

# Home Health

The Practical Advisor for Accurate Home Care Coding and Optimal Ethical Reimbursement

## ICD-9 Alert

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### CODING HOW-TO

#### USE 2 TIPS TO ACE YOUR AFTERCARE CODING

► **Case mix codes in M1024 don't always bring case mix points.**

When caring for a patient following surgery, you'll need to know when to use a numerical code versus an aftercare V code, when to list a V57.x code for therapy, and how M1024 and case mix fit in. Read on for advice that will make your aftercare coding a breeze.

#### 1. Discern Aftercare From Surgical Complications

You'll most often report an aftercare V code from the V58.7x subcategory when the focus of care is your patient's routine recovery from a surgical procedure, says **Jan McLain, RN, BS, LNC, HCS-D, COS-C**, with Adventist Health System Home Care in Port Charlotte, Fla. This holds true provided the underlying reason for the surgery is resolved or resolving and fits the numeric categories for the aftercare V code, she says.

**Don't miss 4 exceptions:** However, the V58.7x codes don't work in the following surgical aftercare scenarios, McLain says:

- **Fractures:** Choose your fracture aftercare code depending on whether the fracture was due to trauma (V54.1x) or was a pathologic fracture (v54.2x), or was repaired by a joint replacement (V54.81). Don't list an acute fracture code in M1020/M1022 because these acute codes are reserved for active treatment (by hospital, physician or emergency department). But you can list the acute fracture code in M1024. However, it will not gain points unless it meets the criteria of a Ortho 1 or Ortho 2 case mix and the patient is receiving either IV or parenteral therapy in the home (M1030 = 1 or 2) or has a pressure ulcer.

- **Trauma:** Report the aftercare code V58.43 (*Aftercare following surgery for injury and trauma*) when the surgery is for traumatic injuries that would classify to diagnoses from the 800-999 (*Injury and poisoning*) categories. But watch for exclusions! Code for those trauma fractures with V54.1x.

- **Joint replacements:** Code for joint replacements with two codes — V54.81 (*Aftercare following joint replacement*) followed by the V43.6x code for the location.

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(Coding How-To *continued from page 41*)

• **Neoplasms:** Report the aftercare code V58.42 (*Aftercare following surgery for neoplasms*) when the surgery is for a neoplasm that would classify to diagnoses from the neoplasm chapter.

**Complications:** You should list the appropriate numeric code for the complication if the surgical wound or post op course is not routine because of a non-healing surgical wound (998.83), dehisced wound (998.3x) or infection (998.59) or any mechanical complication of an orthopedic device since the procedure, McLain says.

## 2. Reserve V57.x for Therapy Only

The way home health has used codes from the V57.x (*Care involving use if rehabilitation procedures*) series has changed over the years as the ICD-9-CM Committee has elaborated on proper use of the code.

Currently, you should only use V57.1 (*Other physical therapy*) as the principal diagnosis when physical therapy only is on the initial plan of care, there is no intention to add nursing, and the focus of the

therapist is to rehab the patient to a former functional level, McLain says.

The V57.x series also includes V57.89 (*Multiple training or therapy*) for rehab cases that involve more than one therapy discipline such as physical therapy and occupational therapy, but again, only if the focus is one of rehabilitation, McLain says. If therapy does not meet the criteria for being the primary diagnosis — for example, when nursing is in the plan of care — the V57 code should not be used at all.

**Why?** This coding separates episodes with a more general focus of care from those that are strictly focused on rehab, McLain says.

Because you can only list codes from the V57.x series as principal diagnoses when nursing is involved, these codes aren't appropriate, says **Jennifer Warfield, RN, BSN, HCS-D, COS-C**, education director with PPS Plus Software in Biloxi, MS. In therapy-only cases, you can list a V57.x code as primary and the case mix code it replaces — as appropriate — in M1024.

