician.

Example

- The patient is admitted to home care after a hospitalization for episode of diabetic ketosis with blood sugar of 857. The physician documents type 2 DM, polyneuropathy and CKD. The neuropathy required pain management and the CKD required dialysis for 2 days as a precaution. Codes for M1011 include:
  a. E10.10, E10.65, E10.42, N18.9
d. E11.10, E11.42, E11.22, N18.9

Explanation:

- Do not code hyperglycemia with ketoacidosis.
- Neuropathy and CKD are assumed related to diabetes.

Remember that diabetes type is unspecified, then type 2 is coded?
- Diabetic ketoacidosis is not assumed to be type 2 because the type of diabetes is unspecified. Query the physician for type.
Diabetes (Other)

- 7—no 4th character 7
- 8—unspecified complications (do NOT use)
- 9—without complications (equivalent to 250.00)

NOT Diabetes

- Borderline diabetes
- Latent diabetes, and
- Prediabetes

R73.03

Diabetic Manifestation Notables

- E11.22 Use additional code for CKD (N18.1- N18.6)
  - Use additional code note (OK to code N18.9, but this may change)

Patients with CKD may also suffer from other conditions, most commonly diabetes and hypertension. The sequencing of the CKD in relationship to codes for other contributing conditions is based on the coding conventions. FOLLOW THE TABULAR INSTRUCTIONS

- The classification assumes a relationship between CKD and HTN.
- The classification assumes a relationship between CKD and Diabetes.

- Diabetes, CKD and HTN
  - E11.22, I12.9, N18.9 OR I12.9, E11.22, N18.9

N18-Chronic kidney disease

- If the physician says diabetic CKD and the patient also has hypertension, code BOTH as related to CKD.
- If the physician says hypertensive CKD and the patient also has diabetes, code BOTH as related to CKD.
- The only time you do not code one or the other as related is if the physician specifically says they are not related.

- If the physician documents diabetic nephropathy (E11.21) and CKD (E11.22), code E11.22.

Related Except If They’re Not

- The ICD-10-CM classification makes a linkage between hypertension with CKD and also makes a link between diabetes and CKD. If there is no documentation clearly stating that the hypertension nor diabetes mellitus is the cause of the CKD, codes I12.0, Hypertensive chronic kidney disease and code E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease, may be reported.

- However, if provider documentation were to clearly state that the CKD is due to a different cause such as diabetes mellitus, and was not due to hypertension, a code from category I12 would not be assigned. Likewise, if provider documentation were to clearly state that the CKD is not due to diabetes mellitus but was due to a different cause, such as hypertension, code E11.22 would not be reported.

- Coding Clinic Letter December 2017
Diabetic Manifestation Notables

- E11.3- Macular edema includes the type of retinopathy
- E11.4- includes neuropathy unspecified, mononeuropathy, polyneuropathy, etc
  - E11.43 Includes gastroparesis/gastroparalysis
- E11.5 DM with gangrene includes the peripheral angiopathy (disease of the peripheral arteries)
  - Atherosclerosis is related to diabetes...
- E11.610 Includes Charcot’s
  - Not M14.6
  - Neurogenic arthropathy

Diabetes, with

- Peripheral arteriosclerosis, peripheral vascular disease and peripheral arterial disease in a diabetic patient should be linked and coded as “diabetic peripheral angiopathy.”
  - Source: AHA Coding Clinic Volume 5 Second Quarter Number 2 2018
- A letter from Coding Clinic
  - E11.51 Diabetes with peripheral angiopathy
  - I170.2- Atherosclerosis of lower extremity

Diabetes with Atherosclerosis of Lower Extremities

Other issues without resolution:
Atherosclerotic ulcer in a diabetic????
- E11.51
- I70.2-
- L97.-
Diabetic ulcer in a patient with atherosclerosis????
- E11.62-
- L97.-
- E11.51
- I70.2-

Diabetic Manifestation Notables

- E11.621 or E11.622 (ankle and above)
  - Use additional code for ulceration
- E11.64- Hypoglycemia
- E11.65 Hyperglycemia
  - Remember not to use this with ketoacidosis.
- E11.69 Other manifestations of diabetes
  - Use additional code, e.g. osteomyelitis
Mrs. Wolfe has diabetic ulcers on three toes of her right foot (muscle necrosis on the worst), diabetic gangrene on a 4th toe and poorly controlled blood sugars.

- She also had CHF and hypertension.
- The ulceration and the blood sugars are the focus of care. The physician says we’re going to let the toe fall off.

Where do we put the CHF and hypertension?

Hyperglycemia

- With, Hyperglycemia
- Inadequately controlled –code to diabetes, by type with hyperglycemia
- Out of control –code to diabetes, by type with hyperglycemia
- Poorly controlled –code to diabetes, by type with hyperglycemia
- Uncontrolled - meaning hyperglycemia - see Diabetes, by type, with, hyperglycemia
  hypoglycemia - see Diabetes, by type, with, hypoglycemia
M1028 Active Diagnoses

- “-” means unable to assess
- Leave blank if the patient doesn’t have either diagnosis.
- 3 None of the Above will be added with OASIS D
- Mark 1 and 2 if the patient has diabetic PVD (e.g., E11.51)

Applicable Codes

Select Response 1 if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), indicated by any of the following diagnosis codes:

- Codes that start with the first 4 characters of:
  - I70.2 – Atherosclerosis of native arteries of the extremities
  - I70.3 – Atherosclerosis of bypass graft(s) of the extremities
  - I70.4 – Atherosclerosis of autologous vein bypass graft(s) of the extremities
  - I70.5 – Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
  - I70.6 – Atherosclerosis of nonbiological bypass graft(s) of the extremities
  - I70.7 – Atherosclerosis of other type of bypass graft(s) of the extremities
  - I70.91 – Generalized atherosclerosis
  - I70.92 – Chronic total occlusion of artery of the extremities

Select Response 2 if the patient has an active diagnosis of Diabetes Mellitus (DM), indicated by any of the following diagnosis codes:

- Codes that start with the first 3 characters of:
  - E08 – Diabetes mellitus due to underlying condition
  - E09 – Drug or chemical induced diabetes mellitus
  - E10 – Type 1 diabetes mellitus
  - E11 – Type 2 diabetes mellitus
  - E13 – Other specific diabetes mellitus

Guideline: Hypertension

- The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index.
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.
- For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.
Index

2019 Change

• List of heart conditions excludes I51.81

• Takotsubo Syndrome is not related to hypertension. It is related to stress, so it was omitted from the list of conditions assumed caused by hypertension.

