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# Diagnosis Coding Pro For Home Health

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


## In this issue



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*ICD-10 C&M Committee meeting*

## Watch for new codes for inflammatory breast cancer, type 2 DM in remission

Coders could see new cancer codes that would capture malignant inflammatory neoplasms of the breast and allow for speedier treatment if a proposal is approved as presented during the September ICD-10 Coordination and Maintenance Committee meeting, held Sept. 10 and 11.

The proposal calls for the addition of a new subcategory, **C50.A** (Malignant inflammatory neoplasm of breast) under **C50** (Malignant neoplasm of breast) with inclusion terms, "Inflammatory breast cancer (IBC)."

Also proposed are three new codes under the subcategory to further capture the location:

- **C50.A0** (Malignant inflammatory neoplasm of unspecified breast)
- **C50.A1** (Malignant inflammatory neoplasm of right breast)
- **C50.A2** (Malignant inflammatory neoplasm of left breast)

These new codes would allow physicians to more readily identify patients with this form of breast cancer, facilitate earlier treatments and raise awareness about IBC in the clinical community, the proposal states.

"This is a very aggressive form of breast cancer and having a specific code to identify it will help in research and developing methods to proactively identify the disease," notes Sherri Parson, CEO of Infusion Health in Ypsilanti, Mich. "By specifying the difference between breast cancer and inflammatory breast cancer, researchers may be able to begin to identify similarities that can help in screening or treatment down the road."

This is one of more than 35 proposals that were presented during the two-day meeting. All of the proposals are being considered for an Oct. 1, 2025, implementation date.

### New code for type 2 DM w/o complications in remission

An updated proposal was also presented for a new code to capture type 2 diabetes mellitus without complications in remission.

A previous proposal for this code was presented during the March 2024 ICD-10 C&M committee meeting; however, revisions were made following public comments to:

- Address concerns of code selection in addition to diabetic complications with the addition of an "Excludes 1" note; and
- Emphasize the importance of adding this code as a means of embracing remission as a key therapeutic goal in type 2 diabetes mellitus.

The updated proposal calls for the addition of new code, **E11.A** (Type 2 diabetes mellitus without complications in remission), under **E11** (Type 2 diabetes mellitus).

Also proposed are "Excludes 1" notes for "Type 2 diabetes mellitus, with complications (E11.0-E11.8)" and "Type 2 diabetes mellitus, without complications not in remission (E11.9)."

This new code reflects the goal to achieve clinical regression along the diabetes continuum in alignment with the current clinical guidelines, the proposal states.

"It has been widely known that Roux-en-Y bypass bariatric surgery has corrected type 2 diabetes as well as led to significant weight loss in many patients," Parson notes. "This has often presented some challenges for coders, because we have always been taught that diabetes is a chronic condition that a patient will always have."

With the advent of GLP-1 medications promoting large amounts of weight loss and increased popularity of bariatric surgeries, coders have seen documentation of the remission or resolution of diabetes in certain individuals, she adds.

This will provide a code selection for those patients who have diabetes in remission as long as there is no associated diabetic manifestations, Parson says.

"Keep in mind that those who have diabetes that is now in remission, but additionally have a diabetic manifestation such as diabetic neuropathy, would still be coded by capturing the diabetic combination code," she adds.

## Postprocedural open deep wound w/o disruption

Another proposal from the ICD-10 C&M Committee meeting would add new code **Z98.88** (Postprocedural open deep wound without disruption) under **Z98.8** (Other specified postprocedural states) with inclusion terms: "Delayed abdominal closure following a procedure," "Postprocedural open abdomen" and "Postprocedural temporary open surgical wound."

The proposal explains that in certain circumstances, a surgical wound is temporarily left open at the end of a procedure.

"Having an open surgical wound after a prior operation is a high-risk situation that strongly affects resource use and care in the hospital, at least until the wound is closed," the proposal states.

While this is a clinically significant concept, there is currently no way to account for it in ICD-10.

