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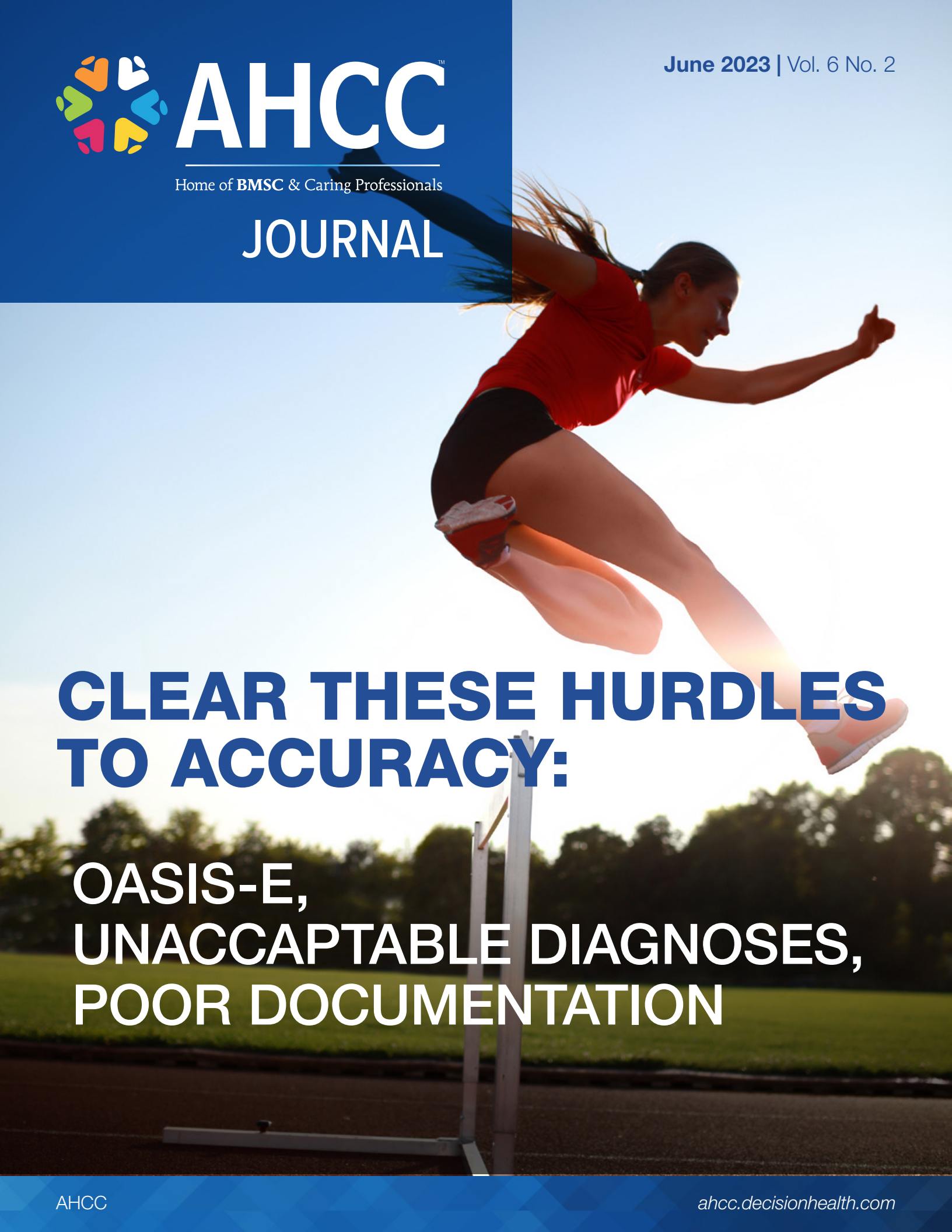

CLEAR THESE HURDLES TO ACCURACY:

OASIS-E, UNACCAPTABLE DIAGNOSES, POOR DOCUMENTATION

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NOTE FROM AHCC

BY JAN MILLIMAN, HCS-D, DIRECTOR, AHCC

It's summertime, and here at AHCC, that means we're preparing for the Home Health Coding Summit. We always look forward to getting together with long-time members and meeting folks new to the industry. We hope you're planning to join us in Phoenix this August.

In the meantime, we have plenty of helpful information to share in this issue of AHCC Journal.

First up, we take a look at the OASIS Brief Interview for Mental Status (BIMS) items. Inappropriately skipping these items can jeopardize patient care. Make sure you're painting an accurate picture of each patient's cognitive ability.

Next, we consider diagnosis coding for UTIs, one of the top 10 most commonly assigned primary diagnoses in 2022. Improve your coding accuracy by knowing when to list a UTI as primary and when it's appropriate to use a combination code.

Our focus on documentation this issue considers the importance of health literacy. Our experts offer tips clinicians can use to better measure health literacy during the assessment and better document the results.

Finally, we explore some new additions to the list of unacceptable primary diagnoses agencies reported at the end of 2022. Find out which new codes joined the list and learn some techniques for avoiding this trap.

We hope this issue brings you useful information you can put to work. We'd love to hear your thoughts about *AHCC Journal* and your ideas for future issues. You can share your feedback and ideas with us at *AHCCMembers@decisionhealth.com*.

What challenges are you facing? What wins are you celebrating? What concerns do you have about the future of home care? Please share your thoughts with us. We're here to support and celebrate the work you do.

