I Passed My HCS-D Exam, Now What? A New Coder's Survival Guide

A WEBINAR PRESENTED ON NOVEMBER 6, 2023

ahcc The Association of Home Care Coding & Compliance

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Presented By

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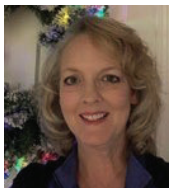

- **Elise Christensen, RN, HCS-D, COS-C,** Coding Manager, Hartford Healthcare

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Learning Outcome

Attendees will be able to:

1. Identify four requirements and three components of a face-to-face encounter.
2. Identify compliant source documents to use in assigning ICD-1CM diagnosis codes.
3. Cite examples of documents that are not eligible to use in assigning ICD-1CM diagnosis codes.
4. Cite examples of comorbid conditions including chronic, acute and resolved conditions.
5. Identify the requirements a condition must meet to be reported as the primary focus of care.
6. Recognize documents that qualify as a valid F2F based on Medicare defined F2F criteria.

Identifying Source Documents

Pam Wandrie and Claudia Baker

Overview of F2F Requirements

Presented By

- **Pamela Wandrie, MA, CCC-SLP, HCS-D, HCS-O**, is a coding and OASIS QA specialist at SimiTree Healthcare Consulting. She has over 29 years of experience in home healthcare, with 23 years spent in the field as a skilled therapy provider. Her clinical experience includes a variety of acute and post-acute care settings, with an emphasis on evidence-based practice. In 2016 she transitioned to a coding and OASIS quality assurance and education role. Her experience includes coding and OASIS reviewer mentorship, education development and delivery, development and maintenance of coding and OASIS assessments, as well as real-time and post-audit QA of coding, OASIS, and plan of care reviews.

Face to Face – What Is it?

- The Face-to-Face encounter is a condition of payment for home health benefits.
- The Face-to-Face encounter is the clinical note for an actual patient-provider visit where the provider has examined the patient.
  - It is *not* just an order for home health containing the date the Face-to-Face encounter was performed.

What Are the Requirements?

The encounter must take place with the certifying physician, or allowed practitioner, within 90 days before or 30 days after the SOC

Who is an allowed practitioner?

- The certifying physician (the physician that will be signing the home health orders)

OR

- The physician that cared for the patient at the acute or post-acute facility if the patient is being directly admitted to home health from an inpatient stay

OR

- An allowed non-physician practitioner, working in accordance with state law, may be:
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Nurse Midwife
  - Physician Assistant

AND

- May not be employed by or have a financial relationship with the home health agency

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What Are the Requirements?

The encounter must address the primary reason home health care is being provided

- The primary diagnosis must be addressed by the provider during the visit
  - The condition and symptoms are discussed
  - The condition is a new problem
  - The condition an old problem that has changed or exacerbated

- The primary diagnosis may not be:
  - A diagnosis simply listed in past medical history without further discussion or follow up
  - A resolved condition

What Are the Requirements?

Additional requirements

- The encounter must be signed and dated
- If the encounter is performed via a telehealth, 2-way audio *and* visual technology must be used

  (This is an extension of the PHE flexibility through December 2024)

Face-to-Face Encounter vs. Certification Statement

Sample Encounter

Includes:

- Reason for encounter/chief complaint
- HPI
- Past medical hx
- Review of systems
- Vitals
- Physical exam
- Assessment/Plan
- Recommendations/follow-ups

A Sample Certification Statement

I certify that this patient is confined to his/her home due to _____ (specific illness, injury or medical condition) and needs intermittent skilled nursing care and/or therapy in order to _____(what will skilled services accomplish or prevent?)

The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a valid F2F encounter with an allowed provider on (insert date) and it was related to the primary reason for home care. I agree with the findings of the F2F encounter and have incorporated them into my record.

(Must be dated and signed)

SOURCE: Medicare Administrator CGS

Face-to-Face Encounter – What Does it Look Like?

HPI
Transitions of Care Visit:
Discharge Diagnosis/Reason: orthostatic hypotension , fall, COVID
Institution: Sparrow
Admission Date: 5/7/23 **Discharge Date:** 5/11/23
Discharged to: Home
Adult General Risk Score: 6

Medication Reconciliation Completed today?: *yes*
Pertinent Diagnostic Information (imaging, labs, consult recommendations):

Moderate or High Complexity Decision Making: High
Pt presented to ED 5/7/23 for cough, sore throat, congestion, chills, headache, lightheadedness, frequent falls.Patient did have episode of near syncope prior to admission. Suspect that this may have been secondary to decreased oral intake in the setting of her acute illness.
She was hypotensive with BP of 91/62. EKG shows no obvious signs of acute ischemia or arrhythmia. Labs reviewed remarkable for BNP 115, mild transaminitis. She was admitted for falls and resp failure. On 5/8 required increase in O2 requirements- From 2 L --> 5-6. Tested positive for COVID- started on remdesivir and decadron. CTA negative for PE. Echocardiogram was performed and showed small pericardial effusion and some aortic valvular disease. EKG displayed bradycardia. Pt able to have O2 requirements weaned down. Pt was discharged with O2- pt has been wearing at home
She was noted to have hypomagnesemia which may have been contributing to the PVCs, magnesium was replaced. Recommend to continue magnesium supplements on discharge. HCTZ was discontinued

Pt started on Magnesium 400 mg daily
Continue Decadron 6 mg tablet- now completed

Calcium/mag/zinc only taking one tablet. Three tabs is one serving with 400 mg of mag and she is only taking t tab

HTN:
BP today: 106/58
Current Regiment:none- previous HCTZ and Amlodipine discontinued at OV 4/25.

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Face-to-Face Encounter – What Does it Look Like?

Some minor dizziness sometime when sitting to standing. Being very careful. Episodes will last 10-15 seconds.
No falls since being home.

Pt states shortness of breath is improving- sometimes with activity "feels heavy". No chest pain or chest tightness. Pt has been using O2 at home- mostly as needed. Has noticed O2 levels drop when sleeping if she does not wear O2. O2 levels 90-92% with activity- closer to 94 with rest. She is not wearing O2 today- typically uses 2L.

Pt ambulated back to exam room- O2 levels maintained 93-94% on RA.

Reports she felt great while on Decadron- improvement in generalized pain.

PMHX:asthma, hypertension, hyperlipidemia, fibromyalgia, obesity, bowel obstruction

Review of Systems
Constitutional: Positive for activity change and fatigue. Negative for appetite change, chills and fever.
HENT: Positive for congestion.
Respiratory: Positive for cough and shortness of breath. Negative for chest tightness.
Cardiovascular: Negative for chest pain.
Musculoskeletal: Positive for myalgias **(chronic)**.
Skin: Negative for rash.
Neurological: Positive for dizziness and light-headedness.

Objective:

Vitals

Vitals:

	05/19/23 0923	05/19/23 0937	05/19/23 0939	05/19/23 0942
BP:	102/58	102/58	106/60	106/58
Temp:	97.4 °F (36.3 °C)			
TempSrc:	Temporal			
Pulse:	80			
Resp:	16			
SpO2:	94%			
Weight:	242 lb (109.8 kg)			
Patient Position:	Sitting	Orthostatic Vitals - Lying	Orthostatic Vitals - Sitting	Orthostatic Vitals - Standing

Face-to-Face Encounter – What Does it Look Like?

Physical Exam

Constitutional:
General: She is not in acute distress.
Appearance: Normal appearance.

HENT:
Head: Normocephalic.
Right Ear: Tympanic membrane and ear canal normal.
Left Ear: Tympanic membrane and ear canal normal.
Nose: Congestion and rhinorrhea present.

Eyes:
Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds.

Pulmonary:
Effort: Pulmonary effort is normal. No tachypnea or respiratory distress.
Breath sounds: Normal breath sounds. No wheezing or rhonchi.

Musculoskeletal:
Cervical back: Normal range of motion.

Skin:
General: Skin is warm and dry.

Neurological:
Mental Status: She is alert and oriented to person, place, and time.

Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.

Face-to-Face Encounter – What Does it Look Like?

Assessment and Plan:

[redacted] was seen today for hypotension and shortness of breath.

Diagnoses and all orders for this visit:

Hospital Follow up- pt reports feeling improved since discharge. shortness of breath mostly with activity- has been weaning O2- using 2L at night and with shortness of breath with activity- no rhonchi or wheezing on exam. Pt states home care has been checking O2 levels and BP. O2 levels range 92-97%. B readings 130's- 150's systolic. BP today 106/58. Pt instructed to continue to hold HCTZ at this time- slow movements with sitting to standing. Neg Orthos in office today. Could consider Holter Monitor as pt did have bradycardia in hospital- heart rate (bpm) today 80. Pt was taking insufficient amount of magnesium supplement- advised 400 mg daily. Provided with shower chair rx.

Orthostatic hypotension (Primary)
- GENERIC MEDICAL SUPPLY ORDER; Shower chair

Benign essential hypertension
- Comprehensive panel; Future

Dizziness
- Comprehensive panel; Future
- GENERIC MEDICAL SUPPLY ORDER; Shower chair

COVID

Bradycardia

Hospital discharge follow-up

Hypomagnesemia
- Magnesium; Future

Return in about 1 month (around 6/19/2023) for hypotension .

Face-to-Face Encounter – What Does it Look Like?

Hospital Course:

Was admitted with respiratory failure secondary to COVID-19 pneumonia. She was initially started on remdesivir and dexamethasone. CT angiogram was negative for PE. Patient did have episode of near syncope prior to admission. Suspect that this may have been secondary to decreased oral intake in the setting of her acute illness. Initial orthostatic vital signs were positive. Patient was hydrated and her hydrochlorothiazide was discontinued. During the course of hospitalization, her orthostatic hypotension resolved, and she no longer complained of lightheadedness with activity. Echocardiogram was performed and showed small pericardial effusion and some aortic valvular disease. EKG displayed bradycardia with PR interval 197 and PVCs. No high-grade heart block was noted. She was noted to have hypomagnesemia which may have been contributing to the PVCs, magnesium was replaced. Recommend to continue magnesium supplements on discharge. Will also recommend for her to continue holding hydrochlorothiazide.

On COVID-19 therapy, patient improved from a respiratory standpoint. She was requiring some oxygen via nasal cannula prior to discharge. Walk test revealed need for 1 L of oxygen with ambulation which will be ordered.

Initially physical therapy and PT recommended subacute rehab, however patient became stronger and improved. Will write order for outpatient physical therapy.

Recheck magnesium in 1 week. Follow-up with PCP in 3 to 5 days.

Discharge Exam:
BP (I) 145/75 (BP Location: Right arm, Patient Position: Sitting) | Pulse 75 | Temp 97.9 °F (36.6 °C) (Axillary) | Resp 19 | Ht 70" (177.8 cm) | Wt 230 lb (104.3 kg) | LMP (LMP Unknown) | SpO2 93% | BMI 33.00 kg/m²

General: No acute distress, speaking in full sentences, no use of accessory muscles, resting in exam bed
HEENT: Pupils equal and reactive to light and accommodation, oropharynx is clear
Neck: Supple, no lymphadenopathy, no JVD
Lungs: Nasal cannula, mild crackles over lung bases bilaterally.
Cardiovascular: Regular rate and rhythm with normal S1 and S2
Abdomen: Soft, nontender, nondistended, normoactive bowel sounds
Extremities: No cyanosis clubbing or edema
Neuro: Nonfocal, A&O x3
Psych: Normal mood and affect

Face-to-Face Encounter – What Does it Look Like?

Follow up Instructions: Take meds as instructed. F/u with PCP and other specialists per instructions. Return to ED if not improved or if symptoms return.

Activity: activity as tolerated

Diet:
Diet Cardiac ()

Therapy Ordered:
No therapy plan of the specified type found.

Follow-up Appointments:
Contact information for after-discharge care
Home Medical Care
SHH HOME CAR[redacted]
Service: Home Health Services
Contact information:
[redacted]Avenue
Suite 4
[redacted]

Time spent on discharge > 35 minutes.

[redacted] **PA-C**
Vituity Hospitalist Service
5/11/2023 12:27 PM

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Certification Statement – *Not* a Face-to-Face encounter:

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face to face encounter that meets the physician face to face encounter requirement on 5/11/2023

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or continues to need occupational therapy. The patient is under my care, and I have initiated the establishment of the plan of care. The patient will be followed by a community physician who will periodically review the plan of care. The findings from this face to face encounter have been communicated with this physician who will be assuming the patient's home health plan of care.