"This new code allows for distinction between postprocedural wounds that are a complication versus those done deliberately for therapeutic purposes," Parson says.

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"Wounds that are large and gaping, even if deliberately left for specific therapeutic reasons, still often require significant attention from the home health agencies."

Adriana Molina, regional coder and OASIS educator with Trilogy/Humana CenterWell, notes she was happy to see this proposal.

"We have a team for antibiotic infusions, and I see scenarios like this quite often," she explains.

For example, she says, consider a patient that is coming to home care for antibiotic infusion status post gallbladder removal. The patient was diagnosed with cholelithiasis with gangrene and perforation of gallbladder causing an acute peritonitis. The surgeon performed an open cholecystectomy and left the surgical wound incision site to heal by secondary intention with a drain.

Even though the scenario might lead coders to think they should assign a complication T code because of the medical complexity, this scenario is not deemed a complication since the surgeon anticipated leaving an open full thickness surgical wound for the purpose of an optimal epithelialization healing without a risk of infection.

"The perfect code to paint this scenario would be Z98.88 (Post procedural open deep wound without disruption)," Molina adds.

### Other proposed tabular changes

*These code changes are being proposed for an. Oct. 1, 2025, implementation date:*

- Under **J43** (Emphysema), delete the "Excludes 1" note, and add an "Excludes 2" note for emphysema due to inhalation of chemicals, gases, fumes or vapors **(J68.4).**
- Under **J44** (Other chronic obstructive pulmonary disease), delete the "Excludes 1" note and add an "Excludes 2" note for chronic bronchitis NOS **(J42),** chronic simple and mucopurulent bronchitis **(J41.-),** chronic tracheitis (J42) and chronic tracheobronchitis **(J42)**.
- Under **Z56.6** (Other physical and mental strain related to work), add inclusion term "Workplace stress." ■

***Editor's note:*** *To view all of the September proposals, visit https://tinyurl.com/4dptjju9.*

*HH Grouper change*

## Experts applaud change to allow vascular dementia as primary

After receiving a Behavioral Health clinical group designation with the most recent Home Health Grouper update, there may now be some instances where vascular dementia can be assigned primary.

Experts note that, in some cases, the change eliminates extra digging to assign correct codes and can improve care by providing a clearer link between the primary diagnosis and the focus of care.

Prior to Oct. 1, vascular dementia was unable to be assigned as the primary diagnosis in home health or the terminal diagnosis in hospice coding. In addition to previously not having a clinical group designation, there was also a "code first" note for the underlying disease process.

However, among the new FY2025 tabular changes is an update to the language to now state: "Code first, if applicable, the underlying disease process."

"This updated verbiage, along with the inclusion of F01.5- codes to a primary PDGM payer group, implies that these codes may be assigned independently, either as primary or secondary, when the underlying cause is not known," explains Ohio-based home health and coding expert Brandi Whitemyer.

Particularly when this is the reason for admission, this change reduces the need for query when there is no known underlying cause of vascular dementia documented, since the code may be assigned on its own, she adds.

And this is a welcome change among industry experts.

"It will be extremely helpful to be able to code vascular dementia as primary for home health," notes Nanette Minton, senior clinical coding manager with MAC Legacy in Denton, Texas. "It has long been a frustration not to be able to code this specified type of dementia as primary when that is the specified focus of care."

### Don't ignore an underlying condition

Despite vascular dementia now having the ability to be assigned in the primary spot, when applicable, keep in mind that it is still best practice to continue to "code first" the condition causing the disease whenever possible.

"However, that information is not always readily available in the medical record," Minton states.

And in some cases, a query to the provider may still be appropriate.

***Note: F01.50*** *(Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) would not be able to be assigned primary under PDGM. You must have manifestations in order for it to be primary for home health, notes Minton. If none are documented, then you will need to reach out to the provider for clarification.*

While vascular dementia generally has a known underlying cause, there are cases where the cause is not stated or not known.

Dementia conditions are often diagnosed through the process of elimination of other differential diagnoses, Whitemyer says.

Vascular dementia can be diagnosed due to specific characteristics and patient-specific factors, such as known medical history and risk, and elimination of different types of dementia, she adds. "A patient may also be awaiting more extensive testing to determine the underlying cause, so the provider cannot yet state the cause."

This does not necessarily negate the validity of the diagnosis of vascular dementia.

"Ideally, when providing a diagnosis of vascular dementia, the physician or NPP will additionally provide documentation indicating the underlying cause/condition as well," Whitemyer says.

### How does this affect hospice?

This change should allow for hospice to also use F01.5- codes as a primary, terminal diagnosis when specified by the provider, Whitemyer notes.

"Hospice may not assign as primary any unspecified dementia diagnosis (F03.9-) or any dementia diagnoses that are true manifestation codes (for which diagnosis sequencing guidelines require another condition to be coded first)," she explains.

By changing the "code first" note to indicate that the underlying cause needs only to be coded "if applicable," this removes the restriction of sequencing guidelines from this code that would prevent it from primary diagnosis assignment, Whitemyer says.

### Consider this scenario

*Here, Minton provides an example of an instance where it would now be appropriate to assign a vascular dementia code as primary:*

***Scenario:*** *Home health receives a referral for therapy due to increased weakness in a patient with frequent falls with a new diagnosis of vascular dementia. Documentation indicates that the vascular dementia is likely from previous history of strokes. The patient also has anxiety and depression.*

- With this type of documentation, you would not be able to assume that the vascular dementia was related to the stroke. Therefore, you now would be able to use vascular dementia with anxiety or vascular dementia with mood disorder as primary. — *Megan Herr* (*megan.herr@decisionhealth.com*) ■

***Editor's note:*** *This story is an update from a previous story on vascular dementia, which ran in the April 2024 issue of Diagnosis Coding Pro for Home Health.*

*New code for CY2025*

## Grouper update causes confusion about encounter for sepsis aftercare

New code **Z51.A** (Encounter for sepsis aftercare), which took effect Oct. 1, did not receive a clinical group designation with the most recent Home Health Grouper update, meaning it can't be used as primary. As a result, experts are left wondering what that means for the accurate use of this code.

This code will be helpful with capturing cases where the provider has documented the sepsis as "resolved" but the reason for the home care admission relates back to the sepsis.

"We were all hoping it would be placed in a clinical group — similar to most of our other aftercare codes — as it would perfectly describe the post-acute care phase where we treat the lingering problems related back to sepsis," says Apryl Swafford, QA Manager with SimiTree Healthcare Consulting based in Hamden, Conn.

Without this distinction coders are left struggling to figure out how and when to use it, she adds.

For example, Swafford explains, if a patient has a lingering symptom of sepsis such as weakness, fatigue

or even muscle wasting, none of those can be coded as primary under PDGM.

"Since the aftercare of sepsis also cannot be primary, that leaves the coder in a quandary," Swafford says.

The new code also does not carry any weight for case-mix comorbidity adjustments when used as secondary diagnosis on the list, notes Kelly Kavanaugh, independent home health and hospice consultant with the OTB Group, based in north Texas.

But it will help to explain the medical necessity of the care being provided and the duration of care in some cases, she adds.

## Additional guidance for accurate coding

More clarification may be needed as to what situations this code would be best used for, Swafford says.

"Without clearer guidance, I would be hesitant to say emphatically use it in this or that situation, but personally, I feel like it would be great for the stage that we get many home care patients diagnosed with sepsis," she adds. "Maybe it would be best used for those patients for whom the provider has documented the acute phase as resolved and they have residual effects which will be the focus for home care and that can be coded as primary."

Prior to this code, patients admitted to home care where the provider documented "resolved" — meaning the acute phase has resolved — were still coded to sepsis in most instances as it's a complicated disease process and there are often moderate to long-term residual issues after the acute phase, she explains.

"This is where we usually pick the patient up," Swafford says. "So, will we now use the aftercare code for those with a resolved acute phase or will it be used for patients who have completed antibiotics (which is where many providers document it as resolved) but still need care?"