As you can see, we at AHCC believe in the value of working together to establish excellence in home health and hospice. We look forward to continuing to work with you to build a better future for our industry. And come visit us at the AHCC booth or around the conference if you're joining us at the Home Health Coding Summit!

AHCC JOURNAL

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NOTE FROM THE BOARD

BY: ROBERT MARKETTE JR., JD, CHC, HCS-C

Dear Members,

In your hands you are holding the second issue of the *AHCC Journal* for 2023. As you open this journal, we can finally say that we have officially moved past the COVID-19 Pandemic. The Public Health Emergency is officially over, which simply means we can focus on a myriad of other compliance issues and there are plenty.

This issue has a little bit of the old and the new. Under "the old" is every home health professional's favorite billing requirement, Face-to-Face. Face-to-Face, or F2F, has been around for more than 10 years. Despite this fact, auditors continue to find new and exciting ways to use F2F to take money back from providers. It seems that every year the home health industry must respond to some "interesting" new wrinkle in F2F compliance and the last year has not been an exception.

Many agencies over the past year have had claims denied due to a failure of the F2F encounter to relate to the primary reason for which the patient is receiving home health. These denials have gone well beyond the industry's understanding of what it means for the F2F encounter to relate to the reason for home health.

This issue also looks at some of the new requirements in the OASIS-E. It will take time to really understand how assessments under OASIS-E will differ from earlier versions of OASIS. CMS has provided estimates as to the time required to complete an OASIS-E assessment. Providers had to make judgment calls to ensure proper scheduling, but are now beginning to see how it works in actual operation. Of course, the initial impact may not represent what the ultimate impact will be.

OASIS-E is not only a primary focus of this edition of the Journal, but it will also be a significant focus of your efforts in the coming months. We will be working throughout 2023 to provide you with the tools and resources you need to navigate the challenges of OASIS-E and the other challenges that are likely to arise this year. This includes our monthly *AHCC Talk* webinars in which AHCC Board Members share their insights in current coding and compliance issues.

You can expect more OASIS-E updates, as well as discussions of Face-to-Face requirements and other critical issues. *AHCC Talk* is a free benefit to our members and the industry. We encourage you to listen. Of course, our preeminent resource remains the annual Home Health Coding Summit and we hope to see many of you there in August.

Another matter that may present a challenge is the end of the COVID-19 Public Health Emergency ("PHE") on May 11, 2023. As we have mentioned in more than one prior *AHCC Journal,* this means that federal regulatory waivers will end as well. Providers who have not unwound all of the policies and procedures they implemented under the waivers will need to begin doing so to ensure they are operating in compliance with the non-waived requirements in time. Our May and June *AHCC Talk* episodes take a look at this issue.

We hope you enjoy this issue of the *AHCC Journal* and that it is a useful resource.

Sincerely,
The AHCC Advisory Board

AHCC UPDATES

Updates

Join AHCC at the DecisionHealth's Home Health Coding Summit.

We're getting ready for the 20th Home Health Coding Summit August 14-16 in Phoenix, AZ. We hope to see you there!

The event kicks off with Monday's pre-con, a Coding, OASIS, and documentation boot camp that will run through everything you need to know to master coding & OASIS review.

New this year: Tuesday morning, AHCC launches the Main conference by honoring the 2023 AHCC Achievement Award winners. We're excited to introduce our winners and celebrate all that they do for the industry.

Then, it's on to the main conference sessions that cover all the coding updates and challenges you need to know. Each year, this conference brings together the perfect blend of excellent speakers and motivated professionals. We hope you'll join us.

Reminders

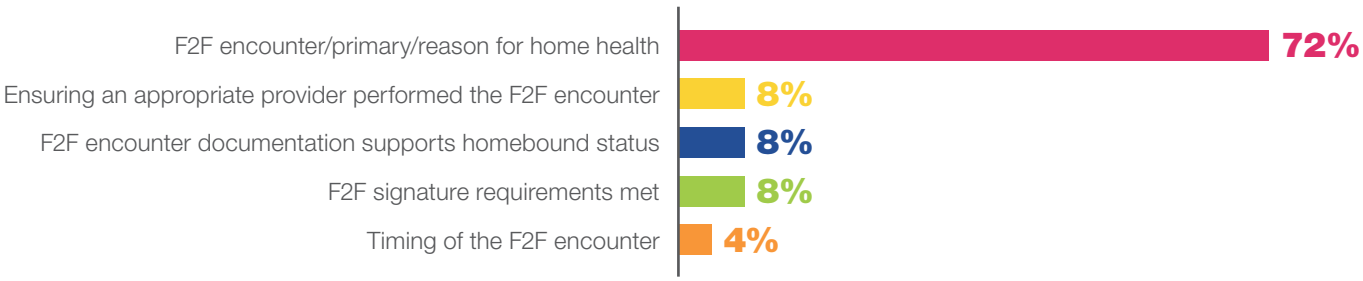
AHCC Talk

Our March *AHCC Talk* looked at Face-to-Face issues. Listeners reported that the most challenging aspect of a compliant F2F was making sure the F2F encounter matches up with the primary reason for home health.

In April, our *AHCC Talk* episode introduced two Face-to-Face tools developed by AHCC's Documentation Committee. These tools should help to alleviate some of the F2F challenges you face. The Face-to-Face checklist walks you through the areas you need to check to be sure F2F documentation is compliant. And the Face-to-Face Decision Tree will help you know what to do when you hit a F2F roadblock. Both tools are on the AHCC website under Resources/Tools.

