ICD-10-CM Coding for Long Term Care/PDPM
Missouri Healthcare Association – Day One

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AHIMA APPROVED ICD-10-CM/PCS TRAINER

Objectives

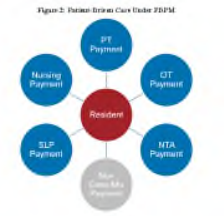
Review ICD-10-CM basics including use of coding books and selection of principal/primary diagnosis

Examine PDPM specifics including clinical categories, SLP and NTA comorbidities and mapping

Apply coding guidelines to long term care specific coding scenarios to select appropriate diagnoses

Patient Driven Payment Model

Patient Driven Payment Model



October 1, 2019

Replacing RUGs, resident is mapped into 5 case-mix adjusted components

CMS maps and tools:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

No ICD-10-PCS Coding

ICD-10-PCS codes (procedure codes) will not be assigned in the long term care setting

Review of the operative report is necessary

Verify the procedure performed to ensure the correct category is selected

Request operative reports as part of transfer documentation needed from acute care provider/facility

Clinical Categories

Acute Infections
Acute Neurologic
Cancer
Cardiovascular and Coagulations
Major Joint Replacement or Spinal Surgery
Medical Management
Non-Orthopedic Surgery
Non-Surgical Orthopedic/Musculoskeletal
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
Pulmonary

Acute Infections code examples

A69.20	Lyme disease, unspecified
B02.7	Disseminated zoster
K94.22	Gastrostomy infection
L03.116	Cellulitis of left lower limb
N39.0	Urinary tract infection, site not specified

Acute Neurologic code examples

G70.00	Myasthenia gravis without (acute) exacerbation
G80.2	Spastic hemiplegic cerebral palsy
I69.120	Aphasia following nontraumatic intracerebral hemorrhage
G20.A1	Parkinson's disease without dyskinesia, without mention of fluctuations
G20.1	Malignant neuroleptic syndrome

Cancer code examples

C18.7	Malignant neoplasm of sigmoid colon
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C79.51	Secondary malignant neoplasm of bone
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes

Cardiovascular and Coagulations code examples

D69.6	Thrombocytopenia, unspecified
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I35.0	Nonrheumatic aortic (valve) stenosis
I50.22	Chronic systolic (congestive) heart failure

Major Joint Replacement or Spinal Surgery code examples

S12.130G	Unspecified traumatic displaced spondylolisthesis of second cervical vertebra, subsequent encounter for fracture with delayed healing
S12.14XK	Type III traumatic spondylolisthesis of second cervical vertebra, subsequent encounter for fracture with nonunion
S12.501G	Unspecified nondisplaced fracture of sixth cervical vertebra, subsequent encounter for fracture with delayed healing
S22.088S	Other fracture of T11-T12 vertebra, sequela
Z47.1	Aftercare following joint replacement surgery

Medical Management code examples

D50.9	Iron deficiency anemia, unspecified
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E44.1	Mild protein-calorie malnutrition
G30.0	Alzheimer's disease with early onset
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system

Non-Orthopedic Surgery code examples

S28.0XXD	Crushed chest, subsequent encounter
S31.105D	Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, subsequent encounter
S35.02XD	Major laceration of abdominal aorta, subsequent encounter
S35.291D	Minor laceration of branches of celiac and mesenteric artery, subsequent encounter
S37.031D	Laceration of right kidney, unspecified degree, subsequent encounter

Non-Surgical Orthopedic/Musculoskeletal code examples

M84.650D	Pathological fracture in other disease, pelvis, subsequent encounter for fracture with routine healing
M86.342	Chronic multifocal osteomyelitis, left hand
S42.494K	Other nondisplaced fracture of lower end of right humerus, subsequent encounter for fracture with nonunion
S63.025D	Dislocation of radiocarpal joint of left wrist, subsequent encounter
S72.21XD	Displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing

Orthopedic Surgery (except Major Joint Replacement or Spinal Surgery) code examples

S62.114S	Nondisplaced fracture of triquetrum [cuneiform] bone, right wrist, sequela
S82.454D	Nondisplaced comminuted fracture of shaft of right fibula, subsequent encounter for fracture with routine healing
Z47.32	Aftercare following explantation of hip joint prosthesis
Z47.81	Encounter for orthopedic aftercare following surgical amputation
Z47.89	Encounter for other orthopedic aftercare

Pulmonary code examples

J15.69	Pneumonia due to other Gram-negative bacteria
J18.9	Pneumonia, unspecified organism
J44.9	Chronic obstructive pulmonary disease, unspecified
J96.11	Chronic respiratory failure with hypoxia
U07.1	COVID-19

Return to Provider

Over 36,000 ICD-10-CM codes (over 49%!) map to the category "Return to Provider" under PDPM

Why??:

- Non-applicable to SNF/LTC
- Unspecified
- Wrong extension
- Coding guidelines prohibit it from being assigned as a principal diagnosis

Comorbidities

SLP – Speech-language pathology

NTA – Non-therapy ancillary

Thoroughly review documentation to ensure capture of these conditions

Query may be necessary to verify and/or clarify diagnoses

Refer to Coding Clinic for current guidance

SLP code examples

C02.8	Malignant neoplasm of overlapping sites of tongue
I69.220	Aphasia following other nontraumatic intracranial hemorrhage
I69.321	Dysphasia following cerebral infarction
I69.322	Dysarthria following cerebral infarction
I69.391	Dysphagia following cerebral infarction

NTA code examples

B20	Human immunodeficiency virus [HIV] disease
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E66.01	Morbid (severe) obesity due to excess calories
E84.9	Cystic fibrosis, unspecified
Z94.0	Kidney transplant status

PDPM Clinical Category Mapping

Go to: CMS maps and tools:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Download "PDPM ICD-10 Mappings"

- Clinical categories by diagnosis
- SLP comorbidity
- NTA comorbidity

Unspecified Codes and Denials

Top problematic unspecified codes:

Z51.89 (Encounter for other specified aftercare) – What is this being assigned for? This code assignment should be specific to the body system. For example: Aftercare following surgery on circulatory, respiratory, digestive, musculoskeletal system.

M62.81 (Muscle weakness, generalized)

R53.1 (Weakness)

These all map to "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, ie. Aphasia, dysphagia, weakness/hemiplegia

E11.9 (Type 2 diabetes mellitus without complications) which may be correct UNLESS there are complications associated/due to diabetes

Falls – neither repeated falls or history of falls are acceptable for principal diagnosis

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 (CKD)
- with congestive heart failure (CHF)
- with CKD and CHF

Weakness versus muscle weakness and documentation issues

Additional Coding Issues

Cancer – when do we assign the cancer to current or history of?

Parkinson's disease – expansion of G20 allows for further specificity to be assigned – are we seeing the supporting documentation?

Continued confusion on assignment of 7th character extensions on injury codes.

What documentation can we use to assign codes?

Who can document?

- Physicians
- Nurse Practitioner*
- Clinical Nurse Specialist*
- Physician Assistant*

* under physician supervision

What documentation can we use to assign codes?

History and physical

Discharge summary

Progress Notes (from authorized providers)

Diagnosis/Problem List (use only diagnoses confirmed by the physician)

Therapy Notes **(if signed by MD, if not signed you may not code from this documentation)**

Transfer Documents (codes included may be incorrect for LTC setting, 7th character A versus 7th character D)

*Cannot code from the drug list unless the drug list identifies the diagnosis that the drug is treating

Recommendations

FCS recommends continual education for your providers on:

PDPM's reliance on provider documentation to determine reimbursement

Need for timely provider documentation including working with office staff to ensure prompt sending of progress notes/H & P

Need for timely access to all hospital records and ensure all documentation used to score the MDS are added to the facility medical record

Importance of quality documentation that appropriately addresses comorbidities and complications as well as clarification of principal diagnosis (reason patient requires long term care)

Principal Diagnosis

Principal Diagnosis - Condition established after study to be chiefly responsible for the patient's admission to the hospital. It is always the first listed diagnosis on the health record and the UB-04 claim form.

Sequencing – What is the patient coming to you for? If weakness, what is the cause of the weakness??

Reimbursement is based on the principal diagnosis, so you will want to make sure your principal diagnosis carries a Case Mix Index or it will be returned to provider which will delay or deny payment.

Sepsis or severe sepsis may not be a principal diagnosis. Use the cause of the sepsis as the principal, for example the residual infection still requiring treatment.

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 (pneumonia) and return back to the facility for further care of their chronic condition (COPD) may continue to receive care for the acute condition if unresolved.

The principal diagnosis is the reason for the continued stay in the LTC facility (COPD).

Principal Diagnosis Quick Check

Code the principal diagnosis:

75 year old male admitted after a CABG in acute care.

Answer

Z48.812

Encounter for surgical aftercare following surgery on the circulatory system

Principal Diagnosis Quick Check

Code the principal diagnosis:

69 year old male patient had a hip replacement in acute care for a left subcapital femur fracture from a fall from a tree while cutting limbs on his farm field.

Answer

S72.012D

Unspecified intracapsular fracture of left femur, subsequent encounter for closed fracture with routine healing

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

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 (note column for "Underdosing")
- External Cause Index
- Tabular A-Z
- Illustrations (Depending on the publisher of the book you are using)

Coding Conventions

NEC – Not elsewhere classified

NOS – Not otherwise specified/Unspecified

[BRACKETS] – Code in brackets must be coded after the code before it

AND/OR – And means OR also

INCLUDES

WITH – Presumes a causal relationship

SEE/SEE ALSO

CODE FIRST – If known

USE ADDITIONAL CODE

CODE ALSO

DEFAULT CODES – Usually unspecified

IN DISEASES CLASSIFIED ELSEWHERE – Cannot be coded before the cause

Excludes 1 and Excludes 2 Notes

EXCLUDES 1

Not coded here

Code elsewhere

EXCLUDES 2

Not included here

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:

K57.1 – Diverticulum of intestine has an Excludes 1 note of "Meckel's diverticulum."

If the diagnosis is "Meckel's diverticulum," the instructional Excludes 1 note instructs the code not to code from category K57. It directs the coder to 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."

Episode of Care

Many (but not all) codes require a 7th character for the "Episode of Care."

The episodes of care may be:

A – Initial episode of care

D – Subsequent episode of care

S - Sequela episode of care

Initial Episode of Care

7th character "A" is assigned for initial episode of care, when the patient is receiving active treatment for a condition.

This includes ER encounter, surgical treatment, evaluation and treatment by a new physician.

This also includes patients that have delayed treatment for a fracture or non-union.

Subsequent Episode of Care

7th character "D" is assigned for subsequent episodes of care.

This includes patients who have completed active treatment and are in the healing or recovery phase.

Sequela Episode of Care

7th character "S" is assigned for sequela episodes of care.

This includes patients who have completed all treatment and healing has been completed, however, a condition exists due to the original condition.

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.

Combination Codes

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

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Combination Code Example

Diabetes with ESRD, Hypertension and chronic diastolic CHF

E11.22 Diabetes with chronic kidney disease

N18.6 End stage renal disease

I13.2 Hypertension & chronic kidney disease with heart failure and with stage 5 chronic kidney/ESRD

I50.32 Chronic diastolic (congestive) heart failure

Example of Multiple Codes for a Condition

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 cerebrovascular disease

I69.920 Aphasia following unspecified cerebrovascular disease

Coding Rules

If the type of diabetes is not documented, we default to Type 2 (even if you know it is type 1).

If the patient has diabetes, and has documented diagnoses such as neuropathy, retinopathy, CKD, hyperglycemia, hypoglycemia, nephropathy, or any diagnosis that is documented as due to diabetes, the combination code for diabetes WITH these diagnoses should be coded UNLESS the documentation indicates the diagnosis is DUE TO SOMETHING OTHER THAN DIABETES.

Diabetes must be documented as "With hyperglycemia," "poorly controlled," or "out of control," in order to code "diabetes with hyperglycemia." "Uncontrolled" may NOT be coded as "with hyperglycemia."

Coding Rules - Hypertension

Category I10 – Essential (primary) hypertension

Category I11 – Hypertension with CHF (Automatically connected UNLESS CHF IS DOCUMENTED AS DUE TO SOMETHING ELSE)

Category I12 – Hypertension with CKD (Automatically connected UNLESS CKD IS DOCUMENTED AS DUE TO SOMETHING ELSE)

Category I13 – Hypertension with CHF and CKD

Category I16 - Hypertension Urgency, Emergency and Crisis (To be used with a code from the other Hypertension Categories). It does not stand alone.

Coding Rules

Sepsis (Category A41) and Severe Sepsis (R65.20 and R65.21) MAY NOT BE THE PRINCIPAL DIAGNOSIS in your setting.

If both COPD and emphysema are documented, code only the emphysema.

If both COPD and asthma are documented, code only the COPD UNLESS the asthma is exacerbated or documented as a specific type of asthma such as mild persistent asthma.

If HIV is documented use code Z21 NOT B20. Only documentation of AIDS can be coded to B20.

Coding Rules – Body Mass Index

Code for body mass index (BMI) value may not be coded UNLESS there is a diagnosis of:

Obesity
Morbid Obesity
Overweight
Underweight
Failure to Thrive
Cachexia
Malnutrition
Abnormal weight loss or gain
Something to indicate a weight issue

Query

A query is a question to physician/provider intended to clarify documentation that is not clear or to obtain greater specificity.

Physician education on documentation issues is vital to improve documentation specificity.

A query can be written or verbal. The physician/provider must document the answer to the query in the record.

How to Write a Query

Queries may not ask leading questions, that is asking for a specific answer.

A query consists of two parts:

- 1. The documentation that requires clarification
- 2. The question you want to ask

EXAMPLE:

1. The progress note dated 10/2 documents "pneumonia."
2. Please clarify the type of pneumonia. Was the pneumonia felt to be:
   - Bacterial (specify organism if known)
   - Viral
   - Aspiration
   - Other
   - Undetermined
   - _____ *Free text

Coding Exercises

Case #1

Resident is a 75 year old female who was transferred from the hospital after tripping over her dog and falling. She suffered a broken left femoral head. In the hospital an ORIF was performed. The discharge summary documents the patient has hypertension, SLE and type 2 DM well controlled on insulin.

Case #1

S72.052D	Unspecified fracture of head of left femur, subsequent encounter for closed fracture with routine healing
W01.0XXD	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter
I10	Essential (primary) hypertension
E11.9	Type 2 diabetes mellitus without complications
M32.9	Systemic lupus erythematosus, unspecified *NTA Comorbidity
Z79.4	Long term (current) use of insulin

Case #2

Resident is an 81 year old male admitted after a week long hospital stay for sepsis. He is transferred to long term care for continued antibiotic treatment. The discharge summary documents the following discharge diagnoses:

1. Sepsis
2. Right lower lobe pneumonia due to Klebsiella
3. Early onset Alzheimer's disease with dementia
4. Right lower leg cellulitis, resolved during stay
5. Major depression, recurrent, moderate
6. BPH with nocturia

Case #2

J15.0	Pneumonia due to Klebsiella pneumoniae
G30.0	Alzheimer's disease with early onset
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F33.1	Major depressive disorder, recurrent, moderate
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
R35.1	Nocturia

Case #3

Resident is a 67 year old male admitted for rehabilitation following an embolic cerebral infarction involving the right middle cerebral artery. He will be receiving PT, OT and ST. He has right sided hemiparesis and oral phase dysphagia. It is noted he is left handed and has AIDS and rheumatoid arthritis.

Case #3

I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side
I69.391	Dysphagia following cerebral infarction *SLP Comorbidity
R13.11	Dysphagia, oral phase
B20	Human immunodeficiency virus [HIV] disease *NTA Comorbidity
M06.9	Rheumatoid arthritis, unspecified

Case #4

New resident is a 78 year old female. Physician documents the patient is admitted for weakness. Additional diagnoses include: COPD, iron deficiency anemia, DM type 2 on Glucophage (oral) and Victoza (injectable) with peripheral neuropathy and proliferative retinopathy with macular edema of the right eye and emphysema. The resident has a history of DVT of the left leg and she is on Coumadin. She has order for PT/INR to be checked monthly.

Case #4 – Query needed for etiology of weakness

J43.9	Emphysema, unspecified
D50.9	Iron deficiency anemia, unspecified
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye *NTA Comorbidity
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
Z79.84 Z79.85	Long term (current) use of oral hypoglycemic drugs Long term (current) use of injectable non-insulin antidiabetic drugs
Z86.718	Personal history of other venous thrombosis and embolism
Z79.01	Long term (current) use of anticoagulants
Z51.81	Encounter for therapeutic drug level monitoring

Case #5

New resident is a 57 year old female with primary osteoarthritis of the right hip treated with a total hip replacement four days prior to arrival. In addition to PT and OT, she will need monitoring of her treatment resistant epilepsy and hypertension. Ketogenic diet and home dose of lisinopril will be continued.

Case #5

Z47.1	Aftercare following joint replacement surgery
Z96.641	Presence of right artificial hip joint
G40.919	Epilepsy, unspecