ICD-10 Challenges

- Codes are much more specific, requiring detailed knowledge of anatomy, physiology and pathophysiology.
- Intake staff need to obtain complete information at referral – *do you know what to ask for?*
- Clinicians need to document detailed assessment information, *and verify any diagnosis questions with the physician.*

Hospice Coding Challenges

- Accurately completing items on Hospice Information Set
- Correctly identifying the terminal illness, related and unrelated diagnoses
- Complying with applicable coding conventions and guidelines
- Avoiding prohibited principal diagnoses
- Impact of FY 2016 Hospice Final Rule on diagnosis selection
Common Coding Errors

- Listing only the terminal condition on the Plan of Care
- Listing a prohibited principal diagnosis
- Failure to list other conditions that co-exist, impact patient’s care or have the potential to affect response to treatment or prognosis
- Listing symptom codes when the medical record identifies a definitive diagnosis causing the symptoms

Common Coding Errors

- Listing diagnoses that are not documented in the medical record or confirmed by the physician
- Utilizing non-specific codes when the medical record has more detailed info
- Listing codes for resolved conditions
- The medical record indicates etiology-manifestation, but conditions are coded as separate unrelated diagnoses & v.v.

Common Coding Errors

- Listing incomplete codes, omitting required characters
- Failure to include Tobacco exposure, use, dependence or history as required for cardiopulmonary conditions, lung CA
- Omitting or using incorrect 7th character
- Utilizing ‘Z’ codes for complicated wounds or other inappropriate situations

Time Points for Diagnosis Coding

- Start of Care
  - Establishes plan of care
- Monthly or Per Benefit Period
  - Update as necessary to current condition: terminal condition doesn’t usually change, but other diagnoses may resolve or exacerbate in the course of hospice services
Step One: Intake

- Check the intake information:
  - What is the terminal illness?
  - Not a symptom code
  - What kind of heart disease?
  - What kind of dementia?
    - Vascular dementia? Has the patient had cerebral infarctions?
  - Any pressure ulcers? Closed and open
  - What is the etiology of any wounds?
  - Where is the neoplasm?
    - Behavior? Primary site? Secondary sites?

Step Two: Assessment

- Check the initial assessment documentation:
  - Physical assessment, including emotional state, behavior and coping of patient and family, past health history.
  - Review medical record to obtain past health history and details of current problems.
  - Review current medications and other treatment approaches to determine if additional diagnoses are suggested by current treatment regimen.
  - Verify diagnoses are documented in the medical record or confirmed with the physician. *Never list a diagnosis that is not confirmed by physician*

Step Three: IDT Meeting

- Check the IDT meeting minutes:
  - Identify the terminal condition
  - Identify related and unrelated conditions
  - Clarify manifestations such as dementia
  - Query physician when terminal diagnosis doesn’t meet criteria for hospice admission
  - Confirm the specific type of wound – i.e., whether ulcers are pressure, arterial, stasis, diabetic, etc.
  - Confirm the type and locations of tumors—i.e., primary malignancy vs metastasis and location
  - Confirm suspected diagnoses
  - Check for documentation of all communication with physician!

Terminal Illness Definition

Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual’s condition such that there is an unfavorable prognosis and no reasonable expectation of a cure; not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less.
**Related Conditions CMS Definition**

Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less.

**FY 2016 FINAL Rule**

CMS says “…we are clarifying that hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.”