Watch the March *AHCC Talk* here: *https://ahcc.decisionhealth.com/ahcc-talk-episode-54-f2f-tools/*

Which of the following aspects of a compliant F2F do you find most challenging?



BMSC CEUs

Earn 2 BMSC CEUs from AHCC Journal

You can earn two CEUs by taking the *AHCC Journal* quiz.

Access Journal CEU quizzes:

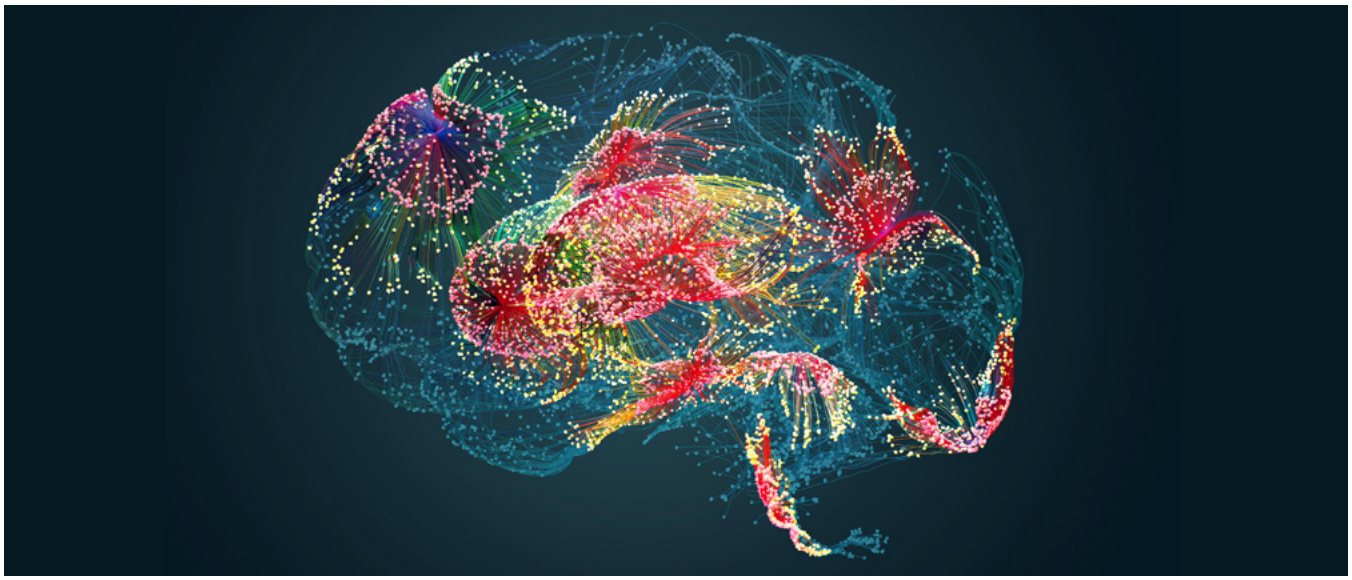
1. Sign into the AHCC website.
2. Access the "Publications" menu and select "AHCC Journal."
3. Click on the CEU Quiz button.
4. Create a new User ID or, if you've used our free CEU Quiz Center before, you can log in with your previous User ID and password.
5. Once you've logged into the Quiz Center, click on the "Exams" tab.
6. Select the "AHCC Journal" quiz you wish to take. (Each quiz indicates the month and year.)

AHCC Insider CEU opportunities

Each month, you can earn 1 BMSC CEU by taking a quiz based on *AHCC Insider,* AHCC's azine.

Read past issues here: *https://ahcc.decisionhealth.com/ahcc-insider*.

Access your quizzes on the Publications page of the AHCC website.



Improve OASIS Accuracy: Know when to say No to C0100

Don't skip BIMS for patients with cognitive impairments.

Conducting the Brief Interview for Mental Status (BIMS) helps identify cognitive impairments and ensures patients get effective care. Yet many clinicians inappropriately skipped the new Section C: Cognitive Patterns items during the early days of OASIS-E.

Clinicians aren't always conducting the BIMS when they should be, says Brandi Whitemyer, RN, CDIP, COS-C, HCS-D, HCS-O, Ohio-based independent home health and coding expert.

Without accurate documentation in Section C, the family and caregivers might not get the education they need to best care for the patient, increasing the risk of poor outcomes and more serious impairments down the road.

Don't Make this BIMS Mistake

Item specific guidance for C0100 (Should Brief Interview for Mental Status (C0200-C0500) be Conducted?) advises "Attempt to conduct interview with all patients."

Problem: Response 0. No (patient is rarely/never understood) may be confusing clinicians.

Clinicians may assume patients with dementia and other cognitive disorders don't need the BIMS, but this assessment shouldn't be skipped just because the patient has confusion or cognitive impairments.

Mistake: Patients with confusion and cognitive impairment aren't necessarily patients who are rarely or never understood.

It's more appropriate to skip the BIMS for patients who are non-communicative such as those who are non-verbal and unable to communicate in writing. And patients who are unable to hear, see, and speak might be unable to hear the questions, visualize written questions/cues, and speak or write responses, Whitemyer says.

Even if you expect nonsensical, inappropriate, or inapplicable responses to the questions posed in C0200-C0400, you should still conduct the interview unless the patient is rarely or never understood.

If a patient fails to respond to a specific item or question or a response is nonsensical, inappropriate, off topic or inapplicable, the appropriate response is "0," Whitemyer explains.