Hypertension

• Hypertension with heart conditions classified to I50.- or I51.4- I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease.

• Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

• The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has specifically documented a different cause.

• New language: if the provider has documented they are unrelated to the hypertension.

Significant Change?

• Just a clarification?

• The patient has documented rheumatic heart failure. The patient also has hypertension.

• specifically documented a different cause: code rheumatic heart failure followed by the appropriate heart failure code. Code hypertension separately.

• documented they are unrelated to the hypertension: Code hypertension with I11.0, and rheumatic heart failure, and appropriate heart failure code.

Hypertensive Heart Disease

Look at I11

• I51.4-I51.9 (but not I51.81) are included however use an additional code for heart failure, if present.

• Specific sequencing required

• The hypertension must be coded prior to the heart failure.
  • Note the ‘code first’ note at I50

• The conditions included in I11 are not coded separately.
  • Patient has hypertension and cardiomegaly (I51.7), then code I11.9 ONLY
Hypertensive Chronic Kidney Disease

- The classification assumes a relationship between hypertension and chronic kidney disease.
- CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.
- Code to I12.0.
  - Stage 5 or ESRD with hypertension I12.0
  - Stage 1-4 or unspecified CKD with hypertension I12.9
  - Specific sequencing required with CKD

Hypertensive Heart and Kidney

- Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement.
- If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
- The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.
Still there in the guidelines

Chronic kidney disease with other conditions
- Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List.

Diabetes, Hypertension and CKD
- Diabetes and hypertension are assumed related to CKD.
- What if the physician says ‘diabetic CKD’ or ‘hypertensive CKD’?
- Code them all related.
  - Exception is if the physician specifically says the diabetes or the hypertension is NOT related.

Examples
- The patient has diabetes, HTN and CKD
  - E11.22, I12.9, N18.9  OR
  - I12.9, E11.22, N18.9
  These are coded like this even if the physician states “diabetic CKD” or “hypertensive CKD”
- The patient has diabetes, HTN, heart failure and CKD
  - E11.22, I13.0, I50.9, N18.9  OR
  - I13.0, E11.22, I50.9, N18.9  OR maybe
  - I13.0, I50.9, E11.22, N18.9

Name that category
- Hypertension and ESRD
  - I10
- Hypertension and CHF
  - I11
- Systolic heart failure due to hypertension
  - I12
- Malignant hypertension
  - I13
- Patient has CKD and hypertensive cardiomegaly
  - “Diabetic hypertension”
  - I15
Name that category

- Hypertension and ESRD I12
- Hypertension and CHF I11
- Systolic heart failure due to hypertension I10
- Malignant hypertension I10
- Patient has CKD and hypertensive cardiomegaly I13
- Diabetic hypertension I15

Answers

- Hypertension and ESRD I12.0, N18.6
- Hypertension and CHF I11.0, I50.9
- Systolic heart failure due to hypertension I11.0, I50.20
- Malignant hypertension I10
- Patient has CKD and hypertensive cardiomegaly I13.10, N18.9
- Diabetic hypertension E11.59, I15.2

Definitions

- Sepsis—Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammation throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail. If sepsis progresses to septic shock, blood pressure drops dramatically, which may lead to death.

- Localized infection—An infection that is limited to a specific part of the body and has local symptoms.

- Septicemia—Septicemia is bacteria in the blood (bacteremia) that often occurs with severe infections. (No separate code)
Sepsis

- Becoming more common in home care
- Sepsis
- Septicemia
- Severe sepsis
- Sepsis from a localized infection
- Postprocedural sepsis

Why is Sepsis becoming more common?

- Aging population. Americans are living longer, which is swelling the ranks of the highest risk age group — people older than 65.
- Drug-resistant bacteria. Many types of bacteria can resist the effects of antibiotics that once killed them. These antibiotic-resistant bacteria are often the root cause of the infections that trigger sepsis.
- Weakened immune systems. More Americans are living with weakened immune systems, caused by HIV, cancer treatments or transplant drugs.

More on Sepsis

- Many doctors view sepsis as a three-stage syndrome, starting with sepsis and progressing through severe sepsis to septic shock. The goal is to treat sepsis during its early stage, before it becomes more dangerous.

Sepsis

To be diagnosed with sepsis, you must exhibit at least two of the following symptoms, plus a probable or confirmed infection:

- Body temperature above 101 F (38.3 C) or below 96.8 F (36 C)
- Heart rate higher than 90 beats a minute
- Respiratory rate higher than 20 breaths a minute

Example of Sepsis vs Septicemia

- Sepsis from Strep pneumoniae
  - A40.3 Sepsis due to Strep pneumoniae

- Septicemia from Strep pneumoniae
  - A40.3

- Index directs to A41.9 (Septicemia NOS)

- A41.9 is also used when the physician documents sepsis without the bacteria

Source: http://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/dxc-20169787
Coding Sepsis

• A' codes for sepsis. Sequencing depends on circumstances. See the codes.
• A40 Streptococcal sepsis
• A41 Other sepsis
• And others
• R65.20 Severe sepsis without septic shock
• R65.21 Severe sepsis with septic shock (if acute organ dysfunction is documented).

Septic Shock

• Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction.
• Low BP that does not respond to treatment.
• Not usually a home care diagnosis, but could be a hospice diagnosis.

Severe Sepsis

• In severe sepsis the patient will also exhibit at least one of the following signs and symptoms, which indicate an organ may be failing:
  • Significantly decreased urine output
  • Abrupt change in mental status
  • Decrease in platelet count
  • Difficulty breathing
  • Abnormal heart pumping function
  • Abdominal pain
• Source: http://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/dxc-20169787

Severe Sepsis Guidelines

• If a patient has sepsis and an associated acute organ dysfunction or multiple organ dysfunction, follow the instructions for coding severe sepsis.
  • Query if not clear whether the organ dysfunction is related to the sepsis.
  • The ‘with’ doesn’t count.
• Minimum of two (but usually three) codes
  • Underlying systemic infection
  • Code from subcategory R65.2-
  • Additional code for the associated organ dysfunction.
  • No need to code circulatory collapse if present
Examples

- Strep sepsis with acute kidney failure
  - A40.9 Streptococcal sepsis, unspecified
  - R65.20 SIRS (severe) without septic shock
  - N17.9 Acute kidney failure, unspecified

- Strep sepsis with septic shock
  - A40.9 Streptococcal sepsis, unspecified
  - R65.21 SIRS (severe) with septic shock

Severe because of associated organ failure.