**Remember:** Coding guidelines ask you to follow the V57.x code with a code for the condition being addressed, such as hemiplegia, Warfield says. Add this code as an additional diagnosis in M1022. □

## ICD-9 2011

### WELCOME DETAILED H1N1 PNEUMONIA COMBINATION CODES WITH 2011 ICD-9 UPDATE

#### ► *New fluency disorder, cystostomy complication codes proposed for Oct 1.*

It's that time of year — the Centers for Medicare & Medicaid Services has unveiled the proposed changes to the hospital inpatient prospective payment system, giving us the first look at the ICD-9 changes for 2011. Prepare to learn new pneumonia, fluency disorder, and cystostomy complication codes come October 1.

#### Report Greater Details for Influenza with Pneumonia Codes

For starters, 488.0x (*Influenza due to identified avian influenza virus*) and 488.1x (*Influenza due to identified novel H1N1 influenza virus*) are getting more specific. The co-operating parties who make up the ICD-9 Coordination and Maintenance Committee found that these subcategories didn't provide the level of detail that category 487 (*Influenza*) does, so they expanded the codes at 488.0 and 488.1. The result is six new influenza with pneumonia codes for the 2011 ICD-9 update:

- 488.01 — *Influenza due to identified avian influenza virus with pneumonia*
- 488.02 — *Influenza due to identified avian influenza virus with other respiratory manifestations*
- 488.09 — *Influenza due to identified avian influenza virus with other manifestations*
- 488.11 — *Influenza due to identified novel H1N1 influenza virus with pneumonia*
- 488.12 — *Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations*
- 488.19 — *Influenza due to identified novel H1N1 influenza virus with other manifestations*

In a letter responding to the proposed ICD-9 changes, **Sue Bowman, RHIA, CCS**, director of coding policy and compliance with the American Health Information Management Association (AHIMA), asked that a “use additional code” note be added under code

(*continued on page 44*)

**Coding Tip****ARE YOU MAKING THESE COMMON AFTERCARE CODING ERRORS?****► Who has more visits? It doesn't matter with V57.x.**

Following the steps to code for aftercare and orthopedic cases can seem easy enough, but coders can fall prey to misconceptions. Make sure your coding accuracy doesn't suffer by banishing these mistakes.

**1st mistake:** Some coders think they can only use an aftercare code for fracture care if the fracture has been repaired, says **Jennifer Warfield, RN, BSN, HCS-D, COS-C**, education director with PPS Plus Software in Biloxi, MS.

For example, a fractured pelvis isn't usually surgically repaired, especially in the elderly, Warfield says. Instead these fractures are often treated with rest. Even though there was no medical repair, you can report V54.19 (*Aftercare for healing traumatic fracture of other bone*) if you are providing care for a fractured pelvis. Note that the V54.1x and V54.2x (*Aftercare for healing pathologic fracture*) codes are not aftercare following surgery codes; they are aftercare for healing fracture codes, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of Selman-Holman & Associates and CoDR — Coding Done Right in Denton, Texas.

**2nd mistake:** People often say "We don't use V codes; they're optional," Warfield says. This isn't a good coding practice — sometimes there is no other choice but to use a V code to describe your patient's condition.

You can't report an acute fracture code as the principal diagnosis when you're providing aftercare for an acute fracture — the V code is your only option, Warfield says. And reporting 781.2 (*Abnormality of gait*) instead of a fracture aftercare code means you cannot complete M1024 for any case mix points you're due, plus you miss out on risk adjustment for the fracture.

**3rd mistake:** When deciding whether to use a V57.x (*Care involving use of rehabilitation procedures*) code, some coders start by tallying up which discipline has more visits — nursing or therapy, Warfield says.

**Example:** You are providing aftercare following a knee replacement. Nursing will make four visits to see the patient; physical therapy will visit three times a week for three weeks to address the patient's abnormal gait.

Therapy is making more visits, but that doesn't mean it's appropriate to list V57.1 (*Other physical therapy*) as the principal diagnosis for this patient. This is an interdisciplinary case, so reporting an aftercare code is the right course to take, says Warfield.