Patient Active Problem List:
- Psoriasis [L40.9]
- Severe anxiety with panic [F41.0]
- Attention deficit hyperactivity disorder (ADHD), predominantly inattentive type [F90.0]
- Osteoarthritis of multiple joints [M15.9]
- Borderline personality disorder (HCC) [F60.3]
- PTSD (post-traumatic stress disorder) [F43.10]
- Psychophysiological insomnia [F51.04]
- History of Roux-en-Y gastric bypass [Z98.84]
- History of small bowel obstruction [Z87.19]
- Memory loss [R41.3]
- B12 deficiency [E53.8]
- Vitamin D deficiency [E55.9]
- Severe depression (HCC) [F32.2]
- History of kidney stones [Z87.442]
- Binge eating disorder [F50.81]
- Fibromyalgia [M79.7]
- MCI (mild cognitive impairment) [G31.84]
- Borderline diabetes [R73.03]
- Fatty liver [K76.0]
- Benign essential hypertension [I10]
- Idiopathic neuropathy [G60.9]
- Palpitations [R00.2]
- Morbid obesity (HCC) [E66.01]
- Fall [W19.XXXA]
- COVID-19 [U07.1]

Primary Reason for Home Health Referral: decline in ADL/IADL function

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Certification Statement – *Not* a Face-to-Face encounter:

Home Care Continued Care and Services Coordination Order(s)
(From admission, onward)

Start		Ordered
05/23/23 0000	Ambulatory Referral to Home Health Comments: ORDER INSTRUCTIONS: 1) The encounter with the patient was in whole or in part for the following medical condition/s, which is the primary reason for the ordered services: *Diabetic gastroparesis (HCC) (5/22/2023) Diabetes mellitus (HCC) () Myasthenia gravis with exacerbation (HCC) () Benzodiazepine dependence (HCC) (9/23/2022) Hypertension associated with diabetes (HCC) (9/13/2019) Morbid obesity (HCC) (2/26/2020) Formatting of this note might be different from the original. MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES Hyperlipidemia associated with type 2 diabetes mellitus (HCC) (5/22/2023) Recurrent major depressive disorder, in partial remission (HCC) (5/22/2023) Fibromyalgia (5/23/2023) Lumbar degenerative disc disease (5/23/2023) Stenosis of lateral recess of lumbar spine (5/23/2023) Generalized abdominal pain (5/23/2023) 2) I certify that the following services are medically necessary and based on my clinical findings they are supported: SKILLED NURSING New diagnosis (knowledge deficit) and New medication/s (administration/teaching), PHYSICAL THERAPY decreased activity tolerance, decreased strength, and risk for falls, and OCCUPATION THERAPY decreased activity tolerance and high risk for falls These services are required because the patient is homebound due to the following reasons: Patient with unsteady gait requires assistance with ADL's and Patient is a fall risk, requires assistance to safely navigate curbs, steps and uneven ground The patient had a face-to-face encounter with a physician who confirmed the above findings.	05/23/23 1357

References

- Palmetto GBA, Home Health Face To Face Checklist, https://palmettogba.com/palmetto/providers.nsf/files/Home_Health_Face_to_Face_Checklist.pdf/$FILE/Home_Health_Face_to_Face_Checklist.pdf
- CGS, Face-to-Face (FTF) *Encounters for Home Health Certification,* *https://www.cgsmedicare.com/hhh/education/materials/pdf/ftf.pdf*
- CMS, Home Health Agencies: CMS Flexibilities to Fight COVID-19, https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
- Medicare Benefit Policy Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Supplemental Documents

Presented By

- **Claudia Baker, RN, MHA, HCS-D, HCS-O**, is senior manager with SimiTree Healthcare Consulting. She has experience in the areas of compliance integrity, quality improvement, and managing regional and corporate operations. She has excellent leadership and analytical skills with a proven track record in compliance, regulatory oversight, and direct management roles in home health, hospice, and private duty settings. Of her 35 years in healthcare, 28 have centered around home-based services. Her experience includes development of clinical software applications for the industries. She also has extensive experience with consultation and education for home health and hospice agencies, specifically related to workflow process and improvement.

Source Documents

- Provider encounter notes, including
  - Signed office documentation from all relevant Providers
  - F2F documentation
  - Hospitalist relevant notes
- Agency confirmed Provider documentation
- Discharge summary, H/P, or Progress Note (if signed by Provider)
- Inpatient or post-acute care facility documentation

Documents That Cannot be Used as Sources

- Unsigned, unauthenticated documents
- Notes from the intern, unless signed by the Provider

Who Determines Diagnosis?

Any Qualified Provider

- Physician
- Nurse Practitioner (If State Practice Act allows)
- Physician Assistant (If State Practice Act allows)
- Doctor of Osteopathy
- Podiatrist
- Lab, X-Ray and pathology reports **if interpreted by a physician**
    - Be sure these are signed by a physician or provider if using

Source Documents for Diagnosis Codes

Yes	Maybe	No
Provider encounter notes: MD, DO, podiatrist	Physician Assistant (make sure allowed by state)	Medications list
• Signed office documentation	Nurse Practitioner (make sure allowed by state)	Unsigned, unauthenticated documents
• F2F documentation	Lab, x-ray and path reports: only if interpreted and signed by Provider	Notes from interns, unless signed by Provider
• Hospitalist relevant notes	Pre-op and operative notes	Facesheets
Discharge summary, H/P, or Progress Notes (if signed)		
Inpatient or PAC facility documentation		

Diagnosis Coding Identification

- Neither the assessing clinician nor the reviewing staff have the authority to diagnosis a patient with an illness, condition or disease.
- Cannot add diagnoses because of medications in home.
- Each admission must have confirmation of the diagnoses used.
- Cannot use diagnoses that were on a prior admission that are not included in new referral information; would need to query and document if still relevant/current diagnoses per coding clinic guidance.

Problem Lists

- All chronic, current and active diagnoses can be coded from the problem list (or equivalent area of the provider's encounter documentation) when there is no conflicting or contradictory documentation in the encounter note.
- The EMR Problem List must be part of the Provider documentation in order to be referenced for diagnostic code assignment.
  - That is, it must be a part of the record in which documentation recorded or reviewed by the diagnosing provider (NP, PA, MD, DO, DPM) also exists and is authenticated.
  - "Authenticated" means generated by the physician by electronic means or by hand.
    - If by electronic means it shall either show electronic signature or indicate a full visit/encounter record, including date of service, CPT code(s) verified by provider, and name of the provider entering data.
    - Encounter notes indicating entry by RN, PT, OT or other non-diagnosing providers such as RD will not be used.

What If I Don't Have Specific Information?

- Query the Provider when:
  - Additional, clarifying information is needed
  - More specific information
  - Medications
  - Unclear of diagnosis
  - Prior diagnosis not listed on recent facility referral or H&P documentation

*Regulations require that all diagnoses used **must be supported by provider documentation.** Be sure to include documentation of query, with whom you spoke, and the information you received. Some agency policies may require a verbal order be completed to verify diagnoses, but typically documentation of conversation is adequate.*

Types of Referrals

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Presented By

- **Nanette Minton, RN, HCS-D, HCS-H, HCS-O,** is the senior clinical coding manager at MAC Legacy. Serving in a leadership capacity for more than 20 years, Minton has held a variety of roles in the home care and hospice industry, including clinical, administrative, consulting, education, and agency startup and development. She provides day-to-day coding and quality support to the home care and hospice agencies receiving coding services. She also serves as a consultant for quality and regulatory issues that arise due to the complex and integrated nature of coding. Minton's experience in the industry gives her a unique perspective and allows her to provide coding and audit knowledge firsthand to clients.

Confirmation in Clinical Records

- The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis be present at the time of assessment.
- Clinical record sources for these diagnoses include, but are not limited to transfer documents, physician/allowed practitioner: progress notes, recent history and physical, discharge summary, orders, and consults.
- Do not include diseases or conditions that have been resolved or do not affect the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the clinical record by the physician (or others as listed above) to ensure validity, follow-up, and coordination of care.
- Only diagnoses confirmed and documented by the physician (or others, as listed above) should be considered when coding this item.

Sources of Referral Documentation in Home Health

- Assisted Living Facility
- Skilled Nursing Facility
- Hospital
- Community

Assisted Living Facility

- Be cautious of face sheet only referrals
- These referrals may include clinical information, but most are not confirmed diagnoses for coding

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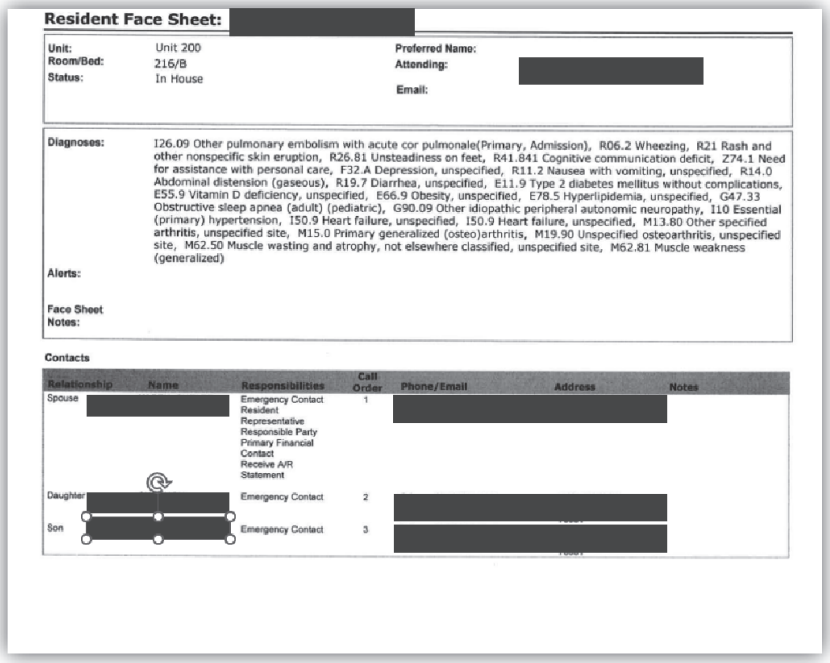
Assisted Living Facility

ALF Resident Face Sheet
List of Diagnoses but not confirmed.



Resident Face Sheet: [redacted]

Unit:	Unit 200	**Preferred Name:**	
Room/Bed:	216/B	**Attending:**	[redacted]
Status:	In House	**Email:**	

Diagnoses: I26.09 Other pulmonary embolism with acute cor pulmonale(Primary, Admission), R06.2 Wheezing, R21 Rash and other nonspecific skin eruption, R26.81 Unsteadiness on feet, R41.841 Cognitive communication deficit, Z74.1 Need for assistance with personal care, F32.A Depression, unspecified, R11.2 Nausea with vomiting, unspecified, R14.0 Abdominal distension (gaseous), R19.7 Diarrhea, unspecified, E11.9 Type 2 diabetes mellitus without complications, E55.9 Vitamin D deficiency, unspecified, E66.9 Obesity, unspecified, E78.5 Hyperlipidemia, unspecified, G47.33 Obstructive sleep apnea (adult) (pediatric), G90.09 Other idiopathic peripheral autonomic neuropathy, I10 Essential (primary) hypertension, I50.9 Heart failure, unspecified, I50.9 Heart failure, unspecified, M13.80 Other specified arthritis, unspecified site, M15.0 Primary generalized (osteo)arthritis, M19.90 Unspecified osteoarthritis, unspecified site, M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site, M62.81 Muscle weakness (generalized)

Alerts:

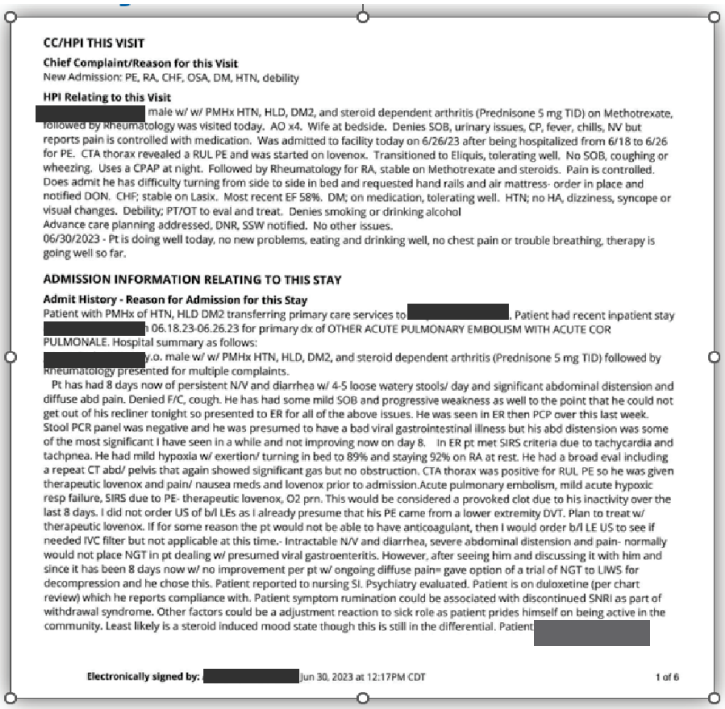
Face Sheet Notes:

Contacts

Relationship	Name	Responsibilities	Call Order	Phone/Email	Address	Notes
Spouse	[redacted]	Emergency Contact Resident Representative Responsible Party Primary Financial Contact Receive A/R Statement	1	[redacted]		
Daughter	[redacted]	Emergency Contact	2	[redacted]		
Son	[redacted]	Emergency Contact	3	[redacted]		

Assisted Living Facility

H&P at ALF by approved practitioner after hospital stay.



CC/HPI THIS VISIT

Chief Complaint/Reason for this Visit
New Admission: PE, RA, CHF, OSA, DM, HTN, debility

HPI Relating to this Visit
[redacted] male w/ w/ PMHx HTN, HLD, DM2, and steroid dependent arthritis (Prednisone 5 mg TID) on Methotrexate, followed by Rheumatology was visited today. AO x4. Wife at bedside. Denies SOB, urinary issues, CP, fever, chills, NV but reports pain is controlled with medication. Was admitted to facility today on 6/26/23 after being hospitalized from 6/18 to 6/26 for PE. CTA thorax revealed a RUL PE and was started on lovenox. Transitioned to Eliquis, tolerating well. No SOB, coughing or wheezing. Uses a CPAP at night. Followed by Rheumatology for RA, stable on Methotrexate and steroids. Pain is controlled. Does admit he has difficulty turning from side to side in bed and requested hand rails and air mattress- order in place and notified DON. CHF; stable on Lasix. Most recent EF 58%. DM; on medication, tolerating well. HTN; no HA, dizziness, syncope or visual changes. Debility; PT/OT to eval and treat. Denies smoking or drinking alcohol
Advance care planning addressed, DNR, SSW notified. No other issues.
06/30/2023 - Pt is doing well today, no new problems, eating and drinking well, no chest pain or trouble breathing, therapy is going well so far.