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**Principal Diagnosis**

- Principal diagnosis describes the terminal illness of the hospice patient; the condition chiefly responsible for patient’s admission to hospice
- Must be determined by certification of patient’s attending physician or the hospice medical director
- Do *not* list symptoms when the underlying condition/disease is known

**Avoid codes considered non-reportable as principal diagnosis for hospice (debility, FTT, unspecified dementia)**

- Follow ICD-10-CM coding conventions and guidelines
  - No V,W,X,Y codes or Z-codes as the principal diagnosis
  - Follow sequencing rules: no manifestation codes as principal diagnosis
### Secondary Diagnoses

- Gather and consider information about related and unrelated co-existing diagnoses, which should be addressed as part of the hospice Plan of Care as determined by the IDT discussion.
- CMS expects hospice agency to provide for all aspects of care that impact the patient’s complex condition and overall prognosis as a terminally ill patient.
- Do not list symptoms when underlying condition/disease is known.
- Report all comorbid, unresolved diagnoses pertinent to POC.
- V,W,X,Y and Z codes allowed.
- May code debility, FTT and/or unspecified dementia as secondary.
- Never list a diagnosis that is resolved.

### Sequencing on POC

- Prioritize the care to be provided under hospice.
- All *pertinent diagnoses* must be listed on the Plan of Care in order of their seriousness related to the care plan.
- Sequencing of Z codes for hospice is discretionary; may be sequenced after the codes for specific diagnoses or symptoms (chapter A-R codes).

### Plan of Care Diagnosis List

- Principal diagnosis
  - Terminal condition
- Related Conditions
  - Other diagnoses affected by the terminal condition or contributing to prognosis.
- Z-codes describing relevant info.
- Unrelated Conditions
  - Additional diagnoses that impact the care or are impacted by it, even if no active interventions.
Diagnoses Must be Consistent

- The principal diagnosis must be the same across the Certification of Terminal Illness (CTI), the Hospice Plan of Care, and the UB-04 Claim Form / Notice of Hospice Election (NOE)
- Paper UB-04 claim allows 18 diagnoses, the electronic 837/5010 claim allows 25 total diagnoses

ICD-10-CM
Overview of Conventions and Official Guidelines with Updates

Placeholder ‘X’

- Addition of dummy placeholder ‘X’ is used in certain codes to:
  - Allow for future expansion
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
  - W11.xxxD Fall from ladder, subsequent
  - Can be upper or lower case ‘x’

Addition of 7th Character - Update

- Used in certain chapters to provide information about the characteristic of the encounter
- Must always be used in the 7th position
- Can be a letter or a number
  - S02.110B
  - O65.0xx1
- If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid
7th Character—Injuries

- A, initial encounter, is used while the patient is receiving active treatment for the injury. **now ignore “initial encounter”**
- D, subsequent encounter, is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase.
- S, sequelae, is used for complications or conditions that arise as a direct result of an injury (ICD-10-CM coding guideline I.C.19.a).

7th Character for Fractures

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

Inclusion Notes

Inclusion notes contain terms that are the condition for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. ‘Includes’ appears at the category level and applies to the entire category. K31.-

Excludes Notes

**Excludes 1:**
- An excludes 1 note is a pure excludes note. It means “NOT CODED HERE”
- Indicates the code excluded should never be used at the same time as the code above the Excludes 1 notes.
- Is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

**Excludes 2:**
- An excludes 2 note represents “not included here”.
- Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time
Excludes 1 Update – “Excludes 1.5”

- What about Excludes1 notes in ICD-10-CM when the conditions are unrelated to one another?
- Answer: If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note. For example, the Excludes1 note at code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes. However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and bipolar disorder.

“Excludes 1.5”

- In another example, code range I60-I69 (Cerebrovascular Diseases) has an Excludes1 note for traumatic intracranial hemorrhage (S06.-). Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage. However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from S06.- and I69.-

Laterality

- For bilateral sites, the final character of the code indicates laterality
- If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side
- An unspecified code is also provided should the side not be identified in the medical record

Sequela

- General Rule: Code what you see first and the sequela code (original injury with an S or original illness, e.g. polio) is listed second
  - G81.11 Spastic hemiplegia affecting right dominant side
  - S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
- Code the sequela code first when what you ‘see’ cannot go first (manifestation code)
  - E64.3 Sequela of rickets
  - M49.82 Spondylopathy in diseases classified elsewhere
- Combination codes: Sequela of cerebrovascular accidents
  - I69.351
Other or Other Specified

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM coding guideline I.A.9.a).