Understand BIMS intent

The purpose of the new mental health section is to obtain an accurate and reliable understanding of the patient's cognitive performance, says AHCC advisory board member Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy in Denton, Texas.

Don't stray: "The new mental health items are meant to be conducted as a clearly structured cognitive interview," Minton says.

The BIMS items include:

Section C: Cognitive Patterns

- C0100 (Should Brief Interview for Mental Status (BIMS) be Conducted?)
- C0200-C0500 (Brief Interview for Mental Status (BIMS))
- C0200 (Repetition of Three Words)
- C0300 (Temporal Orientation)
- C0400 (Recall)
- C0500 (BIMS Summary Score)

Without an attempted structured cognitive interview, a patient might be mislabeled based on their appearance or assumed diagnosis, CMS warned in the January 2023 CMS Quarterly OASIS Q&As.

These structured interviews efficiently provide insight into the patient's current condition which will enhance good care, Minton says. Not following the structure could lead to assigning the wrong score which could prevent appropriate care and interventions.

For example: When conducting the BIMS interview for a new patient, she is unable to repeat any of the words included in the prompt at C0200 (Repetition of Three Words) after the first attempt. You let the patient try again. The patient remembers "blue" and "bed." You score her at a "2. Two" instead of a "0. None."

In this case, the total score indicates a moderately impaired individual rather than a patient with severe impairment.

The failure to score correctly could directly impact the care and services the patient needs as well as the education and support that the family requires in caring for the patient, Minton explains.

Important: Answering this section is not about speed or just "checking the box." "Efficiency is the key, but accuracy is imperative," Minton says. "Conduct audits and ride-alongs to ensure the process is consistent and accurate."

Could your software help?

EMR systems can supplement a "0. No" answer with additional prompts asking clinicians to include a reason for the response, CMS said in the January OASIS Q&As.

This additional data collection is compliant as long as it's part of the comprehensive assessment and doesn't compromise the integrity of the OASIS question, explains BMSC Exam Committee member Lisa McClammy, BSN, RN, COS-C, HCS-D, HCS-O, senior clinical education consultant with MAC Legacy in Denton, Texas.

Being able to record the reason for the "0" response as they asked the questions would take a lot of burden off the clinician, McClammy says.

The EMR system can then prompt the clinician if the patient has refused to answer or answered nonsensically to four or more of the questions in C0200 - C0400, rendering the interview incomplete, McLammy says. "This would be a huge improvement that software companies can make."

RESOURCE

January 2023 CMS Quarterly OASIS Q&As: *https://qtso.cms.gov/system/files/qtso/CMS_OAI_4th%20Qtr_2022_QAs_Jan_2023_final_v_508.pdf*

UTI among the top 10 most commonly assigned primary codes in 2022

Urinary tract infections were among the top 10 most commonly assigned home health primary diagnoses in all of 2022.

The code, N39.0 (Urinary tract infection, site not specified) landed at number eight on the list, which was based on 6.2 million periods in total from Strategic Healthcare Programs' National Client Database.

N39.0 also fell at number 10 on the top 10 list of primary diagnoses for the first half of 2021.

While common, it's important to consider that if untreated, a UTI can be life threatening and lead to a more severe infection including sepsis and renal failure. This makes it important to capture the condition accurately through coding.

Opinions appeared to be mixed around seeing the code among the top 10.

"I find this interesting since UTIs often resolve within a 10-day to 14-day period of time," notes BMSC Exam Committee member Sherri Parson, RN, HCS-D, HCS-O, HCS-H, COS-C, chief compliance officer/director of operations with Infusion Health in Ypsilanti, Mich. "Listing a UTI first means that it is the focus of the episode and primarily driving the entire episode."

Unspecified UTI wouldn't even account for complications, Parson says.

"In some cases, a patient may have both sepsis that has resolved and the local infection that caused the sepsis (UTI in this case), but patient is still receiving treatment for the local infection," Parson explains. This could possibly be one of the reasons why this is coded so frequently, she says.

Other experts say it is not entirely surprising to see UTI among the top codes.

"UTIs are a top reason that many elderly patients seek medical assistance," explains AHCC Advisory Board member Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy in Denton, Texas. "And a UTI in the elderly can present itself in ways that can seem unexpected."

The first clue in some cases can be confusion or an altered mental status, Minton says.

Don't miss these combination codes

When coding for UTIs, keep in mind that ICD-10 does include combination codes for some urinary tract infections resulting from certain organisms, such as those due to candida (yeast).

When the causative organism is known, reference both the Alphabetic Index and the Tabular List before selecting a code to make certain there is no combination code for the patient's specific UTI.

If no combination code is listed, code the causative organism following the UTI code.

Always consider:

- Does the record indicate the UTI is an active infection?
- Is there a more specified site of the UTI such as cystitis?
- Do you know the underlying organism that caused of the infection?

Know when to assign primary

When a UTI is the primary focus of the episode and driving the episode of care, list it as primary, Parson says.

Ensure that the infection is still an active diagnosis or that symptoms related to the urinary tract infection are still resolving before coding, Minton says. "If that is the focus of care then you can code it as primary," she says.

UTIs can be tricky to code if the patient is no longer on antibiotics but is severely debilitated and in need of therapy because of weakness from the infection, Minton says.

"Weakness may be a documented result of the resolving UTI and should be coded as such," Minton says.

