Speaker Information

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AHIMA Approved ICD-10 CM/PCS Trainer

Pam routinely leads and/or participates in Coding Compliance Reviews. She has served as a Financial Data Manager, participated in Quality and Performance Improvement programs, and has expertise in all types of inpatient and outpatient coding activities. Pam also is experienced in Tumor, Myocardial Infarction, and Head and Spinal Cord Injury Registries. Ms. Scott has experience with alternative care facilities such as SNFs, dialysis centers, and long term hospitals, has provided on-site and off-site one-on-one training/oversight for new coders, and assists clients with inpatient and outpatient coding support.

Ms. Scott obtained her RHIT in 1990, has coursework in business, accounting, management training and nursing. She is a member of AHIMA, MoHIMA, and EMoHIMA. She has spoken nationally on a variety of coding related topics.
Agenda

• PDPM
• Denials come from lack of sufficient/specific documentation, Medical necessity edits and unspecified codes
• Documentation requirements for coding
• How to use the code book
• Coding Guidelines
• Specificity/Medical Necessity
• Selection of the Principal diagnosis
• Querying
• Practice Examples
• October 1\textsuperscript{st}, 2019
• Instead of RUGs, patient will be mapped into 5 case-mix adjusted components:
• CMS maps and tools: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html)
Why did they keep ICD-10 codes?

• Many comments on proposed rule asking for checkboxes but:

“Given the use of ICD-10 diagnosis coding in other Medicare payment systems and given efforts to align payment across multiple postacute care payment systems, we believe that using the actual diagnosis code, rather than a checkbox for a category, will provide greater consistency between payment systems and would provide a smoother transition to the extent such payment systems are aligned further in the future.”
We did get one checkbox!

- PCS coding
  - New checkboxes under section J2000 to help capture procedures

**J2000: Prior Surgery**

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Did the resident have major surgery during the 100 days prior to admission?</th>
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<tbody>
<tr>
<td>0.</td>
<td>No</td>
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<tr>
<td>1.</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
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**Item Rationale**

**Health-related Quality of Life**
- A recent history of major surgery during the 100 days prior to admission can affect a resident’s recovery.

**Planning for Care**
- This item identifies whether the resident has had major surgery during the 100 days prior to admission. A recent history of major surgery can affect a resident’s recovery.
### PDPM – Non-Therapy Ancillary Comorbidities Included in NTA Comorbidity Score

<table>
<thead>
<tr>
<th>Condition/Extensive Service</th>
<th>MDS Item</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Lung Transplant Status</td>
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<tr>
<td>Major Organ Transplant Status, Except Lung</td>
<td>I8000</td>
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</tr>
<tr>
<td>Opportunistic Infections</td>
<td>I8000</td>
<td>2</td>
</tr>
<tr>
<td>Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone</td>
<td>I8000</td>
<td>2</td>
</tr>
<tr>
<td>Chronic Myeloid Leukemia</td>
<td>I8000</td>
<td>2</td>
</tr>
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<td>Endocarditis</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Immune Disorders</td>
<td>I8000</td>
<td>1</td>
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<td>End-Stage Liver Disease</td>
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<tr>
<td>Narcolepsy and Cataplexy</td>
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<td>1</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Specified Hereditary Metabolic/Immune Disorders</td>
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<tr>
<td>Morbid Obesity</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Psoriatic Arthropathy and Systemic Sclerosis</td>
<td>I8000</td>
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<tr>
<td>Condition/Extensive Service</td>
<td>MDS Item</td>
<td>Points</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<td>Chronic Pancreatitis</td>
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<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
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<tr>
<td>Complications of Specified Implanted Device or Graft</td>
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<tr>
<td>Inflammatory Bowel Disease</td>
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<tr>
<td>Aseptic Necrosis of Bone</td>
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<tr>
<td>Cardio-Respiratory Failure and Shock</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Myelodysplastic Syndromes and Myelofibrosis</td>
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<td>Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies</td>
<td>I8000</td>
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<td>Severe Skin Burn or Condition</td>
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<td>Intractable Epilepsy</td>
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<td>1</td>
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<tr>
<td>Disorders of Immunity - Except : RxCC97: Immune Disorders</td>
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<td>Cirrhosis of Liver</td>
<td>I8000</td>
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<tr>
<td>Respiratory Arrest</td>
<td>I8000</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary Fibrosis and Other Chronic Lung Disorders</td>
<td>I8000</td>
<td>1</td>
</tr>
</tbody>
</table>
SNF PDPM Clinical Category Mapping