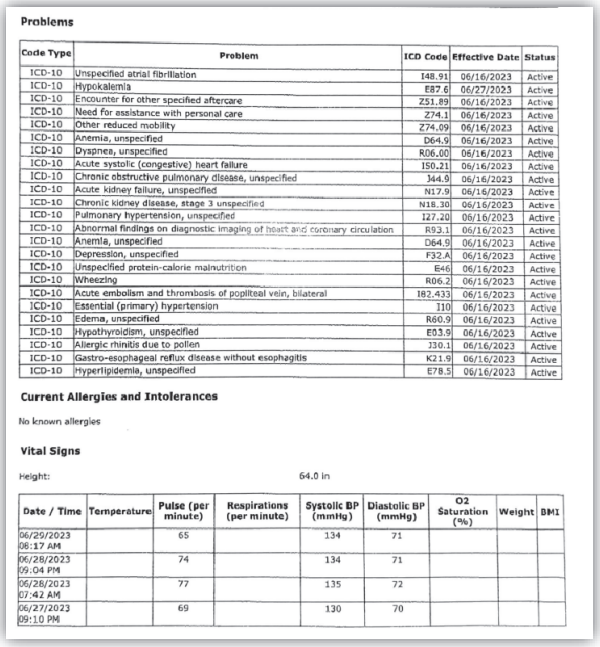
ADMISSION INFORMATION RELATING TO THIS STAY

Admit History - Reason for Admission for this Stay
Patient with PMHx of HTN, HLD DM2 transferring primary care services to [redacted]. Patient had recent inpatient stay [redacted] 06.18.23-06.26.23 for primary dx of OTHER ACUTE PULMONARY EMBOLISM WITH ACUTE COR PULMONALE. Hospital summary as follows:
[redacted]y.o. male w/ w/ PMHx HTN, HLD, DM2, and steroid dependent arthritis (Prednisone 5 mg TID) followed by Rheumatology presented for multiple complaints.
Pt has had 8 days now of persistent N/V and diarrhea w/ 4-5 loose watery stools/ day and significant abdominal distension and diffuse abd pain. Denied F/C, cough. He has had some mild SOB and progressive weakness as well to the point that he could not get out of his recliner tonight so presented to ER for all of the above issues. He was seen in ER then PCP over this last week. Stool PCR panel was negative and he was presumed to have a bad viral gastrointestinal illness but his abd distension was some of the most significant I have seen in a while and not improving now on day 8. In ER pt met SIRS criteria due to tachycardia and tachpnea. He had mild hypoxia w/ exertion/ turning in bed to 89% and staying 92% on RA at rest. He had a broad eval including a repeat CT abd/ pelvis that again showed significant gas but no obstruction. CTA thorax was positive for RUL PE so he was given therapeutic lovenox and pain/ nausea meds and lovenox prior to admission.Acute pulmonary embolism, mild acute hypoxic resp failure, SIRS due to PE- therapeutic lovenox, O2 prn. This would be considered a provoked clot due to his inactivity over the last 8 days. I did not order US of b/l LEs as I already presume that his PE came from a lower extremity DVT. Plan to treat w/ therapeutic lovenox. If for some reason the pt would not be able to have anticoagulant, then I would order b/l LE US to see if needed IVC filter but not applicable at this time.- Intractable N/V and diarrhea, severe abdominal distension and pain- normally would not place NGT in pt dealing w/ presumed viral gastroenteritis. However, after seeing him and discussing it with him and since it has been 8 days now w/ no improvement per pt w/ ongoing diffuse pain= gave option of a trial of NGT to LIWS for decompression and he chose this. Patient reported to nursing SI. Psychiatry evaluated. Patient is on duloxetine (per chart review) which he reports compliance with. Patient symptom rumination could be associated with discontinued SNRI as part of withdrawal syndrome. Other factors could be a adjustment reaction to sick role as patient prides himself on being active in the community. Least likely is a steroid induced mood state though this is still in the differential. Patient[redacted]

Electronically signed by: [redacted] Jun 30, 2023 at 12:17PM CDT 1 of 6

Skilled Nursing Facility

SNF referral—lots of information, but a list of diagnoses alone are not considered confirmed without approved provider date/signature.



Problems

Code Type	Problem	ICD Code	Effective Date	Status
ICD-10	Unspecified atrial fibrillation	I48.91	06/16/2023	Active
ICD-10	Hypokalemia	E87.6	06/27/2023	Active
ICD-10	Encounter for other specified aftercare	Z51.89	06/16/2023	Active
ICD-10	Need for assistance with personal care	Z74.1	06/16/2023	Active
ICD-10	Other reduced mobility	Z74.09	06/16/2023	Active
ICD-10	Anemia, unspecified	D64.9	06/16/2023	Active
ICD-10	Dyspnea, unspecified	R06.00	06/16/2023	Active
ICD-10	Acute systolic (congestive) heart failure	I50.21	06/16/2023	Active
ICD-10	Chronic obstructive pulmonary disease, unspecified	J44.9	06/16/2023	Active
ICD-10	Acute kidney failure, unspecified	N17.9	06/16/2023	Active
ICD-10	Chronic kidney disease, stage 3 unspecified	N18.30	06/16/2023	Active
ICD-10	Pulmonary hypertension, unspecified	I27.20	06/16/2023	Active
ICD-10	Abnormal findings on diagnostic imaging of heart and coronary circulation	R93.1	06/16/2023	Active
ICD-10	Anemia, unspecified	D64.9	06/16/2023	Active
ICD-10	Depression, unspecified	F32.A	06/16/2023	Active
ICD-10	Unspecified protein-calorie malnutrition	E46	06/16/2023	Active
ICD-10	Wheezing	R06.2	06/16/2023	Active
ICD-10	Acute embolism and thrombosis of popliteal vein, bilateral	I82.433	06/16/2023	Active
ICD-10	Essential (primary) hypertension	I10	06/16/2023	Active
ICD-10	Edema, unspecified	R60.9	06/16/2023	Active
ICD-10	Hypothyroidism, unspecified	E03.9	06/16/2023	Active
ICD-10	Allergic rhinitis due to pollen	J30.1	06/16/2023	Active
ICD-10	Gastro-esophageal reflux disease without esophagitis	K21.9	06/16/2023	Active
ICD-10	Hyperlipidemia, unspecified	E78.5	06/16/2023	Active

Current Allergies and Intolerances

No known allergies

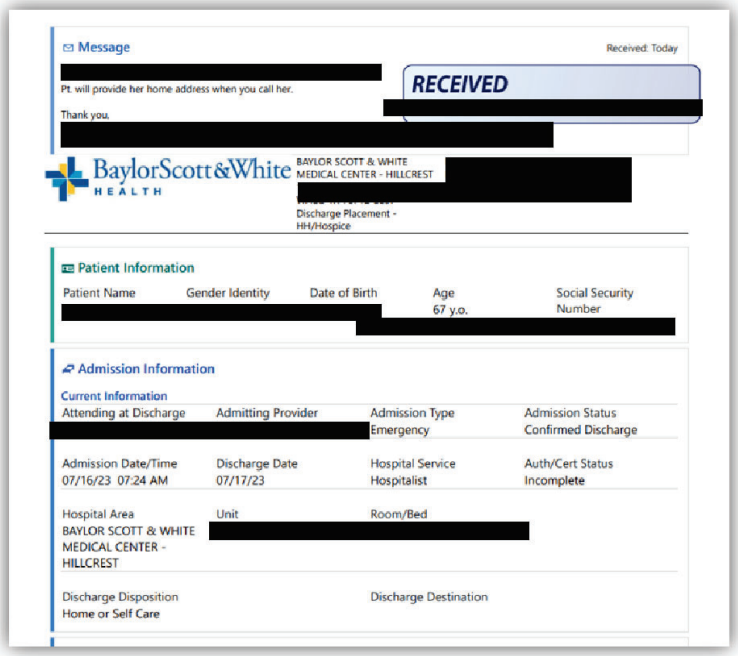
Vital Signs

Height: 64.0 in

Date / Time	Temperature	Pulse (per minute)	Respirations (per minute)	Systolic BP (mmHg)	Diastolic BP (mmHg)	O2 Saturation (%)	Weight	BMI
06/29/2023 06:17 AM		65		134	71			
06/28/2023 09:04 PM		74		134	71			
06/28/2023 07:42 AM		77		135	72			
06/27/2023 09:10 PM		69		130	70			

Hospital

Referral to Home Health after Hospital stay—must review ALL pages. Usually a multiple page document. Good information but does not provide confirmed diagnoses.



Message

Received: Today

[redacted]

Pt. will provide her home address when you call her.

RECEIVED

Thank you.

[redacted]

BaylorScott&White HEALTH

BAYLOR SCOTT & WHITE MEDICAL CENTER - HILLCREST

[redacted]

Discharge Placement - HH/Hospice

Patient Information

Patient Name	Gender Identity	Date of Birth	Age	Social Security Number
[redacted]			67 y.o.	[redacted]

Admission Information

Current Information

Attending at Discharge	Admitting Provider	Admission Type	Admission Status
[redacted]		Emergency	Confirmed Discharge

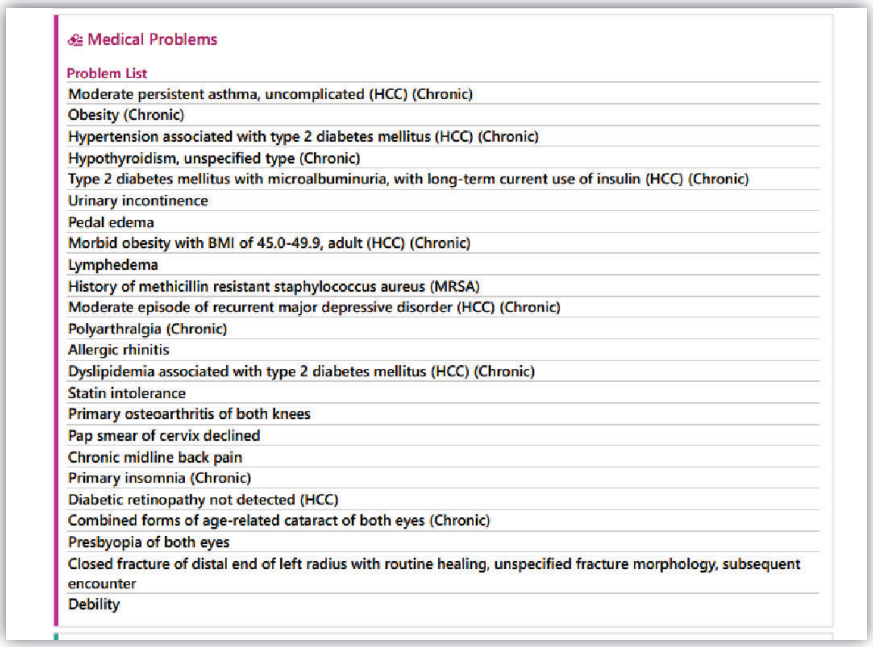
Admission Date/Time	Discharge Date	Hospital Service	Auth/Cert Status
07/16/23 07:24 AM	07/17/23	Hospitalist	Incomplete

Hospital Area	Unit	Room/Bed
BAYLOR SCOTT & WHITE MEDICAL CENTER - HILLCREST	[redacted]	

Discharge Disposition	Discharge Destination
Home or Self Care	

Hospital

Problem list does not equate to confirmed diagnoses. Many of these may no longer be current or appropriate to code. You will need to fully review the record for determination.



