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Our Panel

Host

Jan Milliman, HCS-D,
Director, AHCC

Panelist

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HCS-D, HCS-O,
Executive Director of
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Panelist

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COS-C, HCS-D, HCS-H,
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Coding Scenarios

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Scenario 1

The patient was admitted to the hospital for COPD exacerbation, pneumonia due to klebsiella pneumoniae, centrilobular emphysema, and mild persistent asthma with acute exacerbation. The patient has a 30-year history of cigarette smoking and quit 2 years ago. The home health nurse documents that the focus of care is the COPD exacerbation.

How would you code for this patient?

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Scenario 1 Answer

The patient was admitted to the hospital for COPD exacerbation, pneumonia due to klebsiella pneumoniae, centrilobular emphysema, and mild persistent asthma with acute exacerbation. The patient has a 30-year history of cigarette smoking and quit 2 years ago. The home health nurse documents that the focus of care is the COPD exacerbation.

- 44.1 - Chronic obstructive pulmonary disease with (acute) exacerbation
- J43.2 - Centrilobular emphysema
- J44.0 - Chronic obstructive pulmonary disease with (acute) lower respiratory infection
- J15.0 - Pneumonia due to Klebsiella pneumoniae
- J45.31 - Mild persistent asthma with (acute) exacerbation
- Z87.891 - Personal history of nicotine dependence

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Scenario 2

The patient was admitted to the hospital and diagnosed with MRSA sepsis related to a UTI. The hospital visit notes from the provider document severe sepsis with acute kidney failure.

The patient was hospitalized for 10 days and discharged home with orders for home health. The discharge orders indicate that the acute kidney failure has been resolved prior to the patient discharging home, although the patient does have a history of CKD stage 3b. The patient also has a diagnosis of HTN.

The patient continues at home with IV antibiotics for 20 more days post hospital discharge. Home Health SN will provide IV administration and PICC dressing changes. The PT will provide interventions to improve patients' mobility and include a fall prevention program.

How would you code for this patient?

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Scenario 2 Answer

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- A41.02 - Sepsis due to Methicillin resistant Staphylococcus aureus
- N39.0 - Urinary tract infection
- I12.9 - Hypertensive CKD with Stage 1 through Stage 4 CKD, or unspecified CKD
- N18.32 - CKD Stage 3b
- Z45.2 - Encounter for adjustment and management of vascular access devices
- Z79.2 - Long-term (current) use of antibiotics

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Scenario 3

History of Present Illness:

Patient is a 69 y.o. male with a medical diagnosis of MVC WITH MULTIPLE FRACTURES .

Patient is a 69 y.o. male with a past medical history of hyperlipidemia, Type 2 diabetes, and obstructive sleep apnea who presents to Hospital after a motor vehicle collision. He had a CT of the cervical spine as well as a chest abdomen pelvis CT that demonstrated a possible fracture of the C6 vertebral body that was ruled out later and an L1 compression fracture.

He has overall mild to no neck pain but does have low back pain. He did not lose consciousness. Denies headache, nausea, vomiting, weakness, numbness, tingling, dizziness, or other focal neurological deficit.

How would you code this scenario?

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Scenario 3 Answer

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- S32.018D - Other fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
- E11.9 - Type 2 diabetes mellitus without complications
- G47.33 - Obstructive sleep apnea (adult) (pediatric)
- E78.5 - Hyperlipidemia, unspecified

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Scenario 3 Answer

- S32.018D - Other fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing
- E11.9 - Type 2 diabetes mellitus without complications
- G47.33 - Obstructive sleep apnea (adult) (pediatric)
- E78.5 - Hyperlipidemia, unspecified

- NOTES: This was coded to S32.010D Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing. In order to code to wedge compression, the provider must document it was a wedge compression. Since this was documented only as compression fracture, we would use other specified since there is no specific listing for compression fracture of L1.