• Go to: CMS maps and tools: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
• Download “SNF PDPM Clinical Category Mapping”
• Download “SNF PDPM: NTA Comorbidity Mapping”
• Download “SNF PDPM Grouper Tool”
“Return to Provider”

- There are 24,114 ICD-10 CM codes (37%) that will map to the category “return to provider” under PDPM
  - Non-applicable to SNF
  - Unspecified
  - Wrong extension
Unspecified Codes and Denials

• Top problematic unspecified codes:
  • Z51.89 (Encounter for other specified aftercare)-What are you using this for? Should be specific to the body system. For example: Aftercare following surgery on circulatory, respiratory, digestive, musculoskeletal system.
    • ***Return to provider***
  • Z51.5 (Encounter for palliative care) to be used only for hospice care. May be the principal diagnosis but can be secondary to a medical diagnosis such as end stage cancer.
  • M62.81 (Muscle weakness, generalized)
    • ***return to provider***
  • R53.1 (weakness)
    • ***return to provider***
Unspecified Codes and Denials

• Top problematic unspecified codes:
  • I69.90 (Unspecified sequelae of unspecified cerebrovascular disease) as there should be documentation of any sequela of a CVA, aphasia, dysphagia, weakness/hemiplegia
  • E11.9 (Type 2 diabetes mellitus without complications) which may be correct UNLESS there are complications associated/due to Diabetes.
Unspecified Codes and Denials

• Top problematic unspecified codes:
  • I48.91 (Unspecified atrial fibrillation). The documentation may state, chronic, persistent, permanent or paroxysmal.
  • F32.9 (Major depressive disorder, single episode, unspecified). Look for documentation of mild, moderate, severe, severe with psychotic symptoms.
  • R52 (Pain, unspecified). Look for documentation of a specific site and type (acute, chronic)
    • ***return to provider***
Other Problematic Coding

• Aftercare from surgery
• Aftercare following a joint replacement versus post op injury coding with subsequent episode of care.
• Diabetes
• Hypertension
  • With Chronic Kidney Disease
  • With CHF
  • With CKD and CHF
• Weakness versus muscle weakness and documentation issues
What documentation can we use to assign a code?

- Who can document?
  - Physician
  - Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist under physician supervision

- Medical Record Sources for Documentation
  - H & P
  - Transfer documents (The codes on there may be incorrect for your setting) 7th character A versus 7th character D.
  - Discharge Summary
  - Diagnosis/Problem List (use only diagnoses confirmed by the physician)
What documentation can we use to assign a code?

• Progress Notes (Authorized providers)
• Therapy notes **if signed by MD. If not signed, may not code from this documentation**
• Cannot code from the drug list unless the drug list identifies the diagnosis that the drug is treating.
Principal Diagnosis

- For residents who continue to stay in LTC facilities, the condition requiring the resident to stay should be sequenced first.
- Current LTC residents who transfer to the hospital to receive treatment for acute conditions (i.e. pneumonia) and return to the facility for further care of their chronic condition (i.e. COPD) may continue to receive care for the acute condition if unresolved.
- The Principal Diagnosis is the reason for the continued stay (COPD) in the LTC facility.
Active Diagnoses

• **Active diagnosis** – Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look-back period.

• Only diagnoses confirmed by the physician should be entered.