Medical Problems

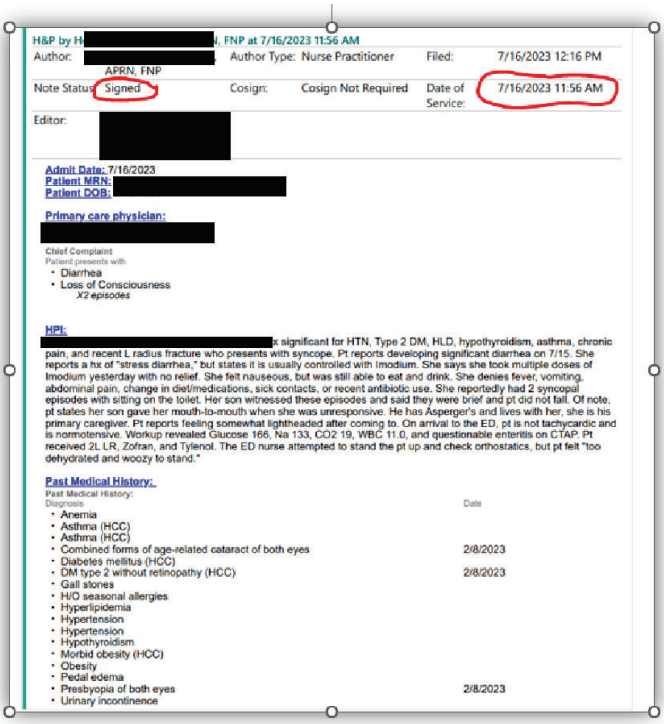
Problem List

- Moderate persistent asthma, uncomplicated (HCC) (Chronic)
- Obesity (Chronic)
- Hypertension associated with type 2 diabetes mellitus (HCC) (Chronic)
- Hypothyroidism, unspecified type (Chronic)
- Type 2 diabetes mellitus with microalbuminuria, with long-term current use of insulin (HCC) (Chronic)
- Urinary incontinence
- Pedal edema
- Morbid obesity with BMI of 45.0-49.9, adult (HCC) (Chronic)
- Lymphedema
- History of methicillin resistant staphylococcus aureus (MRSA)
- Moderate episode of recurrent major depressive disorder (HCC) (Chronic)
- Polyarthralgia (Chronic)
- Allergic rhinitis
- Dyslipidemia associated with type 2 diabetes mellitus (HCC) (Chronic)
- Statin intolerance
- Primary osteoarthritis of both knees
- Pap smear of cervix declined
- Chronic midline back pain
- Primary insomnia (Chronic)
- Diabetic retinopathy not detected (HCC)
- Combined forms of age-related cataract of both eyes (Chronic)
- Presbyopia of both eyes
- Closed fracture of distal end of left radius with routine healing, unspecified fracture morphology, subsequent encounter
- Debility

Hospital

Continuing H&P document has notation of being signed/dated which confirms the diagnoses listed.

Past Medical History does not necessarily mean they are resolved. The full record must be considered.



H&P by H[redacted], FNP at 7/16/2023 11:56 AM

Author: [redacted] APRN, FNP | Author Type: Nurse Practitioner | Filed: 7/16/2023 12:16 PM

Note Status: Signed | Cosign: Cosign Not Required | Date of Service: 7/16/2023 11:56 AM

Editor: [redacted]

Admit Date: 7/16/2023
Patient MRN: [redacted]
Patient DOB:

Primary care physician: [redacted]

Chief Complaint
Patient presents with
- Diarrhea
- Loss of Consciousness
  X2 episodes

HPI:

[redacted]k significant for HTN, Type 2 DM, HLD, hypothyroidism, asthma, chronic pain, and recent L radius fracture who presents with syncope. Pt reports developing significant diarrhea on 7/15. She reports a hx of "stress diarrhea," but states it is usually controlled with Imodium. She says she took multiple doses of Imodium yesterday with no relief. She felt nauseous, but was still able to eat and drink. She denies fever, vomiting, abdominal pain, change in diet/medications, sick contacts, or recent antibiotic use. She reportedly had 2 syncopal episodes with sitting on the toilet. Her son witnessed these episodes and said they were brief and pt did not fall. Of note, pt states her son gave her mouth-to-mouth when she was unresponsive. He has Asperger's and lives with her, she is his primary caregiver. Pt reports feeling somewhat lightheaded after coming to. On arrival to the ED, pt is not tachycardic and is normotensive. Workup revealed Glucose 166, Na 133, CO2 19, WBC 11.0, and questionable enteritis on CTAP. Pt received 2L LR, Zofran, and Tylenol. The ED nurse attempted to stand the pt up and check orthostatics, but pt felt "too dehydrated and woozy to stand."

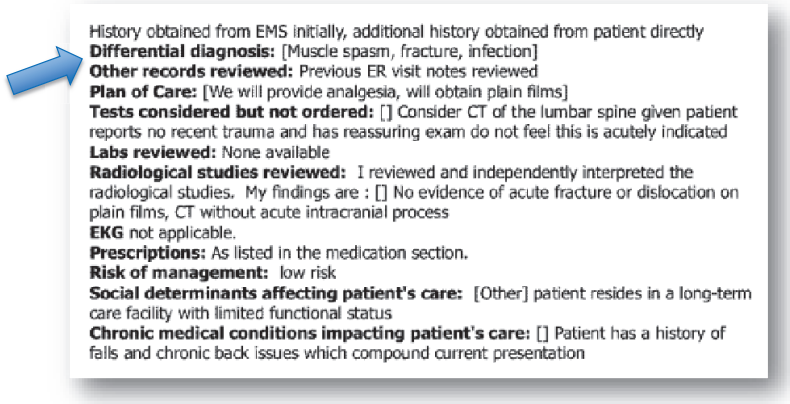
Past Medical History:

Past Medical History: Diagnosis	Date
Anemia	
Asthma (HCC)	
Asthma (HCC)	
Combined forms of age-related cataract of both eyes	2/8/2023
Diabetes mellitus (HCC)	
DM type 2 without retinopathy (HCC)	2/8/2023
Gall stones	
H/O seasonal allergies	
Hyperlipidemia	
Hypertension	
Hypertension	
Hypothyroidism	
Morbid obesity (HCC)	
Obesity	
Pedal edema	
Presbyopia of both eyes	2/8/2023
Urinary incontinence	

Hospital

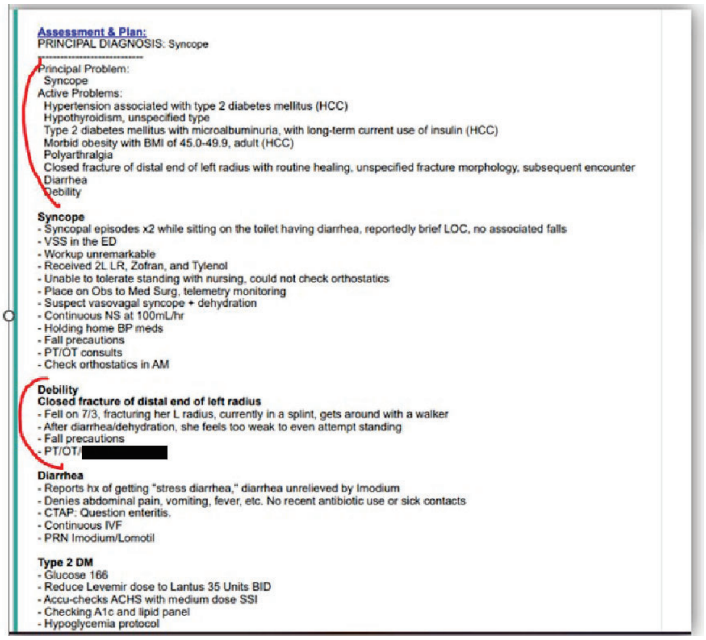
Be aware of the term “differential diagnosis” when reviewing hospital records as those diagnoses are not confirmed. The physician is listing potential causes for the presenting symptomology.

Differential diagnosis is a process used by physicians when trying to differentiate between two or more conditions which share similar signs or symptoms.



History obtained from EMS initially, additional history obtained from patient directly
Differential diagnosis: [Muscle spasm, fracture, infection]
Other records reviewed: Previous ER visit notes reviewed
Plan of Care: [We will provide analgesia, will obtain plain films]
Tests considered but not ordered: [] Consider CT of the lumbar spine given patient reports no recent trauma and has reassuring exam do not feel this is acutely indicated
Labs reviewed: None available
Radiological studies reviewed: I reviewed and independently interpreted the radiological studies. My findings are : [] No evidence of acute fracture or dislocation on plain films, CT without acute intracranial process
EKG not applicable.
Prescriptions: As listed in the medication section.
Risk of management: low risk
Social determinants affecting patient's care: [Other] patient resides in a long-term care facility with limited functional status
Chronic medical conditions impacting patient's care: [] Patient has a history of falls and chronic back issues which compound current presentation

Hospital



Assessment & Plan:
PRINCIPAL DIAGNOSIS: Syncope

Principal Problem:
Syncope
Active Problems:
Hypertension associated with type 2 diabetes mellitus (HCC)
Hypothyroidism, unspecified type
Type 2 diabetes mellitus with microalbuminuria, with long-term current use of insulin (HCC)
Morbid obesity with BMI of 45.0-49.9, adult (HCC)
Polyarthralgia
Closed fracture of distal end of left radius with routine healing, unspecified fracture morphology, subsequent encounter
Diarrhea
Debility

Syncope
- Syncopal episodes x2 while sitting on the toilet having diarrhea, reportedly brief LOC, no associated falls
- VSS in the ED
- Workup unremarkable
- Received 2L LR, Zofran, and Tylenol
- Unable to tolerate standing with nursing, could not check orthostatics
- Place on Obs to Med Surg, telemetry monitoring
- Suspect vasovagal syncope + dehydration
- Continuous NS at 100mL/hr
- Holding home BP meds
- Fall precautions
- PT/OT consults
- Check orthostatics in AM

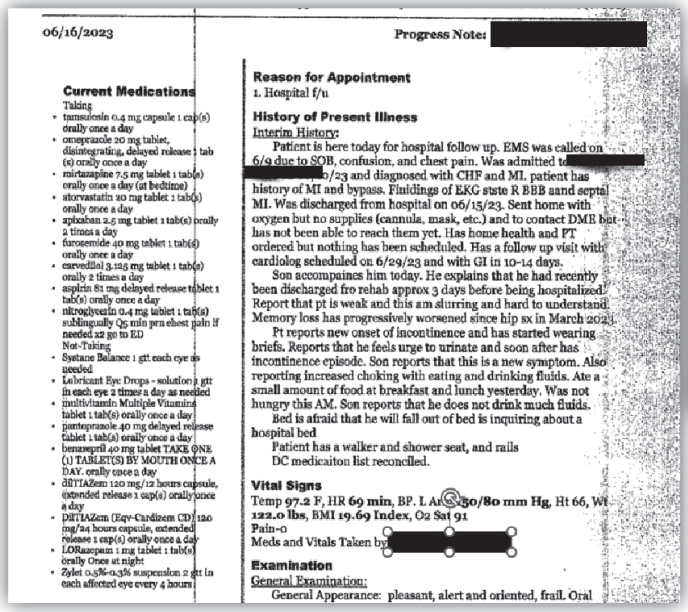
Debility
Closed fracture of distal end of left radius
- Fell on 7/3, fracturing her L radius, currently in a splint, gets around with a walker
- After diarrhea/dehydration, she feels too weak to even attempt standing
- Fall precautions
- PT/OT [redacted]

Diarrhea
- Reports hx of getting "stress diarrhea," diarrhea unrelieved by Imodium
- Denies abdominal pain, vomiting, fever, etc. No recent antibiotic use or sick contacts
- CTAP: Question enteritis.
- Continuous IVF
- PRN Imodium/Lomotil

Type 2 DM
- Glucose 166
- Reduce Levemir dose to Lantus 35 Units BID
- Accu-checks ACHS with medium dose SSI
- Checking A1c and lipid panel
- Hypoglycemia protocol

Principal Diagnosis noted but may not be the primary focus of care for the episode—look closely for where the home health consult is noted.

Community



06/16/2023 Progress Note: [redacted]

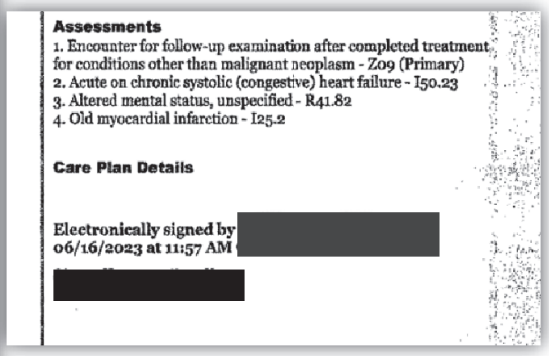
Current Medications
Taking
- tamsulosin 0.4 mg capsule 1 cap(s) orally once a day
- omeprazole 20 mg tablet, disintegrating, delayed release 1 tab(s) orally once a day
- mirtazapine 7.5 mg tablet 1 tab(s) orally once a day (at bedtime)
- atorvastatin 20 mg tablet 1 tab(s) orally once a day
- aphoban 2.5 mg tablet 1 tab(s) orally 2 times a day
- furosemide 40 mg tablet 1 tab(s) orally once a day
- carvedilol 3.125 mg tablet 1 tab(s) orally 2 times a day
- aspirin 81 mg delayed release tablet 1 tab(s) orally once a day
- nitroglycerin 0.4 mg tablet 1 tab(s) sublingually Q5 min prn chest pain if needed x2 go to ED
Not-Taking
- Systane Balance 1 gtt each eye as needed
- Lubricant Eye Drops - solution 1 gtt in each eye 2 times a day as needed
- multivitamin Multiple Vitamins tablet 1 tab(s) orally once a day
- pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- benazepril 40 mg tablet TAKE ONE (1) TABLET(S) BY MOUTH ONCE A DAY. orally once a day
- DILTIAZem 120 mg/12 hours capsule, extended release 1 cap(s) orally once a day
- DILTIAZem (Eqv-Cardizem CD) 120 mg/24 hours capsule, extended release 1 cap(s) orally once a day
- LORazepam 1 mg tablet 1 tab(s) orally Once at night
- Zylet 0.5%-0.3% suspension 2 gtt in each affected eye every 4 hours

Reason for Appointment
1. Hospital f/u

History of Present Illness
Interim History:
Patient is here today for hospital follow up. EMS was called on 6/9 due to SOB, confusion, and chest pain. Was admitted to [redacted]0/23 and diagnosed with CHF and MI. patient has history of MI and bypass. Fiuidings of EKG state R BBB aand septal MI. Was discharged from hospital on 06/15/23. Sent home with oxygen but no supplies (cannula, mask, etc.) and to contact DME but has not been able to reach them yet. Has home health and PT ordered but nothing has been scheduled. Has a follow up visit with cardiolog scheduled on 6/29/23 and with GI in 10-14 days.
Son accompaines him today. He explains that he had recently been discharged fro rehab approx 3 days before being hospitalized. Report that pt is weak and this am slurring and hard to understand. Memory loss has progressively worsened since hip sx in March 2023.
Pt reports new onset of incontinence and has started wearing briefs. Reports that he feels urge to urinate and soon after has incontinence episode. Son reports that this is a new symptom. Also reporting increased choking with eating and drinking fluids. Ate a small amount of food at breakfast and lunch yesterday. Was not hungry this AM. Son reports that he does not drink much fluids.
Bed is afraid that he will fall out of bed is inquiring about a hospital bed
Patient has a walker and shower seat, and rails
DC medicaiton list reconciled.