Those are the questions that still need to be answered, she adds.

## Z51.A helps to paint a picture

Despite not being able to assign the code primary, it will still be a useful addition to help explain a patient's condition, notes Kavanaugh.

"It will still help to capture the severity of the patient's recent situation on the home care plan of care (POC)," she adds. "Using Z51.A as an additional code on the POC diagnosis list will help to paint the clinical picture to boost support of the medical necessity for care being provided and distinguish this patient from other patients recovering from less severe infections."

Sometimes, there will still be a local infection to code as primary, such as UTI or pneumonia that has not resolved, so that would be coded as primary followed by the aftercare sepsis code, Kavanaugh notes.

Other times, she adds, if there was severe sepsis, there could be organ failure/damage that is still being treated such as kidney, respiratory or heart failure which would be coded as primary followed by the aftercare sepsis code.

As of now, coders will likely use it similarly to other Z codes for supplemental and supporting information, Kavanaugh says.

For example, the Z79 codes for medication use or the Z93 codes for artificial opening status.

Kavanaugh says she is hopeful that the code not making the primary list was just an oversight and possibly it will be rectified with the next update.

*Consider this scenario from Kavanaugh on how to assign this new code as of now:*

***Scenario 1:*** *A patient was hospitalized for E coli UTI with severe sepsis with acute renal failure. The sepsis is indicated to be resolved at the time of discharge to home; however, the patient remains on five more days of a 14-day course of antibiotics and the renal failure is indicated to be improving, but labs are still abnormal.*

***Code the scenario:***

| Code | Code Description |
|---|---|
| **M1021a:** N39.0 | Urinary tract infection, site not specified |
| **M1023b:** B96.20 | Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere |
| **M1023c:** N17.9 | Acute kidney failure, unspecified |
| **M1023d:** Z51.A | Encounter for sepsis aftercare |

*— Megan Herr (megan.herr@decisionhealth.com)*

*(continued on p. 7)*

## Advanced Coding Corner

***Scenario:*** A 65-year-old female is referred to home health by her primary care physician for medication education and assessment of cardiac and musculoskeletal-related effects of taking her Effexor incorrectly. She has been on Effexor for major depressive disorder for 3 months and went to the physician due to tachycardia and palpitations along with mild muscle cramping. It was found that she had accidentally been taking double her prescribed dose of Effexor due to misunderstanding the instructions. Her physician reported that she developed serotonin syndrome resulting from toxicity. The physician also diagnosed an exacerbation of her previously diagnosed hypertensive heart disease with cardiomyopathy due to the serotonin syndrome. She has an additional diagnosis of chronic systolic heart failure noted. Home health has been ordered to oversee the patient's medication regime and follow up on serotonin syndrome to assure the resolution of symptoms. How would you code this scenario?

**Answer:** This patient's physician diagnosed serotonin syndrome due to the patient taking more of her Effexor than prescribed unintentionally. This is an unintentional overdose and should be coded as a poisoning, following the guidelines for poisoning codes in category **T43** (Poisoning by, adverse effect of and underdosing of psychotropic drugs, not elsewhere classified).

This requires coding the poisoning code, **T43.221D** (Poisoning by selective serotonin reuptake inhibitors, accidental(unintentional), subsequent encounter), first.

The code for the consequence of the poisoning, **G90.81** (Serotonin syndrome) will follow this along with other consequences related to the poisoning that are manifestations of serotonin syndrome in the case of this patient.

Serotonin syndrome can occur as a result of overdose or underdose (withdrawal) of many drugs or drug combinations that impact the reuptake of serotonin. These drugs include, but are not limited to, SSRIs, SNRIs, Opiate medications, certain antipsychotics (trazadone, lithium), ergot derivatives, and others.

Because the effects resulting from serotonin syndrome may vary and are not consistent from patient to patient, it is important to not only code serotonin syndrome, but also the individual manifestations that remain unresolved.

This patient continues to have an unresolved exacerbation of her hypertension which should be coded. Because her condition is specified as hypertensive heart disease and the patient has a diagnosis of chronic systolic heart failure, the most appropriate code sequence is **I11.0** (Hypertensive heart disease with heart failure) followed by **I50.22** (Chronic systolic (congestive) heart failure).

Additional unresolved manifestations of her serotonin syndrome including tachycardia, palpitations, and muscle cramping are also coded.

Because the patient additionally has a diagnosis of major depressive disorder for which the Effexor was originally prescribed and this should also continue to be monitored, this should also be coded.

| Primary and Secondary Diagnoses | |
|---|---|
| **M1021a:** Poisoning by selective serotonin reuptake inhibitors, accidental (unintentional), subsequent encounter | T43.221D |
| **M1023b:** Serotonin syndrome | G90.81 |
| **M1023c:** Hypertensive heart disease with heart failure | I11.0 |
| **M1023d:** Chronic systolic (congestive) heart failure | I50.22 |
| **M1023e:** Tachycardia | R00.0 |
| **M1023f:** Palpitations | R00.2 |

***Additional diagnoses:*** *R25.2 (Cramp and spasm) and F32.9 (Major depressive disorder, single episode, unspecified)*

***Here's a scenario to work on for next month:*** *A 76-year-old female patient is admitted to home health following an inpatient stay due to COVID-19 pneumonia with severe sepsis and AKI with hypoxic respiratory failure resulting in secondary MRSA pneumonia. The physician has noted that COVID/COVID pneumonia is resolved as well as sepsis, but the patient has severe muscle weakness remaining secondary to both COVID-19 and sepsis. Skilled nursing is ordered to observe and assess the pa-tient's unstable respiratory condition and bacterial pneu-monia w/respiratory failure and obtain ongoing labs re-lated to AKI.*

***Editor's note:*** *To submit a scenario for the Advanced Coding Corner, email it to megan.herr@decisionhealth.com.*

(*continued from p. 5*)

*Q4 update*

## Get new guidance on how to use new codes for anorexia nervosa

The Q4 2024 Coding Clinic update, released Oct. 1, presented a summary of the new ICD-10 codes —which took effect the same day — and included answers to questions about the new codes.

For instance, there were several questions regarding the new codes to capture various eating disorders.

One question asked whether it would be appropriate to assign **F50.012** (Anorexia nervosa, restricting type, severe) based on the inclusion term "Anorexia nervosa, restricting type, with a body mass index (BMI) of 15.0-15.99 kg/m2" for a patient that was admitted for treatment of anorexia nervosa, restrictive type, with a BMI of 15.4. The question further asks if the provider needs to explicitly document the term "severe"?

To this, the Coding Clinic states that the term "severe" does not need to be explicitly documented by the provider.

"It would be appropriate to assign code **F50.012** (Anorexia nervosa, restricting type, severe) when the provider documents anorexia nervosa, restrictive type, with an associated BMI of 15.4," they add in their response. "In this case, the inclusion term supports proper code assignment."

### How to code when BMI fluctuates

The Coding Clinic was also asked about a patient with anorexia nervosa, binge/purging type, who was admitted, and it was noted that the patient's BMI fluctuated during the stay between 15.5, 16.2, and 14.89, respectively.

The question asked:

- Which BMI value should be considered when fluctuations occur during the admission?
- Is it appropriate to assign the anorexia nervosa code that reports the most severe BMI in this case to capture the severity?

In this case, Coding Clinic states, you would assign F50.023 (Anorexia nervosa, binge eating/purging type, extreme).

"When documentation reflects fluctuations in the BMI value in patients who have a specified type of anorexia nervosa, it would be appropriate to assign the diagnosis code for the type of anorexia nervosa that is supported by the most severe BMI value documented during the inpatient admission, based on the inclusion term," they add in their response.

Also, facilities may assign code Z68.1 (BMI 19.9 or less, adult) to identify the BMI, the Coding Clinic adds.