• Do not include conditions that have been resolved, do not affect the resident’s current status or do not drive the resident’s plan of care during the 7-day outlook period.
Active Diagnoses

• Any acute condition treated at the hospital that continues to require follow up or ongoing monitoring should be coded with an acute diagnosis code as long as the condition persists and requires follow up.

• Listing a disease/diagnosis on the problem list is not sufficient for determining active or inactive status.

• The status of the acute condition should be assessed whenever the MDS is updated.

• Z codes may be used to identify history of acute conditions, if applicable.
Navigating the Code Book
If there are CMS mapping tools, why do I need to know all of this?

• CMS mandates it
• CMS refused to “assign a low priority” to MACs, RACs, other auditors to review SNF ICD-10 coding
• Final rule comments from CMS indicated they specifically chose ICD-10 to “provide greater consistency between payment systems and would provide a smoother transition to the extent such payment systems are aligned further in the future”
  • ICD-10 is the common denominator
Navigating the Code Book

• The structure of the code book is:
  • Coding Conventions
  • General Coding Guidelines
  • Chapter Specific Coding Guidelines
  • Alphabetic Index
  • Neoplasm Table
  • Table of Drugs and Chemicals
  • External Cause Index
  • Tabular A-Z
Coding Conventions
Episode of Care

Many codes require a 7th character for the “Episode of Care”. The episodes of care may be:

A-Initial episode of care: When the patient is receiving active treatment for a condition
  • Includes ER encounter, surgical treatment, evaluation and treatment by a new physician
  • Includes patients that have delayed treatment for a fracture or non-union.

D-Subsequent episode of care: Completed active treatment and is in the healing phase

S-Sequela episode of care: All treatment and healing has been completed, however, a condition exists due to the original condition
Practice-7th Character, Placeholder and Episode of Care

• 8 year old male presents to the ER with a dog bite to the right forearm.

• Bite, dog, initial W54.0

• Note that W54.0 requires a 7th character to show the “episode of care”.

• Correct answer is W54.0XXA
CODERS: Coding Conventions that will remain the same as ICD-9

- NEC
- NOS
- [BRACKETS]
- AND/OR
- OTHER
- UNSPECIFIED
- INCLUDES
- WITH

- SEE/SEE ALSO
- CODE FIRST
- USE ADDITIONAL CODE
- CODE ALSO
- DEFAULT CODES
- SYNDROMES
- IN DISEASES CLASSIFIED ELSEWHERE
Excludes 1 and 2 Notes

• Excludes 1 and Excludes 2 notes – New in ICD-10:
  • 1. **EXCLUDES 1**...Not coded here...**code elsewhere**.
  • 2. **EXCLUDES 2**... “Not included here”.

• An excludes 2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.

• When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.
Excludes 1

• Excludes 1-do not code here, code elsewhere:
  • K57.-Diverticulum of intestine has an Excludes 1 note of “Meckel’s diverticulum”.
  • If the diagnosis is “Meckel’s diverticulum, the instructional Excludes 1 note tells the coder not to code from category K57. Instead go to category Q43.0.
Excludes 2

• Excludes 2—**may code together**:
  • K57.XX-Diverticulum of intestine has an Excludes 2 note of “diverticulum of appendix”.
  • If the patient has a “diverticulum of the appendix”, the instructional Excludes 2 note tells the coder that a code from category K57 **may be coded with** K38.2 “diverticulum of appendix”.
General Coding Guidelines
Signs and Symptoms

• Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

• Chapter 18 - Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99)
  • Contains many, but not all codes for symptoms.
Integral Conditions

• Conditions that are an integral part of a disease process
  • Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

• Conditions that are not an integral part of a disease process
  • Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
Acute and Chronic Conditions

• If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.
Combination Code

• A combination code is a single code used to classify:
  • Two diagnoses, or
  • A diagnosis with an associated secondary process (manifestation)
  • A diagnosis with an associated complication
• Are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.
Sequela (AKA-Late Effects)