NEC—Not elsewhere classified
4th digit 8 usually, but not always

Unspecified

“Unspecified” codes should be used when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM coding guideline I.A.9.b).

NOS—Not Otherwise Specified
4th digit 9 usually but not always

Conventions—Relational Terms

- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list
- With—interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the alpha, or an instructional note in the tabular.

The Usual Basics

- Must use the alpha and the tabular
- Read everything; it all means something
- Code to the level of highest specificity
- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter
- All diagnoses must be confirmed in the medical record or verified by physician except….
Three Diagnoses coded based on clinician documentation

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stages

Careful with Complications

- Important to note that not all conditions that occur during or following medical care or surgery are classified as complications.
- There must be a cause and effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. If not clearly documented, query the provider for clarification.

Syndromes

- Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.
- No code for the syndrome? Code all the symptoms/parts separately.

Sign/Symptom Codes

- While specific diagnosis codes should be reported when they are supported by available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter.
- Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
Do/Don’t Code Symptoms

- Code the Symptoms
  - When that’s all we have documented
  - When the patient has a symptom not routinely associated with the condition
  - When there is an instruction to code the symptoms

- Do not code the symptoms
  - When a definitive diagnosis is documented by the physician
  - When the patient has a symptom that IS routinely associated with the condition

Unspecified Codes

- When sufficient clinical information isn’t known about a condition to assign a more specific code, report the appropriate “unspecified” code
- Unspecified codes should be reported when they most accurately reflect what is known about the patient’s condition at the time of the encounter.
- It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Etiology-Manifestation Codes

- When one disease or condition causes another disease or condition, the two conditions are to be coded with the cause (etiologic) listed first and the resulting second condition (manifestation) listed second
- The codes must be coded together and in this order:
  - Etiology (cause)
  - Manifestation (result of the cause)

Etiology-Manifestation

- Buddy codes—sequenced together with the etiology preceding the manifestation
- Conventions
  - Alphabetical index: two codes with second one in *italicized brackets* called manifestation
  - *Tabular List: Code title in italics (a code in italics in the tabular may NEVER be coded without its cause preceding it).*
  - *Tabular List: Code first underlying condition at manifestation code*
  - *Tabular List: Use additional code to identify manifestation (not always) at etiology*
**Code first underlying disease**

- Signifies a manifestation code
- Even though a condition is the primary focus of care, it may have to be coded second according to the coding rules
- This instruction tells you that the underlying condition (or etiology) has to be coded first before the manifestation (which is in italics)
- Code first does NOT mean code as the principal diagnosis or first-listed diagnosis

**“Code first” Sequencing**

- “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.
  - L89

**Implications of CR8877**

- “Manifestation code as principal diagnosis” edit in the Integrated Outpatient Code Editor (IOCE)
- Other diagnoses that shouldn’t be primary (ex: vascular dementia)
- Diagnoses in the SSI chapter when a related definitive diagnosis has been established or confirmed by the provider —Adult failure to thrive (R62.7) and debility (R53.81)

**Coverage Considerations**

- MAC’s have edits set to flag some diagnoses used as the terminal condition for hospice claims
- Keep up to date with your MAC’s local coverage determinations and eligibility considerations for hospice
Neoplasm Scenario 1

- Mrs. Rockwell is admitted to hospice with a terminal diagnosis of secondary metastatic CA of the liver from primary right breast CA. She also has diagnoses of CHF and Diabetes.