This counts as organ failure.

Sepsis with localized infection

- Such as pneumonia, UTI
  - If admitted with sepsis
    - Assign sepsis code first (A40-41)
    - Then localized infection
    - Severe? Add R65.2- & organ dysfunction
  - If admitted with localized and develops into sepsis
    - Code localized infection first

Sequencing is dependent on whether the patient was admitted with sepsis or developed sepsis after admission.

Sepsis with localized infection

- Sepsis due to Serratia from a UTI
  - Sepsis A41.53
  - Localized infection, UTI N39.0

- SIRS (R65.2-) if organ dysfunction is related (severe sepsis)
  - Organ dysfunction, if applicable.

Code it

- Patient was admitted with sepsis due to MRSA pneumonia with continued IV antibiotics
Sepsis due to MRSA pneumonia

- A41.02 MRSA sepsis
- J15.212 MRSA pneumonia
- Z45.2 Management of vascular device

Code it:

- Patient was admitted for E coli sepsis due to acute cystitis.
  - N30.00, B96.20
  - A41.51, N30.00, B96.20
  - A41.51, N30.00
  - A49.51, N39.0, B96.20

E coli sepsis due to acute cystitis

- Patient was admitted for E coli sepsis due to acute cystitis.
  - N30.00, B96.20
  - A41.51, N30.00, B96.20
  - A41.51, N30.00
  - A49.51, N39.0, B96.20

Urosepsis

- The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.
Reminder--7th Character A

• 7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

• Additional examples of “initial” encounter (examples of active treatment)
  - Antibiotic therapy for postoperative infection
  - Wound vac treatment of wound dehiscence

Postprocedural Sepsis (until September 30)

• Must be documented by the physician—
  - Start with the specific postprocedural infection code (e.g., T81.4-)
  - Use appropriate A40-41 code next.

• Patient with postprocedural sepsis related to infected surgical wound caused by MRSA. IV antibiotics.
  - T81.4xxA Post-op sepsis
  - A41.02 MRSA sepsis
  - Z45.2 Management of vascular device
  - Z79.2 LT use antibiotics

Postprocedural Sepsis (October 1)

• Must be documented by the physician—
  - Start with the specific postprocedural infection code (e.g., T81.4-)
  - Code the T81.44x- next.
  - Use appropriate A40-41 code next.

• Patient with postprocedural intramuscular abscess resulting in sepsis caused by MRSA. IV antibiotics.
  - T81.42xA Post surgical infection, deep incisional surgical site
  - T81.44xA Post-op sepsis
  - A41.02 MRSA sepsis
  - Z45.2 Management of vascular device
  - Z79.2 LT use antibiotics

Change in Guideline

As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

For infections following a procedure, a code from T81.40, to T81.43 Infection following a procedure, ... that identifies the site of the infection should be coded first, if known.

Assign an additional code for sepsis following a procedure (T81.44)... Use an additional code to identify the infectious agent.

If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.
Change in Guideline

Postprocedural infection and postprocedural septic shock

• If a postprocedural infection has resulted in postprocedural septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock.

• Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.

Example

• A patient being treated for a peritoneal post-op infection after a cytoreductive surgery involving ovarian cancer became septic and was admitted to the hospital. She returns home continuing on antibiotics for Staph aureus sepsis.

Example Answer

• A patient being treated for a peritoneal post-op infection after a cytoreductive surgery involving ovarian cancer became septic and was admitted to the hospital. She returns home continuing on antibiotics for Staph aureus sepsis.

• T81.43xa Postoperative infection, intraabdominal
• T81.44xa Postoperative sepsis
• A41.01 Staph aureus sepsis
• Ovarian cancer
• Z45.2 Management of the vascular catheter
• Z79.2 antibiotics

Change in Guideline

• For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2, Infections following infusion, transfusion, and therapeutic injection, or code T88.0-, Infection following immunization, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional code(s) for any acute organ dysfunction.
Sepsis Practice

- The patient has a bloodstream infection related to a central line that has resulted in sepsis by Staph aureus (IV antibiotics). The correct coding is:
  a. A41.01, T80.219D, Z45.2, Z79.2
  b. T80.211A, A41.01, Z45.2, Z79.2
  c. T80.219A, A41.01, Z45.2, Z79.2
  d. A41.01, T80.211A, Z45.2, Z79.2

Sepsis Practice

- The patient has a bloodstream infection related to a central line that has resulted in sepsis by Staph aureus (IV antibiotics). The correct coding is:
  a. A41.01, T80.219D, Z45.2, Z79.2
  b. T80.211A, A41.01, Z45.2, Z79.2
  c. T80.219A, A41.01, Z45.2, Z79.2
  d. A41.01, T80.211A, Z45.2, Z79.2

Complications

Application of 7th Characters in Chapter 19

- Most, BUT NOT ALL, categories in chapter 19 have a 7th character requirement for each applicable code.