> **"UTIs can be tricky to code if the patient is no longer on antibiotics but is severely debilitated and in need of therapy because of weakness from the infection."**

Important: Unless a diagnosis is clearly documented as resolved by the provider, do not assume the condition is no longer present, says Ohio-based independent home health and coding expert Brandi Whitemyer, RN, CDIP, COS-C, HCS-D.

"This same concept applies to UTIs in the way it does other conditions," Whitemyer says. If you suspect due to conflicting documentation that the UTI is resolved and should not be coded, but it is not clearly indicated, query the provider, she says.

Scenario: UTI due to candidiasis

A 70-year-old woman is admitted to home health following a provider visit for a new onset of UTI due to candidiasis. The patient also has CKD stage 4.

Code the scenario:

Description	Code
M1021a: Other urogenital candidiasis	B37.49
M1023b: Chronic kidney disease, stage 4	N18.4

Rationale:

Reference the causative organism, candidiasis, in the Alphabetic Index. Look at the list of codes under Candidiasis B37.9 for the site of your patient's infection. If the site is specifically listed, assign the combination code.

In this case, you'll see an entry for urogenital site, NEC, B37.49. B37.49 represents both the UTI and the causative organism, candida.

The patient also has stage 4 chronic kidney disease. Assign additional code N18.4 (Chronic kidney disease, stage 4).

Scenario: UTI/acute kidney injury

A 78-year-old female is referred to home health for recent episode of UTI and acute kidney injury resulting in hospitalization. The UTI was caused by E.Coli per the medical record. The patient also has hypertension and chronic kidney disease stage 3. The patient continues to take her oral antibiotics and the symptoms are improving. Home health is ordered for teaching and training/observation and assessment related to the infection and physical therapy due weakness following the UTI and hospitalization.

Code the scenario:

Description	Code
M1021a: Urinary tract infection, site not specified	N39.0
M1023b: Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere	B96.20
M1023c: Acute kidney failure, unspecified	N17.9
M1023d: Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I12.9
M1023e: Chronic kidney disease, stage 3 unspecified	N18.30

Rationale:

- List N39.0 as primary because the UTI is the focus of care.
- Next, include B96.20 to capture the bacterial agent identified as the cause of the UTI. E. Coli is one of the more common bacterial agents identified in UTIs, and this code indicates E. Coli is specified as the cause.
- Capture the acute kidney injury with N17.9. Coding Guidelines (N17) (Section I.C.9.a.2) advise that if a patient has hypertensive chronic kidney disease and acute renal failure, you should also code the acute renal failure. Sequence according to the circumstances of the admission/encounter.
- I12.9 captures the hypertensive chronic kidney disease. Remember Guidelines (I12) (Section I.C.9.a.2) instruct you to assign codes from category I12 (Hypertensive chronic kidney disease), when both hypertension and a condition classifiable to category N18 (Chronic kidney disease (CKD)), are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.
- Per coding guidelines [I.C.14], include the appropriate code from category N18 as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.
- Finally, list N18.30 to capture the chronic kidney disease as stage 3. We are not clear if it is stage 3 a or b, so use the unspecified code.

EDITOR'S NOTE:
The coding scenarios were provided by Sherri Parson, RN, HCS-D, HCS-O, HCS-H, COS-C, chief compliance officer/director of operations with Infusion Health in Ypsilanti, Mich. and Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy in Denton, Texas. For a tool on coding for UTI, see insert.

DOCUMENTATION TIP

Help patients open up about health literacy for accuracy with OASIS-E

Instruct patients to read their medication labels and teaching sheets out loud to assess for vision but also to assess how well patients read and comprehend health information.

This information allows clinicians to answer B1300 (Health literacy) more accurately and can create a more tailored care plan fostering better management of medications and fewer ER visits.

Assessing a patient's ability to understand health information has always been important, but there has been a renewed focus on health literacy since the implementation of OASIS-E, says AHCC Advisory Board Member Claudia Baker, RN, MHA, HCS-D, HCS-O, senior manager with SimiTree Healthcare Consulting. Without the ability to understand and use health information, patients can't effectively make informed decisions and understand how to best care for themselves, she explains.

Patients who cannot understand information provided to them are less likely to follow treatment plans or effectively manage their medications, and they may go to the emergency room unnecessarily to seek care or not seek care at all due to a lack of understanding about their disease process, Baker says. A lack of comprehension is linked to worse outcomes, the receipt of fewer preventive services and overall higher medical costs, she adds.

Promote open conversations about care

There are a couple of things clinicians need to keep in mind to accurately assess health literacy, Baker says:

Patients may be embarrassed. Patients might not want to admit that they can't understand something. Clinicians should hold back any

judgement and reassure patients that it's okay to not understand something.

Patients think their health literacy is better than it is. Patients may overestimate their ability to understand. This can lead to an inaccurate assessment. If a clinician suspects that a patient isn't actually understanding what they are being told, the clinician can explain it again in simple terms.

Since B1300 is a self-reported question that must be answered with the patient's response, it can open a dialogue with patients to further explore their abilities to comprehend, Baker explains.

Be sure to use open-ended questions because close-ended questions will produce a "yes" or "no" response and aren't as helpful, she says.

Asking a patient to demonstrate that they know how to do something will produce a more accurate assessment than just asking a patient if they know how to do something, Baker says.

Gauge literacy throughout assessments

While the OASIS-E question surrounding health literacy is self-reported, clinicians can assess health literacy throughout the patient assessment, Baker says.