Neoplasm Answer 1

- C78.7 Secondary CA of liver
- C50.911 Primary CA of right female breast
- I50.9 Heart failure unspecified
- E11.9 Type II diabetes without complications

Neoplasm Scenario 2

- Mr. Battles is admitted to hospice with primary CA of the left main bronchus and the upper lobe of the left lung. He also has a history of prostate CA resolved by treatment 10 years ago. The medical record documents he is a “2ppd smoker x 30 years”
Neoplasm Answer 2

- C34.02 Primary CA of left main bronchus
- C34.12 Primary CA of upper lobe, left bronchus or lung
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- Z85.46 Personal history of prostate CA

Coding Clinic Guidance

- Coding tobacco (nicotine) use: may be based on clinician assessment and documentation of cigarette use
- Coding tobacco dependence: may be based on documentation by the physician in the medical record that patient is a “smoker” or physician documentation of tobacco or nicotine dependence
- Coding exposure to environmental tobacco smoke: may be based on clinician assessment and documentation of family member/caregiver smoking

Neoplasm Scenario 3

- Mr. Markem is admitted to hospice following exploratory surgery for abdominal obstruction. Surgery found advanced CA throughout the abdominal cavity and involving multiple organs. A colostomy was performed to relieve the obstruction. POC will address terminal dx of disseminated CA, dressing changes to abdominal incision, instruction on colostomy care and pain management due to the CA.

Neoplasm Scenario 3

- C80.0 Disseminated CA
- G89.3 Neoplasm related pain
- Z43.3 Encounter for attention to colostomy
- Z48.3 Aftercare following surgery for neoplasm
- Z48.01 Encounter for change of surgical wound dressings
Updated COPD Guidance

- J44.0 COPD with acute lower respiratory infection
- J44.1 COPD with exacerbation or decompensated COPD
  - Do not automatically use for “end-stage” - must verify “decompensated” with MD
- J44.9 unspecified COPD
  - Do not use as terminal dx for hospice

Acute exacerbation of chronic obstructive bronchitis and asthma

- An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection. **Cannot** assume an infection = exacerbation

Pulmonary Scenario 1

- Mr. Newton is admitted to hospice with a terminal diagnosis of end-stage COPD. He has MRSA pneumonia and is on po antibiotics for another 4 days. He has disabling weakness/debility, is on continuous O2. His wife of 45 years is a heavy smoker.

Considerations

- Patient currently has pneumonia and COPD dx – code J44.0?
- Can’t code “end-stage” as J44.1, but what about coding exacerbated since patient has pneumonia?
- What do you need to do before coding this patient?
Pulmonary Answer 1

- J44.1 Decompensated COPD
  - Document MD verification
- J44.0 COPD w/lower resp. infection
- J15.212 MRSA pneumonia
- R53.81 Deility NOS
- Z99.81 Dependence on oxygen
- Z77.22 Exposure to environmental tobacco smoke

Cardiovascular Update

- CAD/ASHD does not make a distinction between native arteries and unspecified
- Assume CAD is of native arteries unless otherwise stated by physician
  - I25.7- is NOT correct for any patient that has had a CABG unless MD specifies CAD is affecting graft

Heart Failure Update

- CHF coded as heart failure unspecified: I50.9
  - Look for systolic, diastolic, combined
  - Look for acute, chronic, acute on chronic
- UPDATE: pleural effusion usually considered integral to HF, but if the pleural effusion requires additional treatment (like a chest tube or tap) beyond the HF treatment (diuresis), then it may be coded separately in addition to the HF code

Cardiovascular Scenario

- Mrs. Portland is admitted to hospice with a terminal dx of acute on chronic combined heart failure. She has recurrent pleural effusions, had 1.2 liters of fluid removed in a pleural tap, refuses to have any further taps or chest tubes. Other dx of a STEMI of the LAD 5 weeks ago, chronic respiratory failure with hypoxia, and CAD. She is on O2.
### Cardiovascular Answer

- I50.43 Acute on chronic combined HF
- J91.8 Pleural effusion in conditions classified elsewhere
- J96.11 Chronic respiratory failure with hypoxia
- I25.10 CAD NOS
- Z99.81 Dependence on oxygen
- What about I25.2?