  - A = Initial encounter
  - D = Subsequent encounter
  - S = Sequela

  - Different 7th characters for fractures

A for Awful or Active

D is the Default

S is for Sometimes
Chapter 19 Guideline A vs D

• While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
• Whether or not the patient is still receiving active treatment is key
• A = Initial encounter

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

• 7th character “A,” initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

7th Character A

• These examples are no longer in the guidelines.
• 7th character “A,” initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

A vs D vs S

• 7th character “A,” initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

Additional examples of “initial” encounter (examples of active treatment)
• Antibiotic therapy for postoperative infection
• Wound vac treatment of wound dehiscence
• Side note: NO Z code for wound vac!!!
### A vs D vs S

- **7th character “D”** subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
- The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care.
  - For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

### 7th Character D Examples
- Rehabilitative therapy encounters (e.g., physical therapy, occupational therapy)
- Suture removal
- Follow-up visits to assess healing status (regardless of whether the follow-up is with the same or a different provider)
- Routine dressing changes and other aftercare

### A vs D vs S

- **7th character “S,” sequela,** is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S,” it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

### 7th Character S Examples
- Sequela (Late Effect): Residual effect (condition produced) arising as a direct result of an acute condition
- Traumatic arthritis following previous gunshot wound
- Quadriplegia due to spinal cord injury
- Scar formation after a burn
- Skin contractures due to previous burns
- Auricular chondritis due to previous burns
- Chronic respiratory failure following drug overdose
Each Encounter (Episode) Stands Alone

• Documentation for current encounter
  • Diagnoses current and relevant
  • Key to code selection is based on active treatment
• Documentation from previous encounter – May NOT be used to determine 7th character
  • Just because the previous episode was coded with an “A” in 7th character, does not necessarily mean the same 7th character will be used this time
• Key to code selection is based on active treatment
  • A → D or D → A

Home Health Care Examples

• Home health care services for continuation of IV antibiotics (Use 7th character A)
• Home care for routine dressing changes and care of healing wound (Use 7th character D)
• Example
  • Postoperative wound infection previously treated in acute care hospitalization (Hospital codes A)
  • No longer receiving antibiotics at home – T81.41XD Infection following a procedure, subsequent encounter
  • No longer receiving active treatment
  • Now receiving routine care during healing and recovery phase (USE D!)

Home Health Care Examples

• Home care treatment with wound VAC dressing changes
• Deep right lower quadrant stab wound of the abdomen extending into peritoneal cavity
• S31.613A Laceration without foreign body of abdominal wall, right lower quadrant with penetration into peritoneal cavity, initial encounter
  • Wound VAC is considered active treatment

Complications of Injury Treatment

• Care for complications of surgical treatment of injuries during the healing or recovery phase should be coded with the appropriate complication codes.
• Instead of aftercare because the complication has been “fixed” code the complication with 7th character D
• Continue to code it with a D until:
  1. it becomes complicated again (A)
  2. it heals (quit coding it)
  3. it heals with a residual (S)
What if the Code Does Not Have a 7th Character?

• Certain complication codes do not have 7th characters that indicate active vs resolving.
• Continue to code the complication until completely healed??
• Once the complication has been “fixed” do we revert to aftercare?
  • Cannot do that with injuries

Complications of Care Within Body System Chapters

• Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

What Is This?

• A patient is 11 years post roux en y surgery and presents to ER with abdominal pain (no other hx sent, only surgical report). She underwent laparoscopic surgery. Surgeon provides diagnosis as a perforated anastomotic ulcer (not leak). Would this be a sequelae to the original surgery 11 years ago, a complication, or would K28.1 (acute GJ ulcer with perforation) be appropriate with Z codes addressing aftercare GI surgery and a status of bariatric bypass? The agency will be seeing her for TPN, PICC line site care and weekly labs.

My Answers

• K95.89 Other complication of other bariatric procedure
• K28.5 Chronic or unspecified GJ ulcer with perforation
• Z45.2 Management of vascular catheter

• Change of facts: The physician resected the ulcer with a new anastomosis. What now?
• Z48.815 Aftercare gastrointestinal
• Z98.84 Status bariatric
• Z45.2 Management of vascular catheter
Complications Without a 7th Character

• H&P: 75 y/o female admitted for aortic and mitral valve replacement due to severe stenosis of both valves using bypass. Has history of CAD, HTN, Pulmonary HTN, and chronic afib. Due to significant post-op bleeding, patient underwent re-exploration that same day to remove a hematoma, and then again the next day for another hematoma. She required a thoracentesis a week later for post-op resp failure due to a hemothorax and right pleural effusion. She required a trach and PEG tube until she could be weaned off of the vent and required another thoracentesis for a recurrent pleural effusion a few days later. She will be maintained on Lasix, oxygen at 3L NBP at home. Trach and Peg have been removed and sites have healed. Porcine valves were used. Discharge diagnoses include history of post-op resp failure, post-op hematomas, hemomediastinum, pleural effusion, and hemothorax.

Discussion

• Everything has resolved. Do I capture all of this with simply I97.611 (or I97.618) and J95.89 only? Z48.812?

• What if the ostomies are not healed yet? How do we indicate the care of the tracheostomy and gastrostomy allowed to close on their own?

Mr. Jake

• Mr. Jake has scoliosis with resulting spinal stenosis in the thoracic and lumbar regions with neurogenic claudication. He falls often. He tripped over the threshold walking into his son’s home, fell on his left hip and had to be taken to the ER because of the pain and inability to bear weight on that extremity. Xrays showed a hairline fracture of the left mid shaft of the femur at the end of the hip prosthesis he has had for 9 years. He continues to complain of pain at the head of the prosthesis but all radiological testing indicates the prosthesis itself is intact. Plan was to provide therapy for non-wt bearing while the fracture healed, however the patient could not tolerate and was buckling even with the use of devices such as a rolling walker. Follow up radiological testing indicated that the spinal stenosis was much worse with resulting increasing partial paraplegia. Patient underwent spinal decompression and placement of scoliosis hardware. Strength has improved in both extremities with lessening of the neurogenic claudication. Patient remained hospitalized for 6 days before going to rehab to continue therapy services with PT and OT. Home health will provide nursing services to monitor healing of the surgical wound on back, teach on Coumadin therapy and monitor pt/ptt levels, check O2 sats, and PT to resume gait and mobility training. Physician reports paralytic gait due to incomplete paraplegia, resolving; neurogenic claudication, resolving; periprosthetic fracture due to fall and continued pain due to the prosthesis after the fall. Stitch abscess at the incision line. COPD exacerbation requiring O2 at 2L/m.

Discussion

• Which of the conditions is a complication?
  • Periprosthetic fracture?
  • Paralysis as a result of the scoliosis and spinal stenosis?
  • Pain at the prosthesis?
  • Stitch abscess?
• Code the complications only
## Complications

- T81.41xD Stitch abscess
- T84.84xA or D Pain of the prosthesis
- G89.11 Acute pain due to trauma

## Mr. Parker

- Mr. Parker has Parkinson’s disease and dementia. He required a tracheostomy after several bouts of aspiration pneumonia. His daughter reported to the doctor that her dad pulls at the trach and sometimes is able to pull the cannula out of the stoma. He then sticks his fingers in the stoma. His periostomal area is reddened and edematosus with purulent drainage. The physician documents infection of his trach and cellulitis and noted an increase of aggression.