- Ask the patient to explain their medications. "When talking to the patient about their medications or disease processes, have them explain what they know," she recommends.
- Have the patient explain what they are taking the medication for, what the side effects are and for what condition the medication is used to treat.
- Ask the patient to demonstrate tasks. For example, Baker says clinicians can instruct the patient to show how they use a glucometer as opposed to just asking if they know how to use it.
- The same goes for therapy, Baker says. "The patient may have been provided with a home exercise plan, but they only are able to figure out what to do based on the pictures, not the written instructions," she explains.

Clinicians can ask the patient to explain and demonstrate how they will carry out the exercises.

"It may become evident that further instruction is needed, or the use of an interpreter or caregiver support is needed for the patient to fully capture what needs to be done," Baker says.

"While the OASIS-E question surrounding health literacy is self-reported, clinicians can assess health literacy throughout the patient assessment."

Use simple language. Assess the patient using simpler, plain language where possible. For example, clinicians can call a glucometer a "blood sugar machine" instead.

Simple language can extend to using illustrated instructions as well.

"Information that is provided verbally can be repeated as needed while assessing the patient's level of understanding along the way," Baker says.

Link literacy to patient goals. "Literacy issues can be multifactorial, so continuing to reassess and confirm that patients understand how to apply the health knowledge to their daily care is key," says Lisa Newell, chief clinical officer at Corridor in Overland Park, Kan.

This is why linking the goals of care to something that matters to the patient is very important for long-term success.

For example, a patient looking to gain independence might be more willing to learn about their condition and care if it means they will gain independence sooner.

Educate clinicians on health literacy

Clinicians should familiarize themselves with resources available on health literacy.

The U.S. Department of Health and Human Services has lots of information available on its website (see link below) that offers tips on how

clinicians can have clearer communication, Baker notes. Agencies should provide all staff with methods for understanding and promoting health literacy, which will benefit patients, families and employees as well, she says.

"Everyone, no matter how educated, is at risk for misunderstanding health information at times," Baker adds.

The more educated the clinician is, the better they can educate patients. Look at your written materials for patients, especially those that teach disease management to ensure they were designed in a way that addresses patients with low health literacy, Newell recommends.

Take note: Health literacy may or may not improve over a course of care because of all the variables at play, Newell explains. Clinicians and patients should be aware of limitations, and address those in a way that seems like a positive step forward, she recommends.

RESOURCE

Health literacy information from the U.S. Department of Health and Human Services: *https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy*.

Unacceptable diagnosis codes continue to cause rejections

Now, over three years since the implementation of PDGM, some agencies are still using unacceptable diagnosis codes as primary diagnoses leading to unnecessary claims rejections.

While many of the codes on this list of unacceptable diagnoses are the same old culprits, new inclusions point to training opportunities and query process changes.

Unacceptable diagnosis codes appeared as the primary diagnosis in 687 out of the 359,430 30-day periods in December 2022, according to data from Strategic Healthcare Programs (SHP).

The frequency has declined as agencies continue to settle into PDGM, but it seems some agencies are still sending assessments for coding with referral and medical records giving a reason for home health that cannot be listed as primary, notes AHCC Advisory Board Member Nanette Minton, RN, HCS-D, HCS-H, HCS-O, senior clinical coding manager with MAC Legacy in Denton, Texas.

The problem: In these cases, documentation often points the coder to a symptom code rather than an actual diagnosis or the reason for the symptom.

Among the top 10 unacceptable diagnosis codes were symptoms such as muscle weakness; weakness; low back pain, unspecified; and repeated falls.

QA Tip: Add a step to your quality assurance process that checks for any unacceptable diagnosis codes as a way to avoid getting claims rejected for not having a valid primary diagnosis under PDGM.

"Some software programs may even have an internal scrubber that will check for these things or give you an error of some sort," Minton says.

New entries in the top 10

While several of the top 10 codes have remained on the list for years, there were a few newcomers — such as N18.6 (End stage renal disease) and C34.90 (Malignant neoplasm of unspecific part of unspecified bronchus or lung).

End stage renal disease (N18.6) is a tricky one, notes BMSC Exam Committee member Apryl Swafford, RN, BSN, COS-C, HCS-D, HCS-H, QA manager with SimiTree Healthcare Consulting in Hamden, Conn.

Caution: ESRD, in patients undergoing dialysis, is covered under a separate benefit by Medicare outside of the home health benefit, she explains. "We have to be very careful not to cross the line between what we are doing for the patient and what the ESRD benefit covers. If we creep over that line, most likely someone is not going to get reimbursed — and it could very well be the home care agency."

While an agency may get a referral for ESRD or a new AV graft, an agency must realize that those things are covered by the ESRD benefit so we would need to look at what we can do in relation to the patient's diagnosis, she says.

For example, Swafford says teaching management of hypertension and diabetes if applicable, as these are very often linked to the ESRD.

"It can be a slippery slope, so agencies need to be careful when they get these types of referrals," she says. "Keep in mind that ESRD referrals can come in for patients who are not undergoing dialysis so those would be a different scenario."

Oftentimes, those referrals can be hospice appropriate, and agencies can talk with the patient and family about appropriate levels of care if this applies, Swafford adds.

Top 10 Unacceptable Diagnosis codes

These 10 unacceptable diagnosis codes accounted for nearly 28% of the 687 unacceptable diagnosis codes listed as primary in the month of December 2022, according to the Strategic Healthcare Programs' (SHP) National Client Database.