In this case, you would list V54.81 (*Aftercare following joint replacement*), followed by V43.65 (*Organ or tissue replaced by other means; joint; knee*). Then list 781.2 for abnormality of gait. □

**YOU BE THE CODER****TRY YOUR HAND AT THIS COMPLICATED SCENARIO**

**Question:** *Our new patient was discharged from the hospital after an exacerbation of her asthma. She was sent home with new medications, including steroids, and breathing treatments. We will be monitoring her blood sugar and will need to teach everything to her elderly husband because she has Alzheimer's dementia. Her other diagnoses include controlled hypertension and history of pulmonary embolism. She is on Coumadin and is taken to the lab monthly for PT/INRs due to poor venous access. She also has GERD, which is managed by medication and diet, and a history of breast cancer. How should we code for her?*

— Vermont Subscriber

**Answer:** Determine what you would do in this scenario. Ask your staff members to discuss how they would handle such a situation. Then turn to page 46 to read our expert's answer. □

(ICD-9 2011 *continued from page 42*)

487.0 (*Influenza with pneumonia*), indicating that an additional code should be assigned for the type of pneumonia.

Bowman also recommended adding the same note under proposed new codes 488.01 and 488.11. “We understand that patients with avian influenza virus and novel H1N1 influenza virus may develop bacterial pneumonia, so it is important to capture the specific type of pneumonia,” she said.

### Look for Changes to Fluency Disorder Late Effect

Changes to the fluency disorder ICD-9 codes are also on the horizon. New code titles will help distinguish childhood onset fluency disorder, adult onset fluency disorder, and — here’s where it gets interesting for home care — fluency disorder subsequent to brain lesion or disease.

You’ll probably remember that 438.14 (*Late effects of cerebrovascular disease, fluency disorder*) was implemented on October 1, 2009. The plan for 2010 is to modify the inclusion term “Stuttering” at 438.14 to read “Stuttering due to late effect of cerebrovascular accident.” The 438 codes are all case mix codes, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of Selman-Holman & Associates and CoDR — Coding Done Right in Denton, Texas. The specifics on speech difficulties and swallowing difficulties usually come from the speech language pathologists, so you’ll need to educate their speech therapists on the new choices.

Other related changes include revising 307.0 to read “Stuttering; Adult onset fluency disorder” and adding new code 315.35 (*Childhood onset fluency disorder*).

### Get Specific with New Cystostomy Complications Codes

Currently, you have specific codes for complications of all sorts of artificial stomas, but not for a cystostomy. If you’re trying to code for an infected cystostomy, you’ve got 997.5 (*Urinary complications*) or 996.39 (*Mechanical complication of other genitourinary device, implant, and graft*), but these codes don’t specify that the complication is with the cystostomy or that there is an infection.

For 2011, you can look forward to four new codes that will correct this problem:

- 596.81 — *Infection of cystostomy*  
Use additional code to specify type of infection
- 596.82 — *Mechanical complication of cystostomy*  
Malfunction of cystostomy
- 596.83 — *Other complication of cystostomy*  
Fistula  
Hernia  
Prolapse
- 596.89 — *Other specified disorders of bladder*  
Calcified  
Contracted  
Hemorrhage  
Hypertrophy

The complication codes for cystostomy will clear up a lot of confusion, Selman-Holman says. The 997.5 code never seemed to fit the situation.

**Keep in mind:** Routine care code V55.5 gains up to 23 points in some equations on the HHRG and gains points towards non-routine supplies, Selman-Holman says. If CMS remains true to its other V55.x and complications decisions, the new complication codes will not make the case mix list. For example, V55.0 (*Attention to tracheostomy*) is a case mix code, but its complication code isn’t.

### Welcome Clearer Instructions for Postoperative Aspiration Pneumonia

Confusion abounds when it comes to coding aspiration pneumonia resulting from a procedure. Code 997.39 (*Other respiratory complications*) includes aspiration pneumonia complicating a procedure, but there is a “use additional code” note at the beginning of the category to identify the complication.

This left coders with a quandary. Should you pair 507.0 (*Pneumonitis due to inhalation of food or vomitus*) with code 997.39? Or should you report just 997.39 since aspiration pneumonia is an inclusion term.

The proposal for 2011 is to add a new code and modify the instructional notes at categories 507 and 997 to assist coders in selecting the correct codes for this complication.