Vital Signs
Temp 97.2 F, HR 69 min, BP. L Ar[redacted]50/80 mm Hg, Ht 66, Wt 122.0 lbs, BMI 19.69 Index, O2 Sat 91
Pain-0
Meds and Vitals Taken by [redacted]

Examination
General Examination:
General Appearance: pleasant, alert and oriented, frail. Oral



Assessments
1. Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm - Z09 (Primary)
2. Acute on chronic systolic (congestive) heart failure - I50.23
3. Altered mental status, unspecified - R41.82
4. Old myocardial infarction - I25.2

Care Plan Details

Electronically signed by [redacted]
06/16/2023 at 11:57 AM

Many community referrals may come as a result of hospital or other follow up visits.

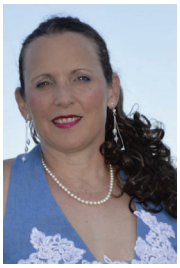
References

- https://www.cms.gov/files/document/oasis-e-manual-final.pdf

Identifying Comorbidities

A Guide for New Coders

Presented By



- **Kelly Kavanaugh, RN, HCS-D, HCS-H, HCS-O, BCHH-C**, has been in home health and hospice for 30 years. She has worked as an agency owner & administrator, DON, and director of education; her experience also spans billing/claims, field nursing, marketing, QAPI, and OASIS review & coding. She has been coding & OASIS certified for 15+ years.

What Is a "Comorbid Condition"?

- Miriam Webster defines a "comorbidity" as – a condition which exists simultaneously with and usually independently of another medical condition.
- Used in a sentence: The frequency of visits will depend upon risk factors, *comorbid conditions* and other home/life circumstances.
- Examples of Comorbid conditions: Hypertension, COPD, diabetes, anemia and cellulitis of the left leg. All these conditions exist together simultaneously in the same patient and make up the patient's medical history.

Acute Conditions: Diagnoses that typically resolve completely; they may even completely resolve prior to being admitted to service (see resolved conditions). Some common Acute conditions coded in Home Health and Hospice are:

- Fractures
- Pneumonia
- Urinary Tract Infections
- Acute Renal Failure
- Acute Respiratory Failure
- Vitamin Deficiencies
- Nausea/vomiting
- Anorexia
- Cellulitis
- Abscesses
- Influenza
- COVID-19
- Pancreatitis
- Gastritis
- Small Bowel Obstructions
- Acute Post Operative Pain

Chronic Conditions: Diagnoses that typically do not resolve completely; they can be managed or under control, but are relapsing and progressive in nature. Some common chronic conditions coded in Home Health and Hospice are:

- Diabetes
- Parkinson's Disease
- Multiple Sclerosis
- Amytrophic Lateral Sclerosis
- Myesthenia Gravis
- Congestive Heart Failure
- Hypertension
- Peripheral Vascular Disease
- Cirrhosis of the liver
- Chronic or Neoplasm Pain
- Dementia
- Atrial Fib, CAD and Cardiomyopathy
- COPD and Emphysema
- Asthma
- Spinal Cord Injuries
- Cerebral Palsy
- Neuropathy
- Chronic Kidney Disease
- Rheumatoid, osteoarthritis or Gout

Conditions That Could be Acute OR Chronic: these diagnoses found on an H&P would need further explanation or possibly a query to the provider.

~

- Anemia
- Depression
- Anxiety
- Protein Calorie Malnutrition
- Osteomyelitis
- Pain

~

- Cancer
- Thrombocytopenia
- Immunosuppression
- Long term use of certain medications
- Hyper or Hypo - kalemia, natremia, calcemia or magnesemia

Resolved Conditions:

- Conditions may be noted to be “resolved” by the provider on the H&P
  - Abnormal labs – troponins, WBC’s
  - Altered mental status
  - Dehydration or electrolyte imbalances – sodium, potassium, calcium, etc
  - Acute renal failure, acute respiratory failure
- Symptoms may be converted into diagnoses
  - Cough to → pneumonia
  - Dysuria to → Urinary Tract Infection
  - Low back pain to → Lumbar spondylosis with radiculopathy
  - Abdominal pain to → diverticulitis
  - Leg redness and swelling to → cellulitis
  - Dyspnea to → COPD exacerbation

Acute? Chronic? Resolved?

- What if you are unsure?
  - Always look for clues in the documentation from the provider such as the terms “resolved” (no longer active condition and we would not code it), “improving” (acute condition, actively being treated) or “stable” (often used with chronic conditions).
  - Look for continuing treatments such as antibiotics, wound care, orders for future lab draws, follow up visits with specialty physicians, appointments for further outpatient testing to give you clues for acute vs chronic or resolved condition status.
  - Sometimes, you might see “back to baseline” documented. This could be referring to an acute flare up of a chronic condition such as acute renal failure on chronic renal failure and could signify that the acute flare up has resolved and the chronic condition remains back to their baseline status.
  - If you have reviewed all the documentation and are still unsure, query the provider to determine if a condition is resolved or remains an active problem or acute vs chronic condition.

Integral Symptoms (a piece/part of a whole, essential item for completeness)

- There are coding guidelines which indicate that codes for symptoms that are an integral part of a condition are not to be coded in addition to the diagnosis. Most (but not all) of the symptom codes are in the R chapter.
- For example:
  - When coding CHF, you would **not** also code edema (R60.-) or dyspnea (R06.-)
  - When coding COPD, you would **not** also code dyspnea (R06.-)
  - When coding lumbar spondylosis with radiculopathy, you would **not** also code back pain (M54.-) which is not in the symptom codes chapter, but is still a symptom of the diagnosis.
  - When coding Irritable Bowel Syndrome with diarrhea, you would **not** also use the code for diarrhea (R19.7)
  - When coding a UTI, you would not code dysuria (R30.0)

History Codes

- History codes can be used for healed fractures (Z87.-) or procedures that may impact current care such as Hx of joint replacements or cardiac stents.
- History codes should be added when they add valuable information to the clinical picture or required by Coding Guidelines. Such as:
  - Add codes for history of cancers that have been deemed resolved or inactive like breast cancer Z85.3
  - Z79.4 insulin use is required by the Guidelines to be coded when coding diabetes
  - Z87.891 hx of nicotine dependence is required with many cardiac and resp conditions
- History codes can be used for coding acute conditions which have resolved. For Example:
  - When the acute UTI is indicated to be resolved by the provider, you may add Z87.440 Hx of UTI to indicate the recent infection.

Tricky Situations

- Watch out for information on H&P that is indicated as family history. Sometimes the heading “Family History” may be on one page, and the list of diagnosis is on the next page and may be easily mistaken as the patient’s history.
- Watch out for negative charting. These are lists of diagnosis that the provider indicates the patient does **NOT** have or the patient **DENIES** having. There also may be a list of diagnoses but the patient only has the ones that are in **BOLD** print.

Identifying the Primary Diagnosis

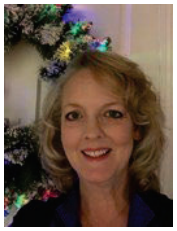
M1021: Primary Focus of Care

ahcc The Association of Home Care Coding & Compliance

decisionhealth

decisionhealth

Presented By



- **Elise Christensen, RN, HCS-D, COS-C, coding manager with Hartford Healthcare**, has been an RN for approaching 34 years. She has spent almost 20 years practicing in the newborn intensive care unit (NICU) setting caring for high-risk newborns. During her NICU career, she continued caring for some of her tiny patients as they transitioned home, thus beginning her home health career. She has now spent over 25 years in the home health industry. Her home health positions held include pediatric and adult field nurse, marketer, coder, and senior leader. For the last 11 years, she has been involved full time in coding and OASIS review, serving as a frontline reviewer, educator/mentor, and coding director. Currently, she is serving as leader of the coding and OASIS review team for a very large hospital-based home health and hospice agency. As a commitment to excellence, Christensen has held uninterrupted HCS-D and COS-C certifications for the past nine years and is a member of both AHCC and AHIMA in good standing.

Focus of Care

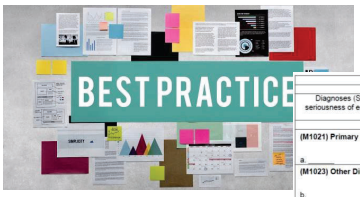
Establishing the primary focus of care is one of the most crucial steps when completing the start of care assessment.

But how can We be Sure We Select the Right One?

- Let's take a closer look.

The primary focus of care represents the chief reason the patient is receiving home care. It is the diagnosis most related to the current plan of care.

So, plan of care interventions, OASIS documentation, and disciplines involved should all support the primary focus of care.



(M1021) Primary Diagnosis & (M1023) Other Diagnoses

Column 1 Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided) Description	Column 2 ICD-10-CM and symptom control rating for each Note that the sequencing of these ratings may not sequencing of the diagnoses ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis a. _____	V, W, X, Y codes NOT allowed a. ☐☐☐☐☐ ☐0 ☐1 ☐2
(M1023) Other Diagnoses b. _____	All ICD-10-CM codes allowed b. ☐☐☐☐☐ ☐0 ☐1 ☐2
c. _____	c. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d. ☐☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

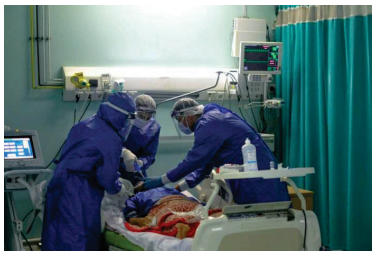
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Centers for Medicare and Medicaid Services, also known as CMS, mandates that the assessing clinician must be the one who determines the primary focus of care, based on the assessment, the medical record, and the physician's input.

However, the assessing clinician can collaborate with the health care team to make the primary focus of care determination.

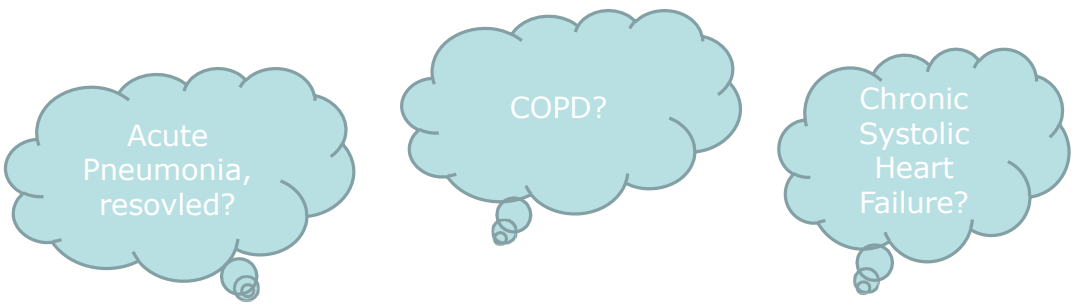
In order for any diagnosis to be coded on the plan of care and on the OASIS, supporting physician documentation of the diagnosis must be present within the medical record.

Keep in mind that the diagnosis your patient had as an inpatient will not necessarily be the same as the primary focus of care for home health.



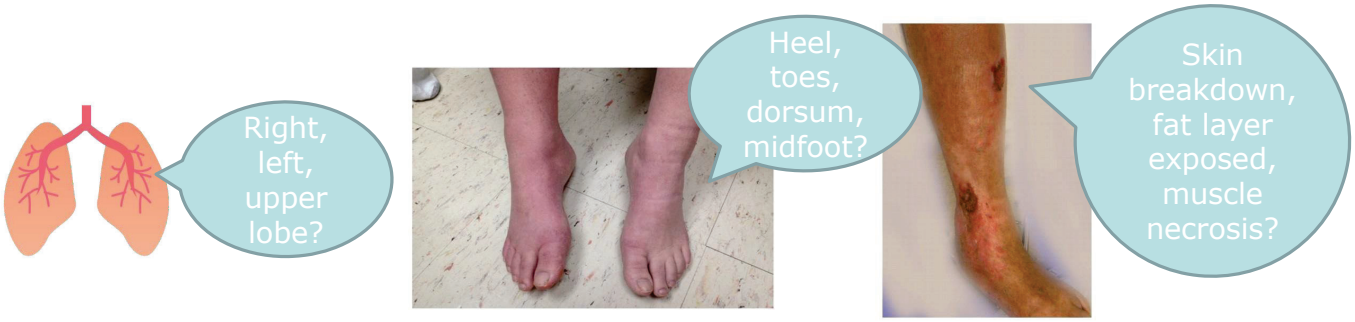

The primary diagnosis must also be an active diagnosis. Coders are unable to code resolved conditions on the home health plan of care and claim.