ICD-10 Code	Description	Periods Count
M62.81	Muscle weakness (generalized)	43
R53.1	Weakness	28
R26.9	Unspecified abnormalities of gait and mobility	20
R26.89	Other abnormalities of gait or mobility	19
R29.6	Repeated falls	17
R55	Syncope and collapse	14
N18.6	End stage renal disease	13
M19.90	Unspecified osteoarthritis, unspecified site	13
M54.50	Low back pain, unspecified	12
C34.90	Malignant neoplasm of unsp part of unsp bronchus or lungs	12

Source: Strategic Healthcare Program's National Client Database

"As for C34.90, I feel this is simply due to an oversight for those coding not remembering that this code is too unspecified to use as a primary diagnosis," Minton notes.

Ongoing issue

Experts express their surprise over continued use of unacceptable primary diagnoses.

"My thought is that these are cases that slipped through the agency's QA process," says Minton.

"The first six codes in that list were very surprising to me," Swafford agrees. These codes were identified as unacceptable diagnoses if used in the primary position prior to the start of PDGM. "It is troubling that agencies are still assigning those as primary diagnosis this far down the road," she says.

Query the provider to determine the underlying cause of the symptoms, Swafford suggests. "That is what Medicare is looking for as far as the primary diagnosis or focus of care," she adds.

There is no choice but to ask for additional information, unless the actual face-to-face encounter notes a diagnosis that indicates the underlying cause of the unacceptable diagnosis, Minton agrees.

Try this: Offer education to providers who routinely send referrals with unacceptable primary diagnoses and without any underlying cause or etiology.

For example: "Many health-related issues can cause muscle weakness and the industry needs to do a better job of educating the providers that we must have the underlying cause," Minton adds.

Providers need to understand that CMS, in line with the ICD-10-CM Official Guidelines for Coding and Reporting, expects the primary diagnosis for any symptom to be the underlying cause and not the symptom itself.

"Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established," the Coding Guidelines advise at Section IV.D.

Exceptions: Keep in mind that there are a few exceptions to this guideline, Swafford says. Namely, the dysphagia codes that fall into the R13.1 (Dysphagia) category. There is a very small number of R codes that are allowed as a primary diagnosis, she says.

Hypertension, bronchiectasis

Q: A patient was referred to home health for observation, assessment, teaching and training on an exacerbation of hypertension requiring medication changes. She attends dialysis three times a week but needs further education related to the hypertension. The patient also has bronchiectasis and obstructive sleep apnea. How should we code for this patient?

A: List I12.0 first because there is no stated cause of the renal disease requiring dialysis so there is an assumed relationship between the hypertension and the CKD.

Sequence N18.6 next because the "code first" note at N18 requires you to code the cause of the kidney disease first. In this case, the patient's hypertensive kidney disease. Although the documentation doesn't specify the stage of the kidney disease, chapter-specific guidance at Chapter 14: Diseases of the genitourinary system advises you to code N18.6 as the stage of kidney disease for a patient is documented as receiving dialysis.

List J47.9 and G47.33 next to capture the comorbidities.

Finally, add Z99.2 to indicate the patient is receiving dialysis. A "use additional code" note at N18.6 requires you to list Z99.2 to capture dialysis status. This code is used when a patient requires any kind of renal dialysis, whether peritoneal or hemodialysis.

Your final code sequence for this patient should be:

Description	Code
M1021a: Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	I12.0
M1023b: End stage renal disease	N18.6
M1023c: Bronchiectasis, uncomplicated	J47.9
M1023d: Obstructive sleep apnea (adult) (pediatric)	G47.33
M1023e: Dependence on renal dialysis	Z99.2

AHCC EXPLAINS

BMSC Credential CEU Requirements

Q: How many CEUs are required to recertify my BMSC credential?

A: You must earn twenty (20) CEUs between the anniversary date and expiration date of your current credential cycle before you can recertify. To recertify you must:

1. Earn 10 educational CEUs and log them in your CEU Tracker. Make sure to keep any documentation of CEUs for at least one year for auditing purposes. You can earn one CEU each month by taking a monthly quiz based on AHCC Insider content. And you can earn additional CEUs by taking a quarterly quiz based on AHCC Journal content. Visit the *Publications* page to find a link to your available CEU quizzes.
2. Take the two annual self-assessment quizzes. The 10 CEUs earned from taking these self-assessments will load into your tracker automatically within three business days. Please keep the self-assessment CEU certificates for your records, in case you are audited.
3. Once you have all 20 CEUs (10 educational, 10 from the self-assessments) logged, you can pay your recertification fee by clicking the blue "Recertify Now" button on your CEU tracker.

MEET A MEMBER

AHCC Member Profile:

Kyla Hemeyer, RN, BSN, HCS-O, HCS-D, Coding and OASIS Resource Nurse Specialist

Q: Kyla, what do you do all day?

A: ICD-10 Coding, OASIS-E review at all time-points, POC for all appropriate orders for all disciplines, Data Analysis, Teaching of OASIS to staff members, Utilization Review, Case Conference, PDGM review at mid-episode for accurate coding and LUPA management, Cohesive chart review, Hospice coding, Audits of clinician documentation.

Q: What did you do before entering home health?

A: Hospital and SNF Nursing-RN.

Q: How long have you been in home health?

A: 30 years.

Q: Why did you get into this line of work?

A: As a teenager I spent a lot of time (4 months) at a hospital visiting my mother who had been seriously injured in a car accident. That is what prompted me to become a nurse 40 years ago.