## Discussion & Answers

## Answers

- J95.02 Infection of tracheostomy stoma
- L03.221 Cellulitis of neck
- G20 Parkinson’s
- F02.81 Dementia with behaviors
Which Are Complications?

- a. Marjolin’s ulcer as a result of a burn
- b. Brain tumor causing hemiplegia
- c. Fracture hip that healed and now that leg is shorter
- d. Osteomyelitis in the sternum resulting from a wire suture that got infected

Mr. Kassidy

- Mr. Kassidy had a transmetatarsal amputation last year as a result of a diabetic ulcer on the right foot that would not heal. Last week, he accidentally hit that foot on the bathtub when he was hopping along attempting to get in and “it just opened up” and starting “oozing like a big pimple.” The physician did some debridement and sent him home with antibiotics. Diagnoses include a dehisced and abscessed amputation stump. Mr. Kassidy also has cataracts, so he will not be able to see to do his own wound care. Other diagnoses include hypertension, heart failure and CAD/angina for which he uses NTG occasionally.

Discussion and Answers
Answers

- T87.81 Dehiscence of amputation stump
- T87.43 Infection of amputation stump, right lower extremity
- L02.611 Cutaneous abscess of right foot (??)
- E11.36 DM with diabetic cataract
  - I11.0 Hypertensive heart disease with failure
  - I50.9 Heart failure
  - I25.119 CAD with angina

Change the Facts

- Patient with left BKA x 3 years. Fell and sustained “wound” to stump which then progressed to an abscess and cellulitis. Had I&D performed.
- Infection of the amputation stump? Or the S81.892A with abscess and cellulitis?

Ms. Salty

- Ms Salty admitted to hospital with MRSA sepsis and septic shock related to infected peritoneal dialysis catheter site, diabetic acute on chronic renal failure, acute on chronic diastolic heart. C&S of PD exit site grew MRSA. Patient has hypertension. Was treated with IV Vancomycin via newly placed PICC and dialysis via newly inserted central line x 7 days and dc’d home. Home health to teach patient/caregiver administration of IV Vancomycin daily x 30 days via PICC, monitor peak/trough levels, perform PICC care weekly, perform/teach cg drsg change to infected PD dialysis cath site. Acute renal failure resolved in hospital, Insulin and Aldactone dosages were increased during hospital stay, and patient began attending outpatient dialysis clinic until PD dialysis catheter infection resolved.

Discussion and Answers

- Complication of dialysis catheter
- Diabetic CKD...what about the hypertension?

- The ICD-10-CM classification makes a linkage between hypertension with CKD and also makes a link between diabetes and CKD. If there is no documentation clearly stating that the hypertension nor diabetes mellitus is the cause of the CKD, codes I12.0, Hypertensive chronic kidney disease and code E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease, may be reported.
- However, if provider documentation were to clearly state that the CKD is due to a different cause such as diabetes mellitus, and was not due to hypertension, a code from category I12 would not be assigned. Likewise, if provider documentation were to clearly state that the CKD is not due to diabetes mellitus but was due to a different cause, such as hypertension, code E11.22 would not be reported.
- Coding Clinic Letter December 2017
Answers (Current Diagnoses)

- T85.71XA Infection and inflammatory reaction due to peritoneal dialysis catheter, initial encounter
- A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus
- I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
- I50.33 Acute on chronic diastolic (congestive) heart failure
- E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
- N18.6 End stage renal disease
- Z79.4 Long term (current) use of insulin
- Z51.81 Encounter for therapeutic drug level monitoring
- Z79.2 Long term (current) use of antibiotics
- Z45.2 Encounter for adjustment and management of vascular access device
- Z99.2 Dependence on renal dialysis

Mr. Perk

- Mr. Perk is a 79-year-old male who was born with congenital dysplasia of the hips. He has had several hip replacements over the years. He underwent his 6th on his right hip 6 weeks ago. He began experiencing increased pain followed by edema and redness at the site. The joint prosthesis was removed and replaced with an antibiotic spacer. The wound was left open to drain and exudate grew MRSA. He spent several weeks in a SNF receiving IV antibiotics and now is coming home. He is scheduled for surgery for a new prosthesis in 2 weeks. Otherwise he is in good health.

Discussion and Answers

- When do we stop coding the complication?
- When is the Z47.3- code appropriate?

Answers

- T84.51xD Infection and inflammatory reaction due to internal right hip prosthesis
- Q65.89 Congenital dysplasia of hips (or history)
- Z89.621 Acquired absence of right hip joint
- Z96.642 Presence of artificial hip joint, left
Resumption of Care

- Mr. Perk’s surgery went well. The physician removed the spacer and used cadaver bone graft to build up the femur because it wasn’t long enough. He’s coming home with a new hip prosthesis on the right.

- Z47.32 Aftercare following explantation of hip joint prosthesis

- Staged procedures only

Supplemental Materials

- OASIS Items for Removal (3 pages)
- OASIS-C2 to OASIS-D Change Table (3 pages)
- OASIS-D Forms (32 pages)
- Removed Items from OASIS D (8 pages)
- OASIS D Guidance Manual: Effective January 1, 2019
  - This version of the manual introduces new and modified items. Some are standardized patient assessment data elements (SPADEs), added to meet the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Standardized guidance for the new items is included. The manual also includes revisions to correct, update or clarify guidance.

IMPACT Act

Changes pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), including

- New standardized items (GG0130, GG0170a-b, d-s, J1800, J1900) to support measurement domains mandated by the Act - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674); and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

- Modification to OASIS items M0300/M1311 to support a new standardized pressure ulcer measure to replace the current standardized pressure ulcer measure. The new measure is Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
**IMPACT Act**

• New items added to OASIS for standardization to align with the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI), the Long-term Care Hospital assessment set, and the Minimum Data Set (MDS).
  • M1900 Prior Function
  • GG0110 Prior Device Use

• Item removals, including the removal of data elements at different time points. This results in largely different assessment times by time point reducing burden for HHAs. Details and calculations of data elements by timepoint are available in Appendix C.