- Coding of sequelae generally requires two codes sequenced in the following order:
  - The condition or nature of the sequela (the symptom) is sequenced first.
  - The sequela code (what caused the sequela) is sequenced second.
Example of Sequela

• The patient has a scar of the left elbow from an accidental 3rd degree burn that occurred 5 years ago

• L90.5-Scar, see cicatrix, skin
• T22.322S-Burn, elbow, left, third degree, sequela
Example

• Old CVA with aphasia (manifestation included in the code)
• Choices are:
  • I69.020-Aphasia following non-traumatic subarachnoid hemorrhage
  • I69.120-Aphasia following non-traumatic intra-cerebral hemorrhage
  • I69.220-Aphasia following other non-traumatic intracranial hemorrhage
  • I69.320-Aphasia following cerebral infarction
  • I69.820-Aphasia following other cerebro-vascular disease
  • I69.920-Aphasia following unspecified cerebro-vascular disease
Use Codes of Sign/Symptom/Unspecified

• If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

• When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).
Use Codes of Sign/Symptom/Unspecified

• Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter.

• It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

• However, payers (including Medicare) are not paying for unspecified codes. In order to combat this issue, physician documentation must be addressed.
Selection of the Principal Diagnosis-Inpatient
Chapter-Specific Coding Guidelines

There is specific coding guidance that applies to several areas that impact LTC, including:

- Sepsis coding
- UTI and organism (infections require organism when available)
- HTN coding
- MI coding
- CVA coding
- Diabetes coding
- Wounds (need to determine cause)
- Fractures (7th digit for encounter, traumatic, pathological)
- COPD and Asthma coding
- CAD
Sequencing

• The sequencing of the principal diagnosis is important.

• The definition of the principal diagnosis is:
  • Principal diagnosis is defined as the condition, after study, which occasioned the admission to the hospital (Facility)
  • What diagnosis was the reason for the admission?
What can we code?

• When coding you can only code what the documentation supports and may not assume any diagnosis from lab results. Coding is literal to the documentation and diagnoses may not be added without the documentation from a qualified provider.

Example:

• E-coli lab result in urine is NOT a UTI to a coder. The documentation must say that the patient has a UTI in order to code it.

• “Infection” to a coder is not specified, What is infected and what is the medical term for that infection.
  • Infection of lower leg
    • Is that cellulitis, traumatic wound infection, post op wound infection, infected ulcer, etc.
Selection of the Principal Diagnosis-Inpatient

- The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
- In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines.
- This applies to acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.
When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

If the condition for which the rehabilitation service is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.
Aftercare

- Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease.
- The aftercare codes are generally first-listed to explain the specific reason for the encounter.
- The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases.
Reporting Additional Diagnoses

- GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES
- For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.
Reporting Additional Diagnoses

• The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission
  • That develop subsequently
  • That affect the treatment received
  • Affect the length of stay”
• Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.
• UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting.
Previous Conditions

• If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded.
• Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay.
• Such conditions are not to be reported and are coded only if required by hospital policy.
• History codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
Querying
Querying

- Queries
  - Written
  - Verbal
  - Strict rules for writing a query
    - Must cite the documentation already there
    - Cannot add a new diagnosis that has not already been documented
    - Must give the provider multiple choices
    - Cannot ask a leading question or ask a question to get a particular answer
Written Queries

- If written
  - Site the documentation you wish to clarify
    - 5/3 progress note indicates Pneumonia
  - Ask the question in a non-leading manner
  - Please clarify the type of pneumonia
    - Aspiration
    - Bacterial-Specify organism if known
    - Lobar
    - Viral
    - Other/Specify
    - Undetermined
Practice
Practice

• Patient is admitted to Rehab with a traumatic right femoral neck fracture. It was repaired with ORIF in acute care.

• What is the principal diagnosis?
Answer

• S72.001D-Fx unspecified part of neck of right femur, subsequent for clos fx w routine healing
Practice

- Patient is admitted to Rehab with a traumatic right femoral neck fracture. It was repaired with a hip replacement in acute care.