If you are considering a primary diagnosis for your patient that has resolved, such as a recent infection, you should consider a current diagnosis that is most likely to cause a recurrence and or a difficult recovery to be the primary focus of care.



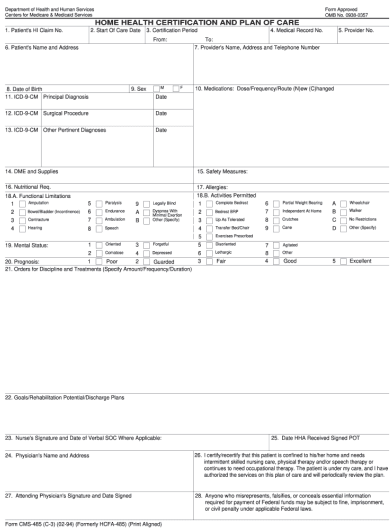
With the Patient Driven Groupings Model Payment System, specificity is key and this starts with obtaining accurate referral information.

- Never enter a primary diagnosis without physician validation.
- Ensure that you have the correct laterality, location, and severity for a diagnosis when needed.



What Does the Primary Focus of Care "Look Like" in an Electronic Health Record?

Where can we find the primary focus of care? What do we look for in the Plan of Care, Plan of Care Summary, Interventions?



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. | 2. Start Of Care Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth | 9. Sex M F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM Principal Diagnosis | Date

12. ICD-9-CM Surgical Procedure | Date

13. ICD-9-CM Other Pertinent Diagnoses | Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

18.B. Activities Permitted

19. Mental Status: 1 Oriented 2 Confused 3 Forgetful 4 Depressed 5 Disoriented 6 Lethargic 7 Agitated 8 Other

20. Prognosis: 1 Poor 2 Guarded 3 Fair 4 Good 5 Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received Signed POT

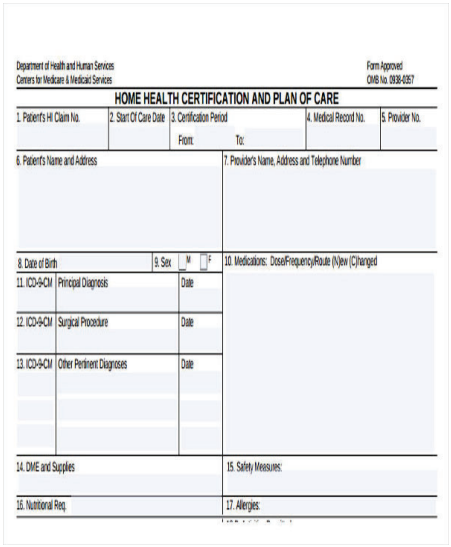
24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)



Department of Health and Human Services
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12. ICD-9-CM Surgical Procedure | Date

13. ICD-9-CM Other Pertinent Diagnoses | Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

Plan of Care

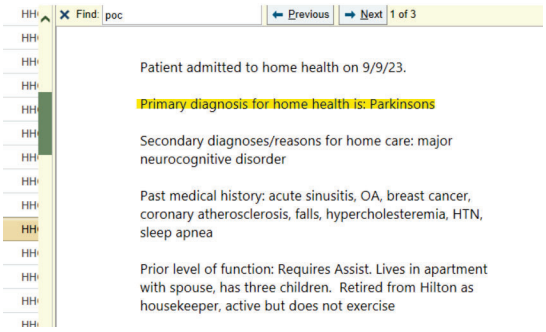
The plan of care may look slightly different in the various home health electronic health records that are used by different home health agencies. It is important to read the interventions in field 21, understand the care that is being provided, the medications that are prescribed, the services being provided. It will be identified as Plan of Care, POC, or even as the 485.

Note Details:*

IS AN 89-YEAR-OLD FEMALE REFERRED TO PHYSICAL THERAPY WITH PRIMARY OSTEOARTHRITIS OF THE KNEE AS THE PRIMARY FOCUS OF CARE PATIENT LIVES IN A SINGLE STORY APARTMENT IN SENIOR LIVING BUILDING WITH ELEVATOR ACCESS WITH HER HUSBAND PATIENT HAS A CAREGIVER THAT COMES 4 HOURS A DAY 5 DAYS A WEEK HER HUSBAND ALSO NEEDS ASSISTANCE ... FOR WHICH THE PATIENT CARE FOR PATIENT USES A CANE TO WALK IN HER APARTMENT AND USES A 2 WHEELED WALKER AMBULATE TO THE DINING ROOM FOR THE GAME ROOM UPON ASSESSMENT PATIENT DEMONSTRATES POOR STANDING BALANCE UPON STANDING ... WEAKNESS IN BILATERAL LOWER EXTREMITY AND DECREASED ACTIVITY TOLERANCE MEDICATION RECONCILIATION WAS PERFORMED AND NO ISSUES WERE FOUND THE DOCTOR WAS INFORMED OF ALL MEDICATION INTERACTIONS AND THE PATIENT WAS EDUCATED ON THE SAME ... PATIENT IS CURRENTLY HOMEBOUND AS SHE NEEDS ASSISTANCE TO LEAVE HER SENIOR LIVING REALLY ARE AND REQUIRES SUPERVISION FOR AMBULATION DUE TO POOR BALANCE I RECOMMEND SKILLED THERAPY TO ADDRESS HER IMPAIRMENTS AND RETURN PATIENT TO PRIOR LEVEL OF FUNCTION

Plan of Care Summary

The Plan of Care Summary, or Narrative Note, Narrative Summary, Clinical Note can also appear in different formats. It is a note that will summarize the clinician's findings after the comprehensive assessment is completed and it should clearly identify the Primary focus of care or Primary diagnosis for home health. Read the narrative note, look for terms, phrases, and interventions that will support the identified primary diagnosis as the chief reason that home health services are being provided.



Document Examples

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Presented By

- **Apryl Swafford, RN, BSN, COS-C, HCS-D, HCS-H**, is QA manager with SimiTree Healthcare Consulting. She has more than 20 years of experience in home health. She began her nursing career in 1994 with a BSN from Jacksonville State University in Alabama and has worked as a case manager, clinical manager, and leader of a cardiopulmonary specialty program. Swafford is a certified OASIS specialist (COS-C) as well as having coding certifications in both home health and hospice (HCS-D, HCS-H). She has led multiple coding and OASIS classes for agencies, as well as speaking on topics of interest to home care and hospice agencies, such as OASIS-E, home health regulations, PDGM, outcomes management, and others, at many state associations. As QA manager for SimiTree, Swafford monitors the overall quality of coding, OASIS, and plan of care reviews completed by both full-time and contract auditors. She works in conjunction with the QA specialists and education department to identify topics of education to address any trending issues noted in QA reviews. She also assists with onboarding new auditors as needed and assists team managers with completing coding and OASIS reviews when volumes increase.

Exploring Document Types

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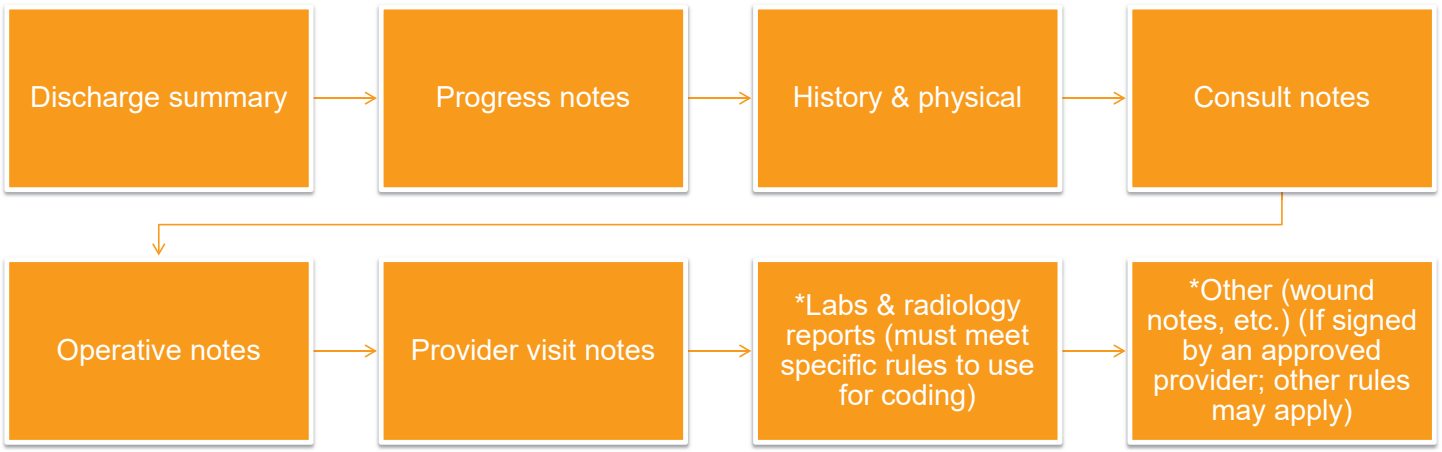
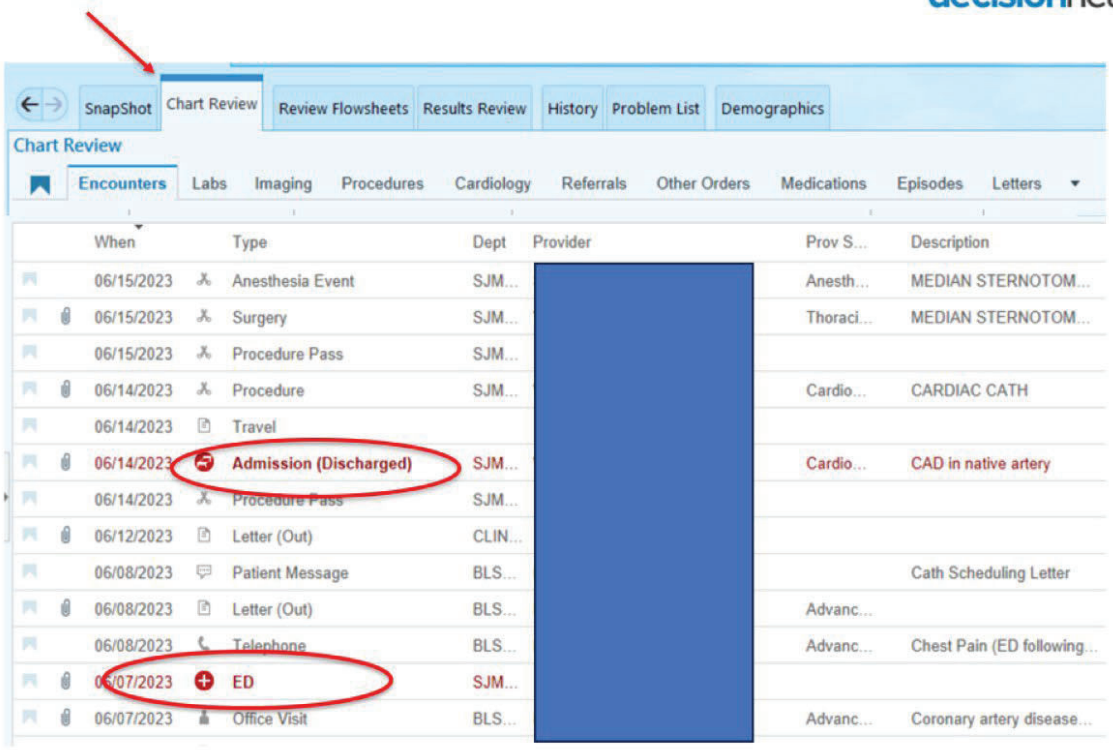
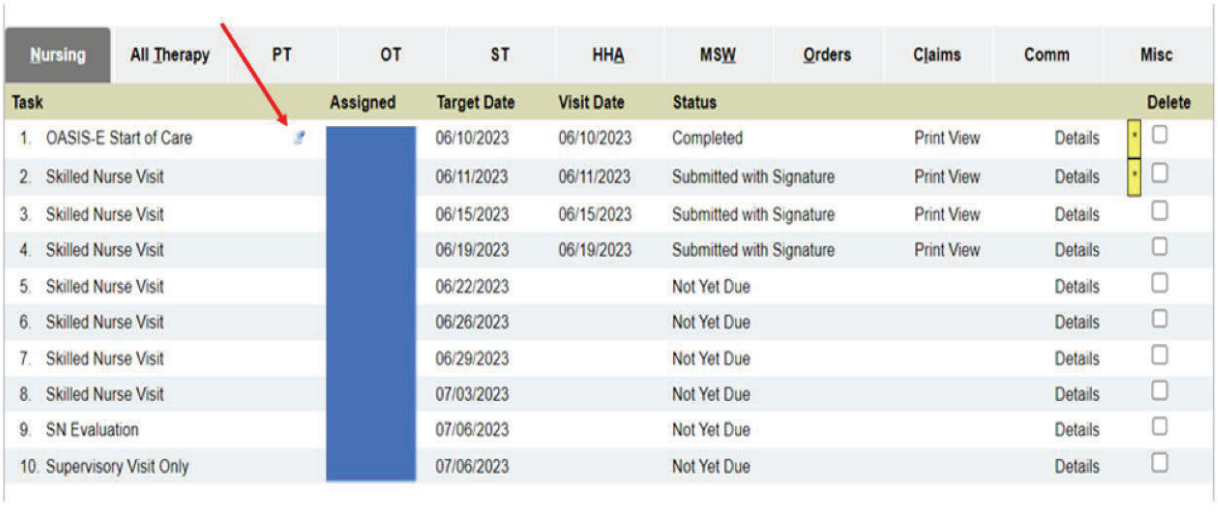
Examples of Documents That can be Used for Coding