**Removed Items**

• M0903 Date of Last (Most Recent) Visit
• M1011 Inpatient Diagnosis
• M1017 Diagnoses Requiring Medical or Tmt Change
• M1018 Conditions Prior to Regimen Change
• M1025 Optional Diagnoses
• M1034 Overall Status
• M1036 Risk Factors
  • M1210 Ability to Hear
  • M1220 Understanding of Verbal Content
  • M1230 Speech and Oral (Verbal)
  • M1240 Pain Assessment
• M1300 Pressure Ulcer Assessment
• M1302 Risk of Developing Pressure Ulcers
• M1313 Worsening in Pressure Ulcer Status
• M1320 Status of Most Problematic Pressure

**Other Changes That Are Not Reflected**

• Cognitive Patterns
  • Brief Interview for Mental Status
  • Signs and Symptoms of Delirium

• Behavioral Symptoms
• Swallowing/Nutritional Status
• Special Treatments, Procedures, Programs
  • Chemo, radiation, oxygen, suctioning, trach care, invasive mechanical ventilator, non-invasive mechanical ventilator, IV meds, transfusions, dialysis, IV access

• M1350 Skin Lesion or Open Wound
  • M1410 Respiratory Treatments
  • M1501 Symptoms in Heart Failure
  • M1511 Heart Failure Follow-up
  • M1615 When does Urinary Incontinence
  • M1750 Psychiatric Nursing Services
  • M1880 Ability to Plan and Prepare Light Meals
  • M1890 Ability to Use Telephone
  • M1900 Prior Functioning ADL/IADL
  • M2040 Prior Medication Management
  • M2110 How Often does the patient
  • M2250 Plan of Care Synopsis
  • M2430 Reason for Hospitalization
Expansion of the One Clinician Rule

13. The comprehensive assessment includes the OASIS items and is part of the patient’s legal home health agency clinical record. While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, s/he may collaborate to collect data for all OASIS items, if agency policy allows.

Collaboration may consider information from others such as the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to the OASIS data collection. When collaboration is utilized, the M0090 Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items. When used, collaboration must occur within the appropriate timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.
M1311 Follow-Up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

<table>
<thead>
<tr>
<th>Number</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers</td>
<td>❌</td>
</tr>
<tr>
<td>B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</td>
<td>❌</td>
</tr>
<tr>
<td>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>❌</td>
</tr>
<tr>
<td>D1. Unstageable: Non-removable dressing/device. Known but not stageable due to non-removable dressing/device. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</td>
<td>❌</td>
</tr>
<tr>
<td>E1. Unstageable: Slough and/or eschar. Known but not stageable due to coverage of wound bed by slough and/or eschar. Number of unstageable pressure ulcers/injuries due to coverage of wound bed by slough and/or eschar</td>
<td>❌</td>
</tr>
<tr>
<td>F1. Unstageable: Deep tissue injury. Number of unstageable pressure injuries presenting as deep tissue injury</td>
<td>❌</td>
</tr>
</tbody>
</table>

Determining Present on Admission

OASIS C2

- The general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC as possible. If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame, the initial stage of the pressure ulcer would be reported in M1311 at the SOC.

OASIS D

- The general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC as possible. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment time frame, the stage of the pressure ulcer/injury at the first skin injury assessment completed would be reported in M1311X1 at the SOC.

Cannot Change Assessment on M1311

- Does the instruction to code based on assessment as close to admission as possible, mean that if the ulcer is unstageable on Day 1 but debrided on Day 2, do we still report it as unstageable at SOC and leave it?

- Example: Pressure ulcer is covered with eschar and slough. Ulcer is debrided on day 3 of episode and ulcer is staged at 4.
  - M1311 CANNOT be updated to stage 4.
Cannot Change Assessment on M1311

• Example: Pressure ulcer is covered with a non-removable dressing at SOC. Patient returns to clinic on day 3 and nurse documents on day 4 that it is a stage 3.
• M1311 CANNOT be updated to stage 3.

When did the skin assessment occur?

We are seeking clarification regarding the reporting of pressure ulcers on the OASIS that are not identified on the initial visit. If a clinician conducts an initial assessment to meet the immediate needs of the patient and does not document the presence of a pressure ulcer and a pressure ulcer is found 2 days later when the comprehensive assessment is performed, is the pressure ulcer reported on the OASIS?

Only applies to pressure ulcers...

If a patient has a non-removable dressing on when the assessing clinician admits, could a different clinician report the wound status to the assessing clinician if the dressing is removed within the assessment time frame?

The answer to this question is dependent on the type of wound involved

Pressure Ulcers: To support consistency of data collection related to pressure ulcers across all post-acute care (PAC) providers, cross-setting guidance states that for pressure ulcers, the first clinical skin assessment is the assessment used to complete the SOC OASIS pressure ulcer items.

For example, a pressure ulcer that is known to be present but that is covered with a non-removable dressing at the admission visit would be reported as Unstageable due to a non-removable dressing/device, even if the ulcer becomes observable by the 2nd visit. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS pressure ulcer items.

Surgical Wounds: OASIS guidance allows the agency to use any skin assessment conducted during the assessment time frame to code the OASIS surgical wound items. Guidance does not limit coding to only data from the first clinical skin assessment. For example, when a patient has a surgical wound under a non-removable dressing at the admission visit, and the dressing is changed the next day by a different nurse, the assessing clinician may report the surgical wound as non-observable based on his/her admission visit, or may collaborate with the second nurse for information to code the surgical wound items based on observation after the dressing was removed.

When did the skin assessment occur?

The OASIS pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the SOC or ROC date as possible. If the first time a skin assessment could be done is on the second home health visit, and a pressure ulcer is identified during that assessment, then it should be reported on OASIS, as that would represent the initial skin assessment.