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Scenario 4

Scenario: 47yoF w/ PMH of bipolar disorder, anxiety, HCV s/p treatment, PMSU including IVDU, E faecalis bacteremia, aortic valve endocarditis, extensive spinal infection (L4-S1 paravertebral abscess w/ OM/discitis, L4-S1 SA, R paraspinal musculature abscess) s/p laminectomy, abscess evacuation, instrumentation of L2-S1 on 8/2/25 (OR cx w/ E faecalis) with plans to complete 6 weeks of ampicillin/ceftriaxone but with pt representing 8/25/25 w/ fevers after missing doses at home and being found to have discitis/OM T11-T12, intraosseous abscess extending into the T11 vertebral body, discitis/OM at T9-T10, stable large epidural collections. Also found to have severe AS on repeat TTE and underwent CABG and AVR 9/17/25 (OR cx NG). MRI 9/25 showed continued improvement in spinal infxn. She was on ampicillin/ceftriaxone 8/3-8/25; 8/29-9/26 and then given dose of dalbavancin on 9/26 and started on Augmentin to take indefinitely.

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Scenario 4 Continued

She presented 3/13 w/ a week of worsening pain around the sternal wound, recent pus-filled lesion around the incision, intermittent fevers, worsening middle/lower back pain (reproduced w/ palpation), and leg weakness w/ R foot drop (R foot dorsiflexion is weak on exam). Afeb, WBC 6. CT showed a 4.8 x 2.2 x 4.3 fluid collection associated w/ sternal OM (acute). TTE w/o obvious veg. Bcx were collected (E faecalis identified) and she was started on cefepime and vancomycin. Of note, patient reports that she has not been taking the Augmentin since 10/2025 when an OSH doctor told her to stop it. Will continue IV antibiotics x 6 weeks at home with home health.

Impression:

1. Sternal wound abscess + OM

2. Back pain d/t relapsed infxn of spine/hardware in setting of pt not taking suppression abx

How would you code this scenario?

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Scenario 4 Answer

- T81.42XA Infection following a procedure, deep incisional surgical site, initial encounter
- B95.2 Enterococcus as the cause of diseases classified elsewhere
- M86.18 Other acute osteomyelitis, other site
- T84.63XA Infection and inflammatory reaction due to internal fixation device of spine, initial encounter
- Z45.2 Encounter for adjustment and management of vascular access device
- Z79.2 Long term (current) use of antibiotics

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Scenario Spotlight

DecisionHealth, an HCPro Brand

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March Scenario

F2F Scenario: A patient referral was sent to the home health agency from community physician, Dr. Jones. Intake reviews the F2F and notices that NP Sarah Poppleton completed the F2F visit and there is no visit note from Dr. Jones in the past 90 days. Intake reviews the medical practice that Dr. Jones works in and determines the NP works in collaboration with Dr. Jones. Intake is unsure if they can accept the patient's referral unless they get the patient in to have a visit with Dr. Jones.

What is the most recent clarification/guidance regarding the home health Face-to-Face that would clarify what is allowed in this situation?

A. Telehealth is allowed for face-to-face encounters.
B. The Face-to-Face date must be noted in the certification statement.
C. The Face-to-Face may be conducted by a different physician/provider in the same practice as the certifying physician/provider with firsthand information of the patient.
D. The physician or allowed provider who completed the Face-to-Face must be the certifying physician.

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March Scenario Answer

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April Scenario

Scenario: Your home health agency completes a Recertification OASIS on Day 52 of the current certification period due to a scheduling conflict. The assessment is submitted, and services continue without interruption. A week later, your agency realizes the assessment was completed outside of the allowed recertification window (Days 56–60).

What should the agency do next?

A. Complete a new Recertification OASIS as soon as possible, even if it is late
B. Leave the assessment as is, since it was submitted
C. Edit the assessment date to fall within Days 56–60 and resubmit
D. Discharge and readmit the patient to establish a new certification period

What is the most recent clarification/guidance regarding the home health Face-to-Face that would clarify what is allowed in this situation?

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Product Spotlight

Home Care Leadership Summit

May 19th through 21st in Orlando, Florida

Don't miss your chance to join industry leaders, gain actionable insights, and connect with peers at this year's summit.

To learn more or reserve your spot at the Home Care Leadership Summit, visit decisionhealth.com/hcls2026.

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What's New with AHCC

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What's new with AHCC

AHCC Credential Holders Survey:

- Open now: https://www.surveymonkey.com/r/8DR9ZQK

AHCC Networking call June 24

- Hospice coding and the HOPE tool.

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The Association of Home Care Coding & Compliance

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