Q: What has been your biggest challenge?

A: Trying to stay up to date with CMS rules and regulations to make sure the agency has the maximum payment that is rightfully due.

Q: What has been your biggest reward?

A: Mastery of ICD-10 Coding

Q: How has the field changed since you began working in home health or hospice?

A: I started before OASIS and remember from the beginning the changes over the years. The patients seem to be much more acute than when I first started in HH 30 years ago.

Q: How has BMSC certification helped in your professional career?

A: It is a requirement for any Coding and OASIS job.

Q: What do you like most about being an AHCC member?

A: The articles and educational opportunities for CEUs and recertification, also the job board is a nice benefit.

Q: If you have attended, how many Coding Summits have you been to? What are your favorite memories?

A: I have been to several over the years. I have attended other Coding Conferences also. Best memories — when switching to ICD-10 and testing in Memphis, TN and staying at the Peabody Hotel. I knew a group of coders and we had a nice time throughout the conference.

Q: What piece of advice would you offer to someone new to home health or hospice?

A: You have to like documentation accuracy and be able to follow the CMS rules. From a patient

perspective, there is no better nurse to patient experience than with home health — you develop life-long relationships with your patients.

Q: If you could have any other job, what would it be?

A: A nursing professor — I think I would have liked teaching nursing students.

Q: What was your first job (what did you do while in high school)?

A: I was a lifeguard and taught swimming lessons most summers.

Q: A few of your favorite things:

A: Vacation spots: Sanibel Island

Hobby: Knitting, gardening, trail biking, comping, mountain hiking

Non-alcoholic beverage: Iced Tea

Foods: Green Smoothies

Activity: Trail biking, camping, mountain hiking and camping

MEET A MEMBER

BMSC Exam Committee member profile

Kelly Kavanaugh, RN, HCS-D, HCS-H, HCS-O, BCHH-C, Team Manager, SimiTree

Q: Kelly, what do you do all day?

A: I currently work doing coding, OASIS and POC reviews and manage a team of folks who do the same.

Q: What did you do before entering home health or hospice?

A: I have been in home health and Hospice for my entire career. I started out in home health working in a home health agency office at the age of 19, went to nursing school and have been doing home health and hospice ever since. I have held just about every position possible from field visits, weekends, on call, triage, case management, education, DON, Administrator and agency ownership. I began coding and OASIS reviews when I became certified in 2005, mainly in house reviews for my own agencies. I branched out to coding for other agencies and outsource companies throughout the last 12 years.

Q: How long have you been in home health?

A: 35 years.

Q: Why did you get into this line of work?

A: I was working in a home health office – typing plans of care, processing handwritten verbal orders and doing the scheduling of visits with magnets on the wall. They asked me to do a ride out with a nurse to take pictures for a marketing flyer. I fell in love with what the nurses were doing for the elderly that day and made the decision to go to nursing school with a goal to work in home health.

Q: What has been your biggest challenge?

A: All the changes we have seen in the industry with CMS regulations.

Q: What has been your biggest reward?

A: Helping people — from patients to staff. I love educating others.

Q: How has the field changed since you began working in home health?

A: Wow, there have been so many changes in 35 years! Some have been good — I believe the level of professionalism has increased through the years. The complexity of what we are able to do in the home setting has improved and kept people from having to seek a higher level of care as often. Some have not been so good – the sheer volume of documentation required in home health and hospice increases every year and makes one wonder if patient care doesn't suffer as a result. The complexity of the rules and regulations and the differences with which CMS contractors interpret the rules leave many a home health agency scratching their heads.

Q: How has BMSC certification helped in your professional career?

A: Having multiple certifications in home health has opened many doors for me and added an additional level of knowledge base to my career.

Q: What do you like most about serving on the BMSC exam committees?

A: I enjoy collaborating with peers, hearing different points of view from different sides of the picture and being able to add input from my perspective to the group. I really enjoy helping to create exam questions. Creating just the right scenarios to extrapolate the desired knowledge base is enjoyable for me. It is almost like working a puzzle.

Q: If you have attended, how many Coding Summits have you been to? Any favorite memories?

A: I have attended many Coding Summits in the past as well as OASIS Conferences too. I have even had the pleasure of speaking at a few over the years.

Q: What piece of advice would you offer to someone new to home health or hospice?

A: Hang in here! Seek out a knowledgeable advisor. Don't give up. It is difficult, but it is one of the most rewarding careers you can have and well worth the effort required. It's ok to not know everything, just do your best and strive to be better today than you were yesterday.

Q: If you could have any other job, what would it be?

A: Retired! Hahaha I couldn't imagine doing anything else.

Q: What was your first job (what did you do while in high school)?

A: I worked at Burger King when I was 15 years old as my very first job. That's when I decided I needed to make good grades to get into college so I didn't have to do that job forever.

Q: A few of your favorite things:

Vacation spots: I love to travel anywhere! My goal is to visit all 50 states in my lifetime. 36 and counting so far.

Hobby: Horses and all things horse related — showing, riding, breeding and raising babies/foals.

Non-alcoholic beverage: Coffee.

Foods: Popcorn, tacos and crab legs — maybe not together though!

Activity: We have a family tradition of baking cookies at Christmas — we bake together as a family for 4 days and give the cookies away as gifts. I love camping and hiking, going to horse events, gardening, and spending time with my dogs and friends.

Clockwise from left: Kavanaugh with Rowdy, Christmas with family, Kavanaugh with Ben