### CVA Scenario

- Mr. Innes is admitted to hospice after a massive CVA, with residual deficits of left-side hemiplegia, dysphagia, vascular dementia, and pseudobulbar affect (involuntary emotional expression disorder) – all conditions documented as due to CVA. He is combative with all care. Advance directive: refuses G-tube and DNR requested and ordered by MD. IDT minutes identify the dysphagia as the terminal condition.

### CVA Answer

- I69.391 Dysphagia following cerebral infarction
- R13.10 Dysphagia unspecified
- I69.354 Hemiplegia left non-dominant side following cerebral infarction
- I69.31 Cognitive deficit following...
- F01.51 Vascular dementia with behavior disturbance
- I69.398 Other sequela of cerebral infarction
- F48.2 Pseudobulbar affect
- Z66 DNR status

### CVA Sequela Update

- *Do NOT ever* code I69.9 for the residual deficits of a CVA, stroke or cerebral infarction!
- Physician documentation must include residuals of CVA – if not, verify when getting orders or with IDT meeting
- Hemiplegia/hemiparesis default rule
**Vascular Dementia (F01.5-)**

- CMS is rejecting as a primary diagnosis in HH and hospice
- Vascular dementia occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease

**F01-F09-Mental Disorders due to known physiological reasons**

- Disorders that have an etiology in cerebral dysfunction (cerebral disease or injury)
- Can be primary or secondary
  - If there is a ‘code first’ note then these conditions must be coded secondary.

**Vascular Dementia F01.5-**

- Let’s look at the conventions:
  - ICD-10: Code first the underlying physiological condition or sequelae of cerebrovascular disease
  - Identify if behavioral disturbances:
    - F01.50 - Vascular dementia without behavioral disturbances
    - F01.51 - Vascular dementia with behavioral disturbances
    - Use additional code for wandering Z91.83

**More Dementia**

- Senile dementia no longer acceptable term in ICD-10 – need type
- Dementia unspecified codes to F03.9- and is not allowed as a principal diagnosis for hospice
- Alzheimer’s dementia is the most common type – early vs late onset
More Dementia

☐ Cannot accept “dementia” as a terminal diagnosis for hospice
☐ Cannot accept senile dementia or vascular dementia as a primary diagnosis for home health or as a terminal diagnosis for hospice
☐ ASK: “Is this dementia of the Alzheimer’s type?”

Alzheimer’s Scenario

☐ Mr. Turner is admitted to hospice with terminal dx of Alzheimer’s dementia, recent decline with increased confusion, wandering, combative nature, gait/balance problems and is dependent for all ADL’s and care. He has stopped eating solid foods, drinks supplements, has lost a lot of weight and BMI is 17.

Alzheimer’s Answer

☐ G30.9 Alzheimer’s Disease unspec.
☐ F02.81 Dementia with behavioral disturbance
☐ R26.9 Abnormality of gait
☐ R63.0 Anorexia
☐ R63.4 Loss of weight
☐ Z68.1 BMI less than 19
☐ Z91.83 Wandering in conditions classified elsewhere

SSI Equivalent Codes

☐ R62.51 Failure to thrive
☐ R62.7 Adult failure to thrive
☐ R53.81 Debility Unspecified
☐ R99 Other unknown and unspecified cause of morbidity or mortality
  ☐ used only for those who have already died
☐ R54 Age related physical debility (old age)
  ☐ Don’t use as terminal dx for hospice
**Coding Malnutrition**

- Must have a specific diagnosis of malnutrition documented in medical record or verified with physician
  - Cannot list diagnosis based on lab results; low albumin level can be an *indicator* of protein deficiency, must query physician to confirm *diagnosis* of protein-calorie malnutrition

**Malnutrition Considerations**

- Marasmus and kwashiorkor (E40-42) affect primarily children with profound low protein and calorie intake
- If the patient is dying of malnutrition, it isn’t mild (E44.1) or moderate (E44.0)
- What about T73.0 starvation noted in Excludes 2 note?
  - This is under injuries, “deprivation of food” infers by another person