If a skin assessment was conducted on the SOC visit and no pressure ulcer was identified, then a subsequent skin assessment was conducted on the second visit and a pressure ulcer was identified, the pressure ulcer would not be reported on the OASIS at that time point, since the pressure ulcer status should be based on the first skin assessment conducted at the SOC/ROC time points.
**M1322/ M1324**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Stage of Most Problematic Unhealed Pressure Ulcer(s) that is Stageable: (Excludes pressure ulcer(s) that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Stage 1</td>
</tr>
<tr>
<td>1</td>
<td>Stage 2</td>
</tr>
<tr>
<td>2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>3</td>
<td>Stage 4</td>
</tr>
<tr>
<td>4 or more</td>
<td>NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries</td>
</tr>
</tbody>
</table>

**M1332**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Current Number of Stasis Ulcer(s) that are Observable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One</td>
</tr>
<tr>
<td>2</td>
<td>Two</td>
</tr>
<tr>
<td>3</td>
<td>Three</td>
</tr>
<tr>
<td>4</td>
<td>Four or more</td>
</tr>
</tbody>
</table>

**Remember this one?**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance (example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
<tr>
<td>b. IADL assistance (example, meals, housekeeping, laundry, telephone, shopping, finances)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
<tr>
<td>c. Medication administration (example, oral, inhaled or injectable)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
<tr>
<td>d. Medical procedures/treatments (example, changing wound dressing, home exercise program)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOC/ROC**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Supervision and safety (example, due to cognitive impairment)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

**Needed for HHVBP**
Discharge

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Exclude all care by your agency staff.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>ADL assistance (for example, transfer, ambulation, bathing, dressing, toileting, feeding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Medication administration (for example, oral, inhaled or injectable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Medical procedures/treatments (for example, changing wound dressing, home exercise program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Supervision and safety (for example, due to cognitive impairment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed—patient is independent or does not have needs in this area</td>
</tr>
<tr>
<td>1</td>
<td>Non-agency caregiver(s) currently provide assistance</td>
</tr>
<tr>
<td>2</td>
<td>Non-agency caregiver(s) need training/supportive services to provide assistance</td>
</tr>
<tr>
<td>3</td>
<td>Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</td>
</tr>
<tr>
<td>4</td>
<td>Assistance needed, but no non-agency caregiver(s) available</td>
</tr>
</tbody>
</table>

Gone from M2102

(M2310) Reason for Emergent Care

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)

- Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- Injury caused by fall
- Respiratory infection (example, pneumonia, bronchitis)
- Other respiratory problem
- Heart failure (example, fluid overload)
- Cardiac dysrhythmia (irregular heartbeat)
- Myocardial infarction or chest pain
- Other heart disease
- Stroke (CVA) or TIA
- Hypertension or hypotension, diabetes or control
- GI bleeding, obstruction, nausia, vomiting
- Dehydration, malnutrition
- Urinary tract infection
- IV or arterial-related infection or complication
- Wound infection or deterioration
- Uncontrolled pain
- Acute mental/behavioral health problem
- Deep vein thrombosis, pulmonary embolism
- Other than above reasons
- Reason unknown

GG: Functional Abilities and Goals

Alignment with standardized sections in other PAC instruments
Patient instead of Resident (as in the original)
SOC/ROC instead of admission
Full assessment timeframe to complete assessments/data collection
GG0100

Impact
Act

When to Code Not Applicable

• The patient uses a walker for ambulation, but uses a stair lift for the stairs.
• C Stairs would be coded Not Applicable (9)

GG0110

Impact
Act

GG0100 Previous Device Use

• Interview patient or family or review the patient’s clinical record describing the patient’s use of prior devices and aids.
• GG0110C - Mechanical lift, any device a patient or caregiver requires for lifting or supporting the patient’s bodyweight. Examples include, but are not limited to:
  • Stair lift
  • Hoyer lift
  • Bath tub lift
• GG0110D - Walker, All types of walkers. Examples include, but are not limited to:
  • Pick-up walker
  • Hemi-walker
  • Rolling walker
  • Platform walker
Example

- Mr. C has bilateral lower extremity neuropathy secondary to his diabetes. Prior to this current episode, he used a cane. Today, he is using a walker.
- Answer Z None of the above. He did not use the walker prior to the current episode.

GG0130 Self-Care SOC/ROC

<table>
<thead>
<tr>
<th>SOC/ROC Performance</th>
<th>Discharge Goal</th>
<th>Enter Codes In Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Oral Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Toilet Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Shower/Bathe Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Upper Body Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Lower Body Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Putting on/Taking off Footwear</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Activity D is "Wash Upper Body"

Notice there is no D

Contrast and Compare

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Enter Code

0 Able to independently feed self
1 Able to feed self independently but requires:
   (a) meal set-up; OR
   (b) intermittent assistance or supervision from another person; OR
   (c) a liquid, pureed or ground meat diet.
2 Unable to feed self and must be assisted or supervised throughout the meal/snack.
3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
5 Unable to take in nutrients orally or by tube feeding.

GG0130, Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance – Helper sets up or cleans up, patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadingy and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance – Helper does LESS THAN HALF the effort, helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reasons:
07. Patient refused
09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. Not attempted due to environmental limitations (e.g. lack of equipment, weather constraints)
88. Not attempted due to medical conditions or safety concerns
Contrast and Compare

B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.

Contrast and Compare

C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Contrast and Compare

E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excluding washing of back and hair). Does not include transferring in/out of tub/shower.

Contrast and Compare

F. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable.

Getting clothing out? Ace bandages, splints, prosthetics, collars?
Contrast and Compare

G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.

H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

Response Specific Instructions SOC/ROC

- Code the patient’s functional status based on a functional assessment that occurs at or soon after the patient’s SOC/ROC. The SOC/ROC function scores are to reflect the patient’s SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient’s true baseline status. This is because therapy interventions can affect the patient’s functional status.

GG0130 Self-Care at Follow-Up

**GG0130: Self-Care**

Code the patient’s usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

**Coding:**
- Safety and Quality of Performance – If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistive devices.
- Set up or clean-up assistance – Helper sets up or cleans up; patient completes activity.
- Supervision or touch assistance – Helper provides verbal cues and/or touch, standing and/or contact guard assistance as patient completes activity.
- Partial/limited assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports back or limbs, but provides less than half the effort.
- Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk, limbs, and provides more than half the effort.
- Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
- If activity was not attempted, code reason:
  - Patient refused
  - Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
  - Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
  - Not attempted due to medical conditions or safety concerns

**Follow-Up Performances**

- **A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
- **B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
- **C. Toilet/Urinal:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
For the Home Health (HH) Quality Reporting Program (QRP) a minimum of one self-care or mobility goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal. Code the patient’s discharge goal(s) using the 6-point scale. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded.

Licensed clinicians can establish a patient’s discharge goal(s) at the time of SOC/ROC based on the patient’s prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession’s practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient’s care plan.

**Response Specific Instructions Discharge**

- **Discharge Performance:** The discharge time period under consideration includes the last 5 days of care. This includes the date of the discharge visit plus the four preceding calendar days.
- **Code the patient’s functional status based on a functional assessment that occurs at or close to the time of discharge.**

**GG0130 Self-Care at Discharge**

<table>
<thead>
<tr>
<th>3. Discharge Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ Enter Codes in Boxes</td>
</tr>
</tbody>
</table>

- **A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
- **B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
- **C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
- **E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
- **F. Upper body dressing:** The ability to dress and undress above the waist, including fasteners, if applicable.
- **G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
- **H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

**GG0130A Eating**

- **Assistance with tube feedings or TPN is not considered when coding the item eating.**
- **If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN due to a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns.**
- **If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, injury or exacerbation, code GG0130A as 09, Not applicable.**
- **If the patient eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code eating based on the amount of assistance the patient requires to eat and drink by mouth.**
GG0170 Mobility SOC/ROC

**GG0170 Mobility**

**Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).**

**Coding:**

- **Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
- **Activities may be completed with or without assistive devices.**

**Activities:**

- **Independent** - Patient completes the activity by himself/herself with no assistance from a helper.
- **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- **Supervision or touching assistance** - Helper provides verbal cues and/or touching/standing and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

**If activity was not attempted, code reason:**

- **07. Patient refused**
- **09. Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
- **10. Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- **18. Not attempted due to medical conditions or safety concerns**

---

**GG0170 Mobility at Follow-Up**

**Follow-Up Performance**

**Enter Codes in Boxes:**

- **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
- **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- **C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- **E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
- **F. Toilet transfer:** The ability to get on and off a toilet or commode.
- **G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door of fasten seat belt.
- **H. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.**
- **I. Walk 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- **J. 1 step (curl):** The ability to go up and down a step and/or up and down one step.
- **K. 4 steps:** The ability to go up and down four steps with or without a rail.

---

**GG0170 Mobility**

**1. SOC/ROC Performance**

**Enter Codes in Boxes:**

- **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
- **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- **C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- **E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
- **F. Toilet transfer:** The ability to get on and off a toilet or commode.
- **G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door of fasten seat belt.
- **H. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.**
- **I. Walk 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- **J. 1 step (curl):** The ability to go up and down a step and/or up and down one step.
- **K. 4 steps:** The ability to go up and down four steps with or without a rail.

**2. Discharge Goal**

**Enter Codes in Boxes:**

- **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
- **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- **C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- **E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
- **F. Toilet transfer:** The ability to get on and off a toilet or commode.
- **G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door of fasten seat belt.
- **H. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.**
- **I. Walk 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- **J. 1 step (curl):** The ability to go up and down a step and/or up and down one step.
- **K. 4 steps:** The ability to go up and down four steps with or without a rail.
GG0170A Roll Left to Right

- The activity includes the patient rolling to both the left and to the right while in a lying position,
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.
- For example, if a clinician determines that a patient’s new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns.

For GG0170A, Roll left and right, clinical judgment should be used to determine what is considered a “lying” position for the patient. For example, a clinician could determine that a patient’s preferred slightly elevated resting position is “lying” for that patient.
Example

- At SOC, the physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side. He then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. R completes the activity without physical assistance from a helper. Mr. R was moving about in bed without difficulty prior to hospitalization. The therapist expects Mr. R will roll left and right by himself by discharge.
  - Coding: GG0170A, Roll left and right, SOC Performance would be coded 04, Supervision or touching assistance. Discharge Goal would be coded 06, Independent.
  - Rationale: At SOC, the physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back. The physical therapist does not provide any physical assistance. After assessment and considering his current condition, the therapist expects Mr. R will be independently rolling left and right at discharge.

J1800 Definition of Fall

- **Unintentional** change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.
- CMS understands that challenging a patient’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

J1800 Transfer, Death at Home and DC

Unwitnessed Fall

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** This item addresses unwitnessed as well as witnessed falls.

<table>
<thead>
<tr>
<th>J1800. Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enter Code</strong></td>
</tr>
<tr>
<td>□ No — Skip J1900</td>
</tr>
<tr>
<td>1. Yes — Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J1800. Any Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enter Code</strong></td>
</tr>
<tr>
<td>□ No — Skip J1900</td>
</tr>
<tr>
<td>1. Yes — Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent</td>
</tr>
</tbody>
</table>
Intercepted Fall

• An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.
  • **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  • **Rationale:** An intercepted fall is considered a fall.

Balance Training – Challenge Balance

• A patient is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging patient’s balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow the patient to maintain standing.
  • **Coding:** J1800, Any Falls since SOC/ROC, would be coded 0, No.
  • **Rationale:** The patient’s balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.

Unanticipated Fall During Therapy

• A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient’s weight in order to prevent a fall.
  • **Coding:** J1800, Any Falls since SOC/ROC would be coded 1, Yes.
  • **Rationale:** The patient’s stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

J1900 Transfer, Death at Home and DC

<table>
<thead>
<tr>
<th>J1900.</th>
<th>Number of Falls Since SOC/ROC, whichever is more recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING:</td>
<td>Enter Codes in Boxes</td>
</tr>
<tr>
<td>0. None</td>
<td>A. No injury; No evidence of any injury is noted on physical assessment by the nurse or primary care physician; no complaints of pain or injury by the patient; no change in the patient’s behavior is noted after the fall</td>
</tr>
<tr>
<td>1. One</td>
<td>B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains, or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td>2. Two or more</td>
<td>C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
**J1900 Definitions**

- **INJURY RELATED TO A FALL** Any documented or reported injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

- **NO INJURY** No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

- **INJURY (EXCEPT MAJOR)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

- **MAJOR INJURY** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

**Response Specific Instructions**

- Determine the number of falls that occurred since the most recent SOC/ROC, and, code the level of fall-related injury for each.

- Code falls no matter where the fall occurred.

- Code each fall only once.

- If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

**Example**

- Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes. The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink. The RN assessment identified no injury. The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

**Coding:**

- J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.

- J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.

- J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

**Rationale:** The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

**What questions do you have?**