### More guidance from Q4 Coding Clinic

- **Anastomotic dehiscence of the small bowel to the transverse colon.** Assign **T81.320A** (Disruption or dehiscence of gastrointestinal tract anastomosis, repair, or closure, initial encounter) for the dehiscence of the intestinal anastomosis.
- **Cement and Fat Pulmonary Artery Embolisms without Acute Cor Pulmonale.** Assign **T81.718A** (Complication of other artery following a procedure, not elsewhere classified, initial encounter) and **I26.96** (Fat embolism of pulmonary artery without acute cor pulmonale) for a patient who developed a postsurgical fat embolism in the pulmonary artery. — *Megan Herr* (*megan.herr@decisionhealth.com*) ■

**Coding Basics**

## Know combination codes when coding for CAD and MI

*In the final installment of the cardiac coding basics series, we are going to look at atherosclerotic coronary artery disease (CAD) and myocardial infarction (MI).*

About 20.5 million U.S. adults have CAD, making it the most common type of heart disease in our country. Per the National Heart, Lung, and Blood Institute, a division of the National Institute of Health. Additionally, about 366,000 Americans die from coronary heart disease each year.

In order to accurately code for the conditions, it is important to first understand them.

### Breaking down the pathophysiology

CAD is caused by atherosclerotic plaque buildup in the walls of the arteries that supply the heart.

As the deposits of plaque (which is made up of cholesterol, other fatty substances, cellular waste products, calcium and fibrin) grow, the lumen of the artery becomes narrower over time and can partially or totally block blood flow to the heart.

As the blood lessens, it can lead to muscle ischemia and prevent the heart from performing its important task of oxygenating the heart.

Symptoms include chest pain, also known as angina pectoris, which is the most common symptom of CAD.

This pain can be a warning of an impending myocardial infarction. The pain may occur in the chest, often described as "an elephant sitting on my chest", but may also occur in the shoulders, arms, neck, jaw, abdomen or back.

Women especially tend to have more non-typical anginal pain, occurring in the throat, jaw, neck as well as feeling out of breath and experiencing nausea and vomiting whereas men are more likely to experience the expected pain in the chest area.

This difference has often led to under-diagnosing and treatment for CAD in women. Unfortunately, not all patients experience angina, and their first sign of CAD is when they experience an MI.

## Know the risk factors

The risk factors we traditionally see for CAD include a high LDL (low-density lipoprotein) cholesterol, a low HDL (high-density lipoprotein) cholesterol, high blood pressure, family history, diabetes, smoking and obesity.

The risk for men increases after age 45, for women, after age 55.

However, plaque buildup begins young so a policy of a healthy diet and weight as well as regular exercise should begin in childhood.

## How to code for CAD

ICD-10 coding has combination codes to capture CAD with angina as there is an assumed causal relationship between both CAD and angina.

These are further divided into CAD without angina (I25.10), CAD with angina in the native arteries (I25.11-), and CAD with angina in coronary artery bypass grafts and transplanted heart (I25.7-).

As a coder, you would first need to know the angina is occurring in a native artery/s, a coronary artery bypass graft (CABG), or in a transplanted heart.

You would then need to have documentation of the type of angina the patient is experiencing. The types include:

- Unstable angina pectoris
- Angina pectoris with documented spasm
- Refractory angina pectoris
- Other forms of angina pectoris (such as stable angina)
- Unspecified angina pectoris

You would need provider documentation of the artery affected and the type of angina to select the appropriate code.

If the type of artery affected is not specified to bypass graft or transplanted heart, the default is native artery.

If you use one of the CAD/angina combination codes, you would not need to code a separate code for the angina as it's included in the combination code.

There is an "Excludes 1" note under both angina pectoris and the CAD codes which excludes you from coding the angina code with any code from I25.1- or I25.7-.

## What is MI?

A blocked coronary artery, in which there is a lack of sufficient oxygen to the heart muscle, can result in injury or even death of the portion of the heart impacted. This is referred to as a myocardial infarction.