Locating the Documents



Locating the Documents



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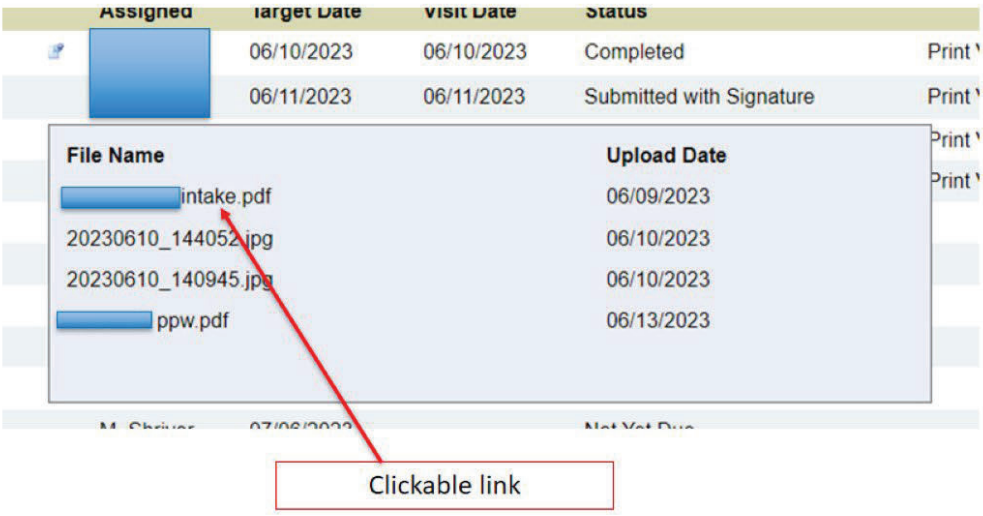
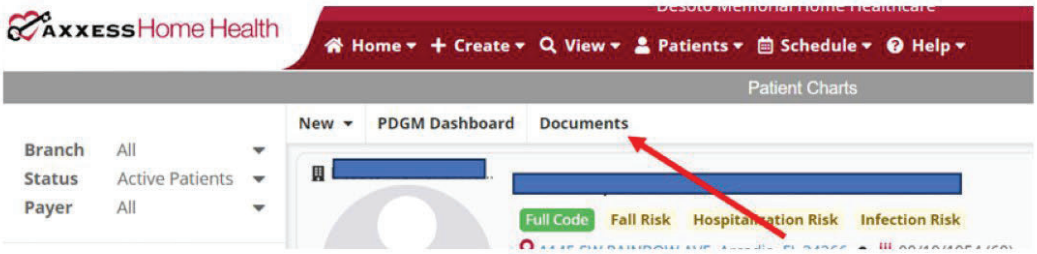
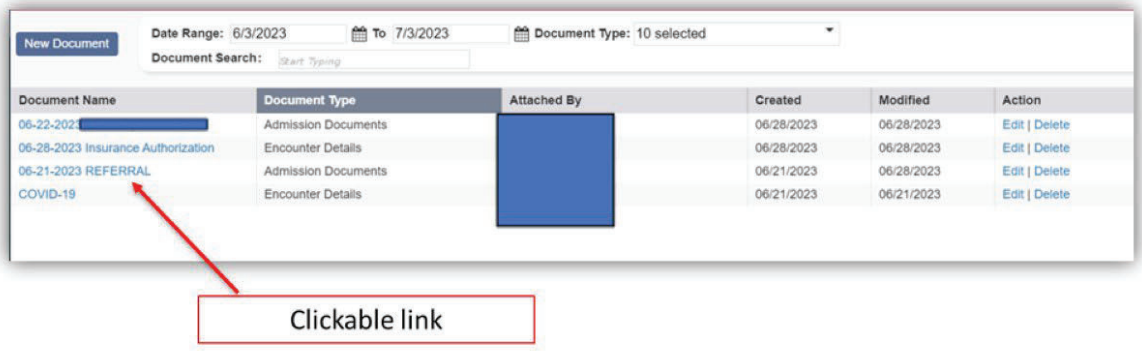


Locating the Documents





Examples of Appropriate Documentation

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Example

HOSPITAL DISCHARGE SUMMARY

Primary Care Physician: [redacted]

Admitting Physician: [redacted]

Admit date: 6/14/2023

Surgical date: 6/15/2023

Discharge Date: 6/17/2023

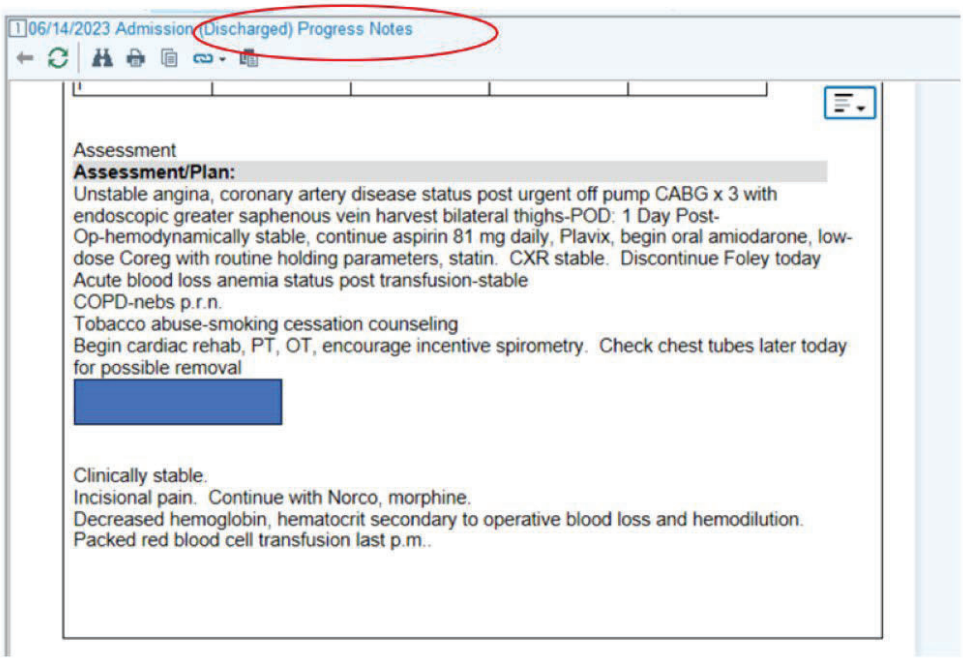
Discharge Diagnoses: Unstable angina. Coronary occlusive disease

Surgical Procedure(s): Coronary artery bypass grafting x3. LIMA to LAD. Vein to distal right coronary artery. Vein to the obtuse marginal artery.

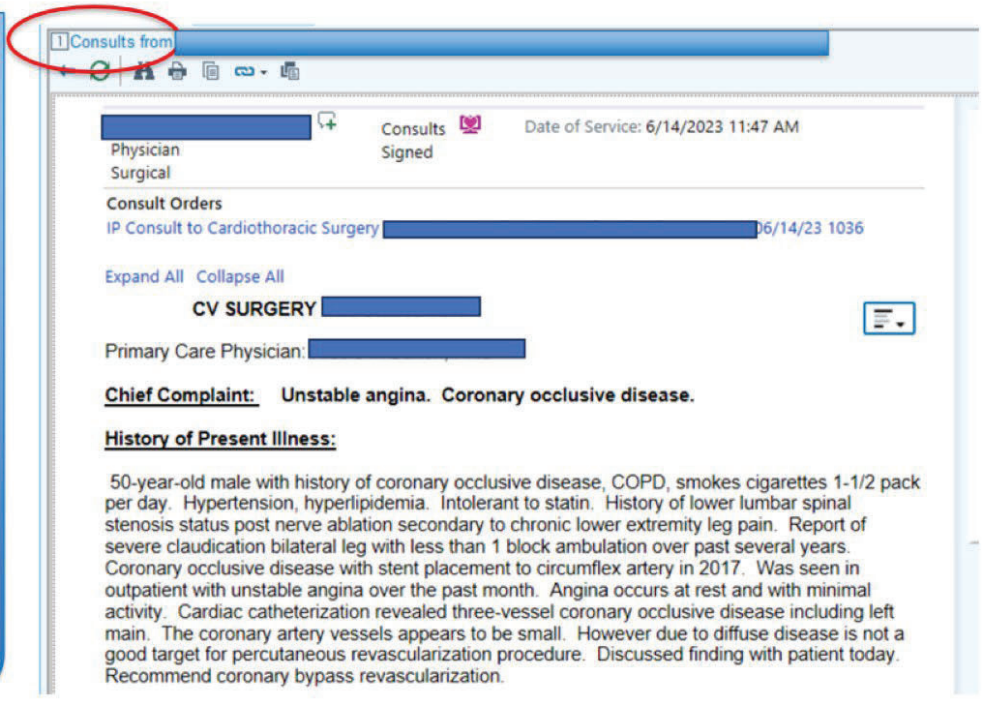
Summary of History and Hospital Course: 50 y.o. admitted for unstable angina. Coronary occlusive disease. Underwent Procedure as above on 6/15/2023
Post operative course have been unremarkable.
Recovering well. Ambulating well. Tolerating PO well. Hemodynamically stable.
Incisions healing well.
No chest pain. Mild shortness of breath, chronic from COPD.

Allergic to statin medication past with severe muscle aches and pain. Unable to tolerate. Thus patient discontinue statin medication in past.

Example



Example



Example

06/07/2023 Office Visit [redacted]

[redacted] (Advanced Practice Nurse) • Advanced Practice Nurse • Creation Time: 6/7/2023 2:53 PM • Signed

Expand All Collapse All

Assessment/Plan:
Primary Care Physician: [redacted]

1. Unstable angina- Patient with complaints of exertional chest discomfort over the last month that is worsening and lasting longer. He is having significant Activity intolerance. He has associated shortness of breath. The pain goes into his neck and settles into his bilateral arms. He has to stop what he is doing for extended period of time 5-15 minutes before the pain goes away. EKG in clinic today shows no significant changes.
2. CAD- Cardiac catheterization February of 2017 with a patent mid left circumflex stent with 40-50% stenosis after the stent, mid 40% stenosis of RCA. Currently on aspirin 81 mg, rosuvastatin 40 mg.
3. Hypertension- Blood pressure is controlled at 120/68. On Coreg 3.125 mg b.i.d..
4. Dyslipidemia- Most recent LDL of 184 in May 2023. Not taking his rosuvastatin 40 mg due to muscle aches. Stopped it about 6 months ago.
5. Current smoker - 1- 1.5 packs per day.
6. History of patent foramen ovale
7. COPD

Plan
- Emergency room for further evaluation of unstable angina.

Example

Operative Reports

DOCUMENT NAME: Operative Reports
SERVICE DATE/TIME: 6/19/2023 16:17 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted]
SIGN INFORMATION:

Indication for Surgery
Left knee pain

Preoperative Diagnosis
Left knee osteoarthritis

Postoperative Diagnosis
Left knee osteoarthritis

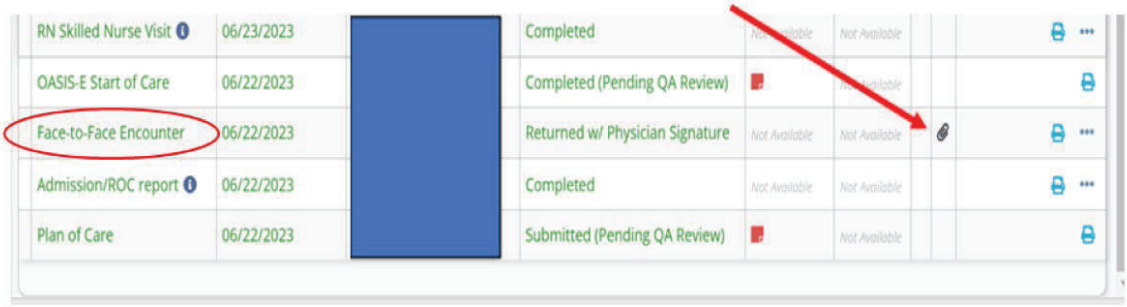
Operation
Left total knee arthroplasty

Surgeon(s)
[redacted]

Assistant
[redacted], necessary for patient positioning, safe retractor and instrument placement, and overall surgical efficacy. No Interns, residents or fellows are available for assist.

Would also need a pre-operative note to accompany the operative note for a valid F2F, especially in RCD states.