So you’ll see following new and modified codes:

- 507 (*Pneumonitis due to solids and liquids*)  
*(continued on page 47)*

## CODING 101

### GET THE SKINNY ON SYMPTOM CODING

#### ► Read sequencing instructions to catch exceptions to the symptom coding rule.

You've heard it said before: Don't code the symptom when you have a definitive diagnosis. But even when you keep this general guideline in mind, symptoms can still trip you up. Brush up on your symptom coding with this primer provided by our experts.

#### What is a Symptom?

A symptom code is one that describes some sign or symptom that the patient is experiencing without having a diagnosis that confirms the symptom, says **Tricia A. Twombly, BSN, RN, HCS-D, CHCE**, senior education consultant and director of coding with Foundation Management Services in Denton, Texas.

So, if you have a patient who is exhibiting symptoms and they don't have a more definitive diagnosis it's appropriate to code for the symptom.

**Example:** Your patient is experiencing shortness of breath and edema and has no diagnosis that explains those symptoms. In this case, you should code shortness of breath (786.05) and edema (782.3), Twombly says.

However, if the same patient has shortness of breath and edema and also has a diagnosis of congestive heart failure (CHF), then you would only list 428.0 (*Congestive heart failure, unspecified*) because shortness of breath and edema are integral to CHF.

#### What Makes a Symptom Integral?

You shouldn't code a symptom that's integral to a disease process, but how do you know when the symptom makes the grade? An integral symptom is one that is associated routinely with a disease process, Twombly says. For example, shortness of breath and edema are routinely part of the disease process of CHF, so they are considered integral to the condition.

**Another example:** Your patient has liver failure and is experiencing ascites, urticaria, and jaundice. You would only code the liver failure because those symptoms are integral or routinely occur with liver failure (572.8), Twombly says.

But not all symptoms are integral. If your patient has Parkinson's (332.0) and they are experiencing slurred speech (784.59) you would code both

because not all Parkinson's patients experience slurred speech.

#### Watch for Exceptions

Sometimes, even though symptoms are integral to the condition, you're instructed to code the symptoms in addition to the condition, Twombly says. For example, your patient has benign hypertrophy of the prostate (BPH) with urinary obstruction (600.01). When you turn to the tabular listing, there is a sequencing instruction to "use an additional code to identify symptoms" even though all the listed symptoms are integral to BPH with lower urinary tract symptoms (LUTS). □

#### Banish Symptom Coding Confusion with these Guidelines

Follow these guidelines when deciding whether to code for a symptom, says **Judy Adams, RN, BSN, HCS-D, COS-C**, president and CEO of Adams Home Care Consulting in Chapel Hill, N.C:

Code a symptom when:

- There is no definitive diagnosis. Such as when a patient has syncope or nausea but the etiology is unknown
- The definitive diagnosis misrepresents the focus of care. For example, when you are caring for only one aspect of a chronic condition like urinary incontinence in a patient with Multiple sclerosis
- The symptom is not always part of the condition. Such as gait abnormality in a patient with Multiple sclerosis
- A diagnosis has been resolved. For example, muscle weakness following surgery for a herniated disc
- The coding manual instructs you to code the symptom. Such as when your patient has benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (LUTS).

Code the condition if it is a new diagnosis, an exacerbation of an existing diagnosis, or when you are treating multiple aspects of a chronic condition, Adams says. □

## EDUCATION

### MASTER OASIS C CODING INTRICACIES

► **Check out this audioconference for the latest coding news.**

Get vital information from the comfort of your own office:

**Diagnosis Coding And OASIS C.** *Wed. May 26, 1 p.m. ET.* The guidance for completing M1010/M1016/M1020/M1022/M1024 has changed. Never before have procedure codes been a required OASIS

item and Appendix D can be difficult to understand. Walk through the new items and receive vital clarifications from coding expert **Tricia Twombly**. For more information go to [www.audioeducator.com/conference-Diagnosis-Coding-and-OASIS-C-260510](http://www.audioeducator.com/conference-Diagnosis-Coding-and-OASIS-C-260510) or call 1-866-458-2965. □

#### *You Be The Coder Answer*

#### TRY YOUR HAND AT THIS COMPLICATED SCENARIO

**Question:** *Read the question on page 43 and determine how you would code for this scenario before reading on to see our expert's answer.*

**Answer:** Code for this patient as follows, says **Judy Adams, RN, BSN, HCS-D, COS-C**, president and CEO of Adams Home Care Consulting in Chapel Hill, N.C.:

M1020a: 493.90 (*Asthma unspecified; unspecified*);

M1022b: 331.0 (*Alzheimer's disease*)

M1022c: 294.10 (*Dementia in conditions classified elsewhere without behavioral disturbance*)

M1022d: V58.65 (*Long-term [current] use of steroids*)

M1022e: V12.51 (*Personal history of pulmonary embolism*)

M1022f: 401.9 (*Essential hypertension, unspecified*)

Other pertinent diagnoses: V58.61 (*Long-term [current] use of anti-coagulants*).

The primary focus of care for this patient is her asthma, Adams says. The patient has been prescribed new medication and continues her use of steroids to care for the asthma. Code for this condition with 493.90. Query the physician to find out whether the asthma is acute or chronic for more specificity and possible case mix points.

**Mistake:** You might be tempted to list a diabetes code for this patient because you will be monitoring her blood sugar, but diabetes isn't one of her diagnoses, Adams points out. This patient's blood sugar is being monitored because she has a higher risk of elevated blood sugar due to her steroid use.

The first secondary diagnosis you should list is Alzheimer's disease (331.0) followed by dementia (294.10); these conditions are the reasons you are doing teaching with the husband to look for signs and symptoms and to manage her care, Adams says. The patient cannot care for herself and it will be more difficult for her to tell you how she's feeling due to her Alzheimer's dementia.

Listing 294.10 indicates that the dementia is a manifestation of the Alzheimer's disease. It's important to list this diagnosis as well as the Alzheimer's diagnosis because you can't assume an Alzheimer's patient also has dementia, Adams says.

Next, list V58.65 to indicate that your patient is taking steroids. Watching for a risk of elevated blood sugar as a result of steroid use is a focus of your care, so it's important to include this V code, Adams says.

Report the patient's history of pulmonary embolism with V12.51. Past history with pulmonary embolisms leaves your patient at high risk of reoccurrence. She may not be able to tell you that she is running into difficulties that could indicate a reoccurrence of pulmonary embolism, so you need to watch her for signs.

Hypertension almost always impacts the plan of care, so list 401.9 as your last diagnosis code in M1022.

Additional diagnosis code V58.61 for long-term use of anti-coagulants adds clarity to this case, Adams says.

While you're not drawing lab values, you will be monitoring the patient for any incidents of abnormal bleeding, etc.

Remember that with the exception of the Alzheimer's and dementia codes, secondary codes can be sequenced to best reflect the seriousness of the patient's condition and the sequencing is discretionary. You didn't code for gastroesophageal reflux disease (GERD), but if the GERD will impact the care — for example if you'll be teaching regarding the pain of GERD versus the pain of pulmonary emboli — then GERD may be coded, otherwise it is of mere historical significance and shouldn't be coded. □

(ICD-9 2011 *continued from page 44*)

Add Excludes: postprocedural pneumonitis (997.32)

- 997.32 (*Postprocedural aspiration pneumonia*)  
Chemical pneumonitis resulting from a procedure  
Mendelson's syndrome resulting from a procedure
- 997.39 (*Other respiratory complications*)  
Delete Mendelson's syndrome resulting from a procedure

Delete Pneumonia (aspiration) resulting from a procedure

These codes appeared in the Federal Register as part of the proposed Hospital Inpatient PPS rule, but we won't know the final list of new and changed codes for a few months.

Watch upcoming issues of *Home Health ICD-9 Alert* for the word on final 2011 ICD-9 changes. □

## READER QUESTIONS

*Reader questions were answered by Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, consultant and principal of Selman-Holman & Associates and CoDR – Coding Done Right in Denton, Texas.*

### Get to the Root of Charcot Foot Diagnosis

**Question:** *Our new patient has “Charcot foot” that requires treatment. The main cause of this condition is uncontrolled type 2 diabetes mellitus (DM). Should I code 250.00 for the diagnosis?*

*Oregon Subscriber*

**Answer:** To code correctly for Charcot foot, work from the bottom up. Start with the secondary diagnosis code, which would be 713.5 (*Arthropathy associated with neurological disorders*).

Both Charcot's arthropathy associated with diseases classifiable elsewhere and neuropathic arthritis associated with diseases classifiable elsewhere fall under 713.5, according to the brackets following the code's description.

Then tackle the underlying disease as the primary diagnosis. Under 713.5, ICD-9 includes these possibilities:

- tabetic [syphilitic] (094.0)
- diabetic (249.6, 250.6)
- syringomyelic (336.0).

**Tip:** Check the documentation for etiology. That way, you will avoid labeling a patient with a diagnosis like neurosyphilis if he or she does not have it.

**Important:** While diabetes is the most common cause [of Charcot arthropathy], there are others. So 250.60 should not be an automatic coding choice. If the diagnosis is in fact Charcot foot due to diabetes, then code 250.6x

(*Diabetes with neurological manifestations*) before 713.5. When in doubt, ask the physician for specifics.

Despite an improvement in the understanding of the cause and development of diabetic foot problems in the last two decades, the current epidemic of type 2 diabetes ensures that the incidence of foot problems will continue to increase in the diabetic population.

Charcot foot — also known as Charcot's joint or neuropathic arthropathy — is one such problem. The condition occurs when a joint deteriorates because of nerve damage, a common complication of diabetes. Charcot's joint primarily affects the feet, hence the term “Charcot's foot.”

### Know the Facts on Hypercoagulable States

**Question:** *We recently discovered an ICD-9 diagnosis code that we are hoping is appropriate for a fair amount of the cases that we see coming through our agency. This code, 289.82 (*Secondary hypercoagulable state*), generally would not be a primary diagnosis but used as a secondary to support V58.83 (*Encounter for therapeutic drug monitoring*) and V58.61 (*Long-term [current] use of anticoagulants*). We use these V codes during aftercare following surgery for joint replacements, fracture repairs, and so on.*

*As I understand the terminology of hypercoagulable state, it indicates a tendency to the occurrence of thrombus/clotting. The patient would be receiving anticoagulants to prevent blood clots following surgery*

*(continued on page 48)*

(Reader Questions *continued from page 47*)

and we would be drawing blood for pro-times/INR levels. Does this fall into the description of a secondary hypercoagulable state?

**Answer:** You're right that a hypercoagulable state indicates that a patient's blood tends to clot too much. Hypercoagulable states can be inherited (289.81 — *Primary hypercoagulable state*) or acquired (289.82).

Lupus, malignancies, myeloproliferative disorders, pregnancy, inflammatory bowel disease, and certain drug side-effects can all cause secondary hypercoagulable states.

However, simply taking a drug that can cause increased clotting tendency doesn't automatically mean a patient has a secondary hypercoagulable state. To be diagnosed with a hypercoagulable state, first a patient must have a clot. Then the physician will probe the patient's history for risk factors including thrombosis at a young age, recurrent thrombosis, family history of thrombosis, and thrombosis in unusual sites.

If the physician concludes that there is a possibility of a hypercoagulable state, he'll order lab tests to confirm his suspicions. A patient who is taking anticoagulants as a prophylactic measure after joint replacement surgery or for atrial fibrillation does *not* have a hypercoagulable state.

**Don't sell yourself short:** Are you listing V58.83 and V58.61 as principle diagnosis codes? If so, you may be undercoding for the care you provide. When providing aftercare for surgery and joint replacements, you're doing much more than monitoring medications.

An aftercare V code from the V58.7x (*Aftercare following surgery to specified body systems, not elsewhere classified*) or V54.x (*Other orthopedic aftercare*) or the condition itself, such as A. fib, better represents the work your agency is doing and can be followed by the medication monitoring codes to provide greater detail. □

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