The blockage in the artery can be caused by atherosclerotic plaque, blood clots, infections of the heart, and even spasms of the coronary artery which block blood flow.

Categories of MI:

- **Transmural infarctions:** the damage extends through the entire thickness of the heart muscle. These are referred to as ST-elevation MIs (STEMI). In these Mis, there will be elevation of the ST wave on an EKG. They can be classified by site of occurrence such as anterior, inferior, lateral, and/or anteriolateral walls. These are usually the more debilitating of the two categories as there is a greater area affected by the lack of oxygen.

- **Subendocardial infarctions:** these Mis involve a smaller area of the heart, mostly confined to the inner portion of the heart muscle. These are referred to as non-ST elevation MIs (NSTEMI). These usually occur when the coronary artery is only partially occluded. You may also see these referred to as non-transmural MIs.

### Types of MI

There are five types of MIs:

**Type 1:** These are the STEMI and NSTEMI discussed above and will be covered in greater detail

**Type 2:** These are a result of a mismatch between oxygen supply and demand at the tissue level. These code to I21.A1 and have a code first note to add the code for the underlying cause

**Type 3:** These are related to sudden cardiac death. These MIs occur before any changes to EKG or lab indicative of MI. While we do have a code for type 3 MI (I21.A9), we would not expect to see this code used in home care.

**Type 4:** MIs are associated with percutaneous coronary intervention (PCI) while **type 5** MIs are associated with coronary artery bypass grafting (CABG). These would both be captured with I21.A9, other myocardial infarction type, and also have a code first note to capture the procedure preceding the MI.

### Type 1 Myocardial infarction:

**STEMI:**

- These code to subcategories I21.0-I21.2 if the specific site of the MI is documented. There are specific codes for anterior and inferior MIs; any other documented site will code to I21.2-. I21.3, STEMI of unspecified site, would be used if no specific site documented but is stated as a STEMI or transmural MI without the site.
- These codes are assigned to a new MI and will be coded while the MI is less than or equal to four weeks duration. If after four weeks and no treatment needed, it would default to I25.2, old MI
- If documentation states an unspecified acute MI, the appropriate code will be I21.9, acute MI, unspecified.

**NSTEMI:**

- These MIs, which may be documented as NSTEMI, nontransmural or subendocardial MI are coded to I21.4.
- If the MI is documented as a NSTEMI or nontransmural/subendocardial MI and a site is provided, it would still be coded to I21.4.

*Consider these tips for coding:*

- If the documentation indicates a NSTEMI evolves to STEMI, assign the STEMI code,
- If the patient has thrombolytic therapy and a STEMI converts to a NSTEMI, you will still code the appropriate STEMI code.
- If the documentation supports patient is requiring care after the four-week time frame for the same MI, you will want to assign the appropriate aftercare code rather than an acute MI code from category I21-. The appropriate aftercare code is Z51.89, encounter for other specified aftercare, followed by the code for an old MI (I25.2)

### Subsequent Acute MI:

If the patient is diagnosed with another type 1 (STEMI or NSTEMI) during the four-week timeframe, that new MI would be coded to category I22, subsequent STEMI and NSTEMI.

You would also code the initial MI with the appropriate I21- code. Sequencing of the two codes would depend on the circumstances or focus for the encounter.

I22 category ONLY applies to subsequent type 1 MIs so other types of MI, such as type 2, would be captured with the appropriate code for that category.

***TIP:*** *If the patient with CAD is admitted due to an acute MI, the MI should be sequenced before the CAD.*

***About the Author:*** *Apryl Swafford is a QA Manager with SimiTree Healthcare Consulting, based in Hamden, Conn.*

***Editor's note:*** *For Coding Basics articles on hypertension/heart failure and cardiac arrhythmias, see the September and October issues of Diagnosis Coding Pro for Home Health. For a scenario on coding STEMI of circumflex artery, see insert.*

*OASIS-E*

## Understand M2010 doesn't refer to N0415 to avoid survey deficiencies

Clinicians should take note that the answer to **M2010** (Patient/Caregiver High-Risk Drug Education) does not refer to responses in **N0415** (High-Risk Drug Classes: Use and Indication).