- What is the principal diagnosis?
Answer

• Z47.1-Aftercare following joint replacement surgery
• Z96.641-Presence of right artificial hip joint
Practice

• The patient is admitted from acute care where the patient had sepsis due to aspiration pneumonia and acute pyelonephritis. IV antibiotics will be continued until completed.

• What are the code in the correct sequence?
Answer

• J69.0-Pneumonitis due to inhalation of food and vomit
• N10-Acute pyelonephritis

• No code for sepsis as the sepsis is resolved but the pneumonia and pyelonephritis are still being treated to complete the IV antibiotics.
Practice

• The resident is admitted to REHAB with left hemiplegia, expressive aphasia and has a G-tube for oropharyngeal dysphagia all due to a cerebral infarct. He has paroxysmal a-fib, and hypertension.
Answer

- I69.354-Hemiplegia, following cerebral infarct
- I69.320-Aphasia, following cerebral infarct
- I69.391-Dysphagia, following cerebral infarct
- R13.12-Dysphagia, oropharyngeal phase
- I48.0-Fibrillation, atrial, paroxysmal
- I10-Hypertension
- Z43.1-Attention to Gastrostomy
Practice

- A resident is admitted to SNF for wound care for a healing stage 3 right hip decubitus ulcer. The patient has a pacemaker. He has early onset Alzheimer’s dementia without behavioral disturbances. He has COPD/asthma, neurogenic bladder, urinary incontinence, chronic A-fib, depression and anxiety.
Answer

- L89.213-Ulcer, pressure, hip, right, stage 3
- G30.0 and F02.80-Early onset Alzheimer’s dementia
- N31.9-Neurogenic bladder
- R32.-Incontinence, urinary
- I48.2-Chronic A-Fib
- J44.9-COPD
- No code-Asthma
- F32.9-Depression
- F41.9-Anxiety
- Z95.0-Pacemaker
Practice

- The patient is a 55 year old right handed female admitted to REHAB following a CABG in acute care for her CAD. She is having no anginal symptoms. The patient is a cigarette smoker. She has diabetes, hypertension, Graves’ disease, left sided weakness from an old intracranial hemorrhage,
Answer

- Z48.812-Aftercare, following surgery on, circulatory system.
- Z95.1-Status, aortocoronary bypass
- I25.10-Disease, arteriosclerotic, cardiovascular
- F17.210-Smoker, See dependence, drug, nicotine, cigarette, uncomplicated
- E11.9-Diabetes
- I10-Hypertension
- E05.00-Graves’disease, see hyperthyroidism, with goiter
- I69.254-Hemiplegia, following Cerebrovascular disease, non-traumatic intracranial hemorrhage, non-dominant side
Practice

• The patient is admitted with pneumonia, COPD exacerbation, chronic systolic and diastolic CHF. Also being treated is cellulitis of the left groin, resolving oral thrush and rheumatoid arthritis. There is a history of bilateral knee replacements.
Answer

• J18.9-Pneumonia
• J44.1-COPD in exacerbation
• J44.0-COPD with lower respiratory tract infection
• I50.42-Failure, heart, diastolic, combined with systolic, chronic
• L03.314-Cellulitis, groin
• B37.0-Thrush, oral
• M06.9-Arthritis, rheumatoid
• Z96.653-Presence of knee joint implant, bilateral
Other Helpful Diagnoses

- Z60.2-Living alone
- Z74.1-Need, care provider because (of)
  - assistance with personal care
- Z74.3-Need, care provider because (of)
  - continuous supervision required
- Z74.09-Need, care provider because (of)
  - impaired mobility
- Z74.2-Need, care provider because (of)
  - no other household member able to render care
- Z74.8-Need, care provider because (of)
  - specified reason NEC
Other Helpful Diagnoses

• Z91.81-History of falling
• R29.6-Repeated falls
Questions???
Thank you!!!