Example



RN Skilled Nurse Visit	06/23/2023	[redacted]	Completed	Not Available	Not Available	
OASIS-E Start of Care	06/22/2023		Completed (Pending QA Review)		Not Available	
Face-to-Face Encounter	06/22/2023		Returned w/ Physician Signature	Not Available	Not Available	
Admission/ROC report	06/22/2023		Completed	Not Available	Not Available	
Plan of Care	06/22/2023		Submitted (Pending QA Review)		Not Available	

Example

[redacted] Community Hospital Health System
Medical Records Department

[redacted]

H&P Exam - Hospitalist
06/07/23 2010

F2F

MR#: [redacted]
Name:
DOB:
PCP:

Acct: [redacted]
Rep #:
From:
Status: ADM IN

Location: ICU [redacted]

HPI - General

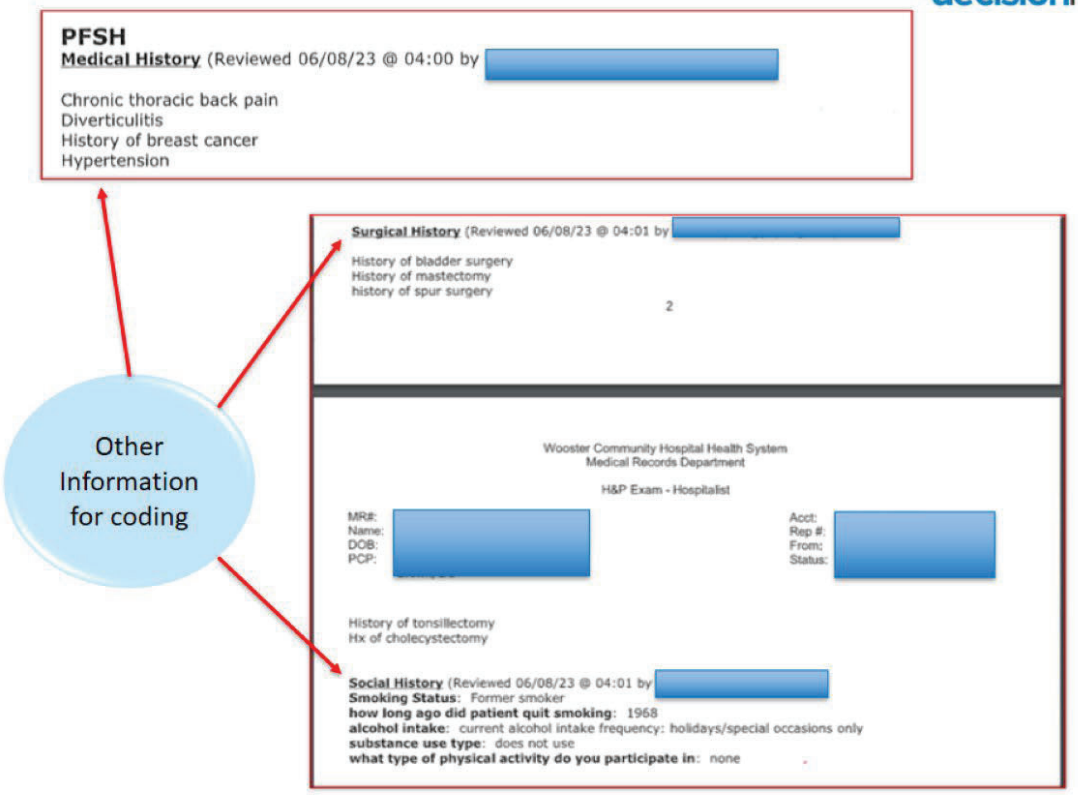
General

Date of Admission: 06/07/23
Date of Service: 06/07/23
Chief Complaint: Hyperglycemia

HPI Narrative

[redacted] is a 79 F with a significant history of short-term memory loss; hard of hearing; chronic back pain secondary to elastofibromas; and chronic urinary urgency and retention (reports her colon lies on top of her bladder) who reports emergency department with hyperglycemia. Also patient complains of dry mouth. Because of patient's symptoms above she went to see her PCP. Lab work initiated by PCP returned with blood glucose in the 800s so patient was sent to the hospital. Patient reports that her hydration habits has no change and she think that she does not drink enough. Her symptoms of dry mouth started about 3 months ago yet and her hydration habits has not changed.
She reports urinary urgency with inability to completely empty her bladder that has also not changed.
She reports fatigue.

Example



Other Areas to Find Information for Coding

Check the following areas for additional information that could impact coding

Medication profile	While you cannot code from the med profile, you will find meds that should be coded to long term use.
Orders	May contain confirmation of diagnosis, specificity or additional information
Communication notes	Again, may not code from this area but could contain information about clarification on diagnosis, wound etiologies, etc.
Miscellaneous & Other areas	EMRs will vary on where other information is located that may be helpful for coding.
Notes & Media tab <Epic specific>	May find interval progress notes, wound photos, etc.

Problem List can be a Problem!

Use caution with diagnosis lists if not supported by provider documentation.

Check your agency policy in regard to the use of various problem or diagnosis lists utilized by your EMR

Visit Diagnoses

- Coronary artery disease involving native coronary artery of native heart without angina pectoris
- Pulmonary emphysema, unspecified emphysema type (HCC)
- Chest pain, unspecified type
- PFO (patent foramen ovale)

Problem List

Hospital Problem List

- History of pulmonary embolism
- Paroxysmal atrial fibrillation (HCC)
- Subtherapeutic international normalized ratio (INR)
- OSA on CPAP
- COPD (chronic obstructive pulmonary disease) (HCC)
- Mixed hyperlipidemia
- Lupus anticoagulant syndrome (HCC)
- Symptomatic bradycardia
- Temporary transvenous cardiac pacemaker present
- Acute respiratory failure with hypoxia (HCC)
- Acute kidney injury (HCC)

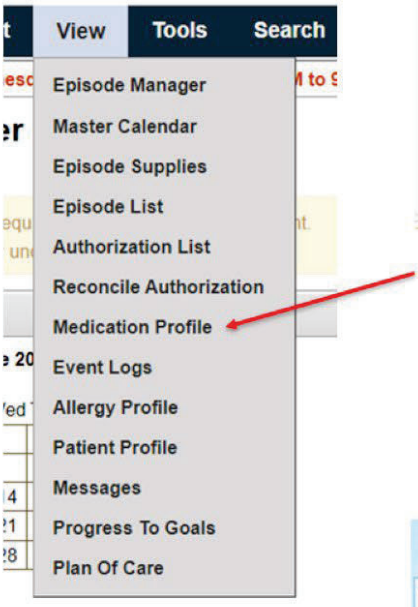
Problem List
As of 6/7/2023 2:29 PM

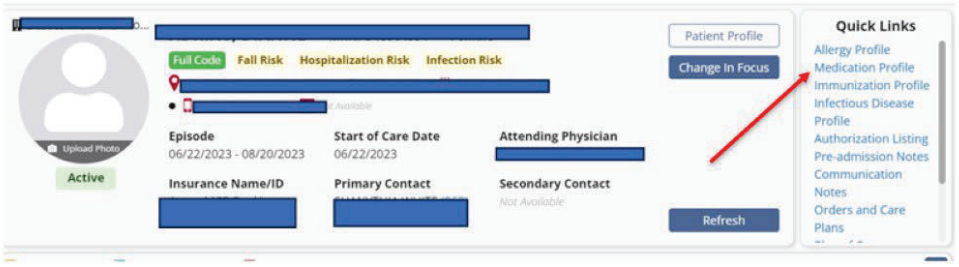
Cardiovascular
- Hyperlipidemia
- Coronary artery disease involving native coronary artery of native heart without angina pectoris
- PFO (patent foramen ovale)

Respiratory
- COPD (chronic obstructive pulmonary disease) (HCC)

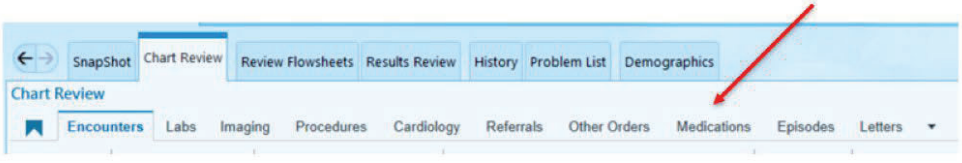
Musculoskeletal
- Spondylolisthesis of lumbosacral region
- Lumbar stenosis with neurogenic claudication

Risks and Care Concerns
- Insomnia
- S/P Decompression And Fusion Lumbar 5 To Sacral 1
- Nicotine dependence, cigarettes, uncomplicated
- RLS (restless legs syndrome)





Medication Profile



What is NOT a F2F

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Example

While there are diagnosis listed on here, this is a home care referral. Cannot be used as a F2F.

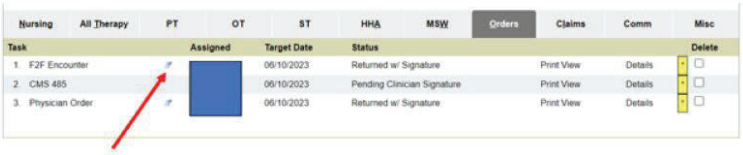
Reason for Referral

Home Health Evaluation (Routine) - New Request

Specialty	Diagnoses / Procedures	Referred By Contact	Referred To Contact
Home Health	Diagnoses Nonischemic cardiomyopathy (*) NSTEMI (non-ST elevated myocardial infarction) (*) Physical deconditioning Tachycardia	[redacted]	[redacted]

Referral ID	Status	Reason	Start Date	Expiration Date	Visits Requested	Visits Authorized
10061374	New Request	Specialty Services Required	6/7/2023	6/6/2024	12	12

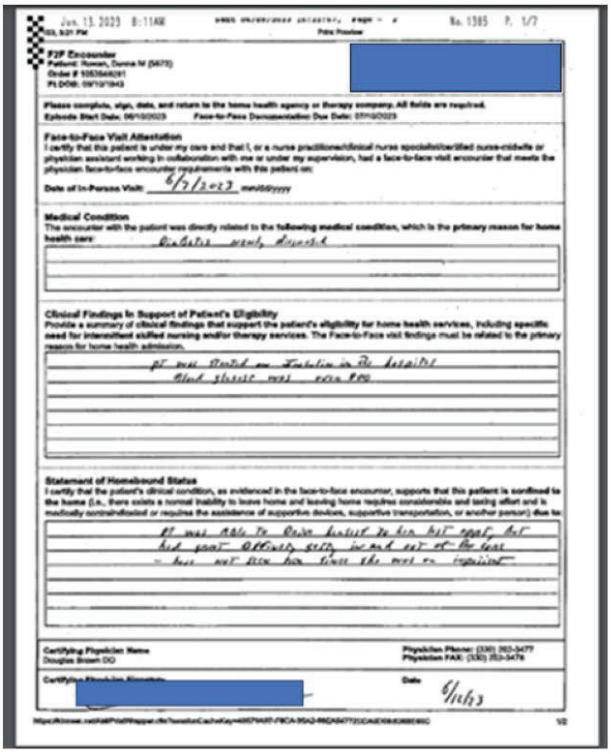
Question	Answer
Physician to Follow Patient's Care:	[redacted]
Requested Start of Care Date:	6/7/2023
Category for referral: Select all that apply	Other
Disciplines Requested: Select all that apply	Physical Therapy, Skilled Nursing
Physical Therapy Services: Select all that apply	Eval & Treat
Skilled Nursing Services: Select all that apply	Disease Management, Medication Management
Reason for referral:	recent hospitalization, oxygen dependent, falls risk, needs PT



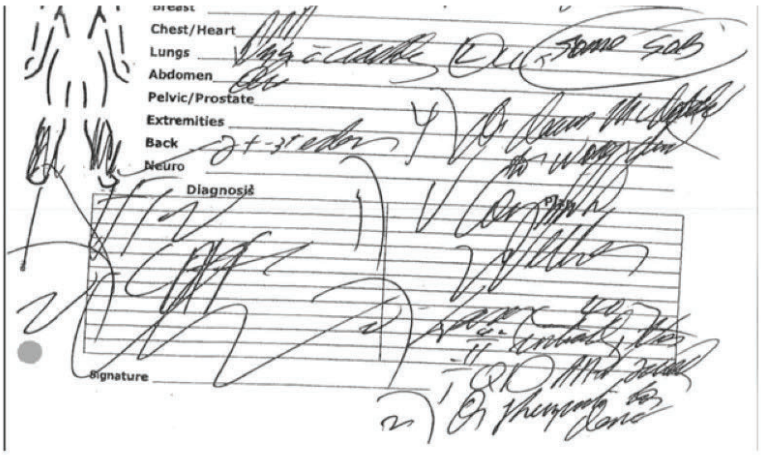
Example

The chart may indicate a F2F has been uploaded, however, it may not always be a document that meets the criteria for a F2F.

This is an old F2F "form" that was used prior to 2015. It is no longer required and cannot stand as a valid F2F per CMS guidelines.



Example



If it's not legible, it's not a valid F2F.

Questions & Answers

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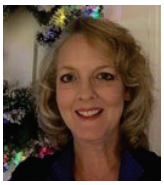
Claudia Baker, RN, MHA, HCS-D, HCS-O
Senior Manager
SimiTree Healthcare Consulting



Elise Christensen, RN, HCS-D, COS-C
Coding Manager
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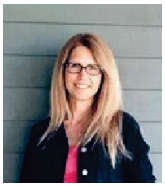
Kelly Kavanaugh, RN, HCS-D, HCS-H, HCS-O, BCHH-C
Quality Assurance Specialist
Riverside Home Health and Hospice

Nanette Minton, RN, HCS-D, HCS-H, HCS-O
Senior Clinical Coding Manager
MAC Legacy

Apryl Swafford RN, BSN, COS-C, HCS-D, HCS-H
QA Manager
SimiTree Healthcare Consulting



Pamela Wandrie, M.A.CCC-SLP, HCS-D, HCS-O
Coding and OASIS QA Specialist
SimiTree Healthcare Consulting

To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your "Enter" key.

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Thank you for attending!

Continuing education credits are available for this program.

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http://events.hcpro.com/materialspub.cgi?YHODA110623A

We kindly request that this link be forwarded to everyone in your group who attended the program.

This concludes today's program.

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