Ensuring accuracy with M2010 is important, particularly when it comes to surveys.

Surveyors are looking for this when reviewing patient charts or visits. If clinicians mark this incorrectly it could give surveyors a reason to dig deeper,

explains Jennifer Osburn, senior clinical consultant with SimiTree Healthcare Consulting in Hamden, Conn.

It could result in a standard or condition-level deficiency depending on the severity of findings, she adds.

Clinicians often don't understand the OASIS guidance for M2010 versus N0415, says Robbi Funderburk James, director of coding and OASIS with Healthcare Provider Solutions in Nashville, Tenn. "They also often aren't given a document or other reference for a list of high-risk medications from an authoritative source."

This sometimes leads to clinicians assuming that they should only assess and provide education for the medications listed in N0415 to answer M2010.

"M2010 guidance does not reference the list in N0415," Funderburk James says. M2010 guidance states "high-risk medications" are those identified by an authoritative source.

## Identify authoritative sources

Agencies should ensure that clinicians are aware of how to access a list from an authoritative source.

***Note:*** *Keep in mind that a clinician's professional judgement should not be considered an authoritative source for this item.*

OASIS guidance provides the following examples of an authoritative source:

- The Institute for Safe Medication Practices
- The American Geriatrics Society
- The Joint Commission

Clinicians should ensure they are referencing the list prior to answering M2010, Funderburk James says.

## Tips for answering M2010

- **Identify the high-risk medications.** "To accurately answer M2010, the clinician should ensure the patient's current, reconciled medication profile is reviewed against one or more reputable authoritative sources to identify high-risk medications," Osburn says.
- **Test the patient's knowledge.** "The patient's knowledge regarding these high-risk medications should be assessed and documented, along with any teaching and instruction given because of knowledge deficits," Osburn says. Assessing the patient's knowledge can be done by asking the patient why the medication(s) were prescribed for them and what special precautions they are taking because of the drug(s), she adds.

## Responding to M2010

If high-risk medications are prescribed and education was provided within the assessment timeframe for SOC/ROC, then the item should be coded "1 — Yes."

If the patient/caregiver is fully knowledgeable about special precautions associated with all high-risk medications in their medication profile, or if there are no high-risk drugs in their medication profile, code "NA."

Otherwise, the clinician must code "0 — No" if the interventions were not completed as outlined in the item.

*Consider this patient scenario for accurately responding to M2010:*

## Scenario 1

*A patient is taking insulin, lisinopril, Xarelto and metformin at SOC. The SOC nurse references the ISMP (Institute for Safe Medication Practices) List of High-Alert Medications in Community/Ambulatory Care Settings and provides education to the patient on insulin and Xarelto. She notes that lisinopril is not on the list and for oral hypoglycemics, only sulfonylureas are on the list.*

***How would you answer M2010 for this scenario?***

- You would check response "1 — yes," because education has been provided on all of the medications considered high risk.

## Scenario 2

*The assessing clinician at SOC finds the patient is on Pradaxa, Lanoxin, Lisinopril and Metformin. You learn that he was recently prescribed Pradaxa instead of Eliquis and assumed the medications and related guidance was the same. The clinician looks up these drugs on the agency's authoritative resource list and finds that Pradaxa is listed as a high-risk medication. The patient is not aware that he should use an electric razor and soft bristled toothbrush but is able to voice other safety precautions and symptoms to report to the RN or physician. The clinician would document this information as well as the teaching of the need to use an electric razor and soft bristled toothbrush.*

***How would you answer M2010 for this scenario?***

- For this scenario, you would check response "1 — yes" because education has been provided on the new high-risk drug Pradaxa. — *Megan Herr* (*megan.herr@decisionhealth.com*)

***Editor's note:*** *Printable medication safety tips for several high-risk medications from ConsumerMedSafety.org can be found http://tinyurl.com/mtd6cax4.*