**Malnutrition Considerations**

- What about E43 Unspecified severe protein-calorie malnutrition?
  - What is *starvation edema*?
- What about cachexia?
  - General physical wasting with loss of weight and muscle mass due to a disease
  - R64 Cachexia
    - Wasting syndrome
    - Code first underlying condition, if known
    - Excludes 1: abnormal weight loss R63.4 nutritional marasmus E41

**Diagnosis of “VSED”**

- Physician documented terminal diagnosis of “VSED - Voluntarily Stopped Eating and Drinking”
- *Is there a code for this??*
Malnutrition

- “Unspecified malnutrition” 263.9 as a terminal diagnosis has been RTP (equivalent in ICD-10: E46 Malnutrition NOS)
- Need type of protein-calorie malnutrition: severe?
- Also code loss of weight and BMI

Arthritis Scenario

- Mrs. White admitted to hospice with a terminal dx of Rheumatoid lung disease with rheumatoid arthritis. She is bedfast, curled in fetal position with limbs immobile, dependent for all care and physician verified diagnoses of functional quadriplegia, pharyngo-esophageal dysphagia due to positioning, and a Stage III pressure ulcer on left buttock.

Arthritis Answer

- M05.19 Rheumatoid lung disease with R. arthritis of multiple sites
- R53.2 Functional quadriplegia
- R13.14 Pharyngo-esophageal dysphagia
- L89.323 Pressure ulcer left buttock stage III
- Z74.01 Bed confinement status

Arthritis Update

- Arthritis defaults to Osteoarthritis
- OA divided into primary OA and secondary OA - ask at intake
- Update: ankle, hand, foot and hip default to primary in index – knee does not default to primary
**MS Scenario**

- Mrs. Meyers is admitted to hospice after several recent falls related to progression of her MS. Additional related dx of neurogenic bowel and bladder (requires intermittent catheterizations), HTN, and has a UTI caused by E. coli

**MS Answer**

- G35 Multiple Sclerosis
- N31.9 Neurogenic bladder NOS
- K59.2 Neurogenic bowel NOS
- N39.0 UTI
- B96.20 E. coli as cause of diseases classified elsewhere
- I10 HTN
- Z46.6 Encounter for fitting/adjustment of urinary device
- Z91.81 History of falling

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**Diabetes with ESRD Scenario**

- Mr. Lightwood is admitted to hospice with ESRD due to diabetic chronic kidney disease. He is refusing to continue hemodialysis treatment.

- *Note: the terminal condition is the ESRD*

**DM with ESRD Answer**

- E11.22 Diabetes with diabetic CKD
- N18.6 ESRD

- What about these?
  - Z91.15 Patient’s non-compliance with renal dialysis
  - Z53.29 Procedure/treatment not carried out for other reasons (patient refusal)
Diabetes Update

- E08.- never listed first: code first the underlying condition
- No Insulin code Z79.4 with Type I DM
- ICD-10 has no code for DM Type II with ketoacidosis. CC says to use E13.10, CC has requested a new code for this condition

Reminders for Hospice

- Intake:
  - If you get a symptom at referral, ask for the underlying condition that is causing the symptom(s)
- Clinician assessment:
  - Do not list symptoms that are integral to the condition on the diagnosis list

Z Codes used for Hospice

- Z51.5 Encounter for palliative care
  - End-of-life care
  - Hospice care
  - Terminal care
- Z66 Do Not Resuscitate status
- Z74.01 Bed Confinement status
- Z98.85 Transplanted organ removal status
- Z76.82 Awaiting Transplant
- Z99.3 Wheelchair dependence
- But NEVER use a Z-code as PRINCIPAL!
What questions do you have?

- Lisa@selmanholman.com
- Teresa@selmanholman.com
- Selman-Holman & Associates, LLC
  - Home Health Insight
  - CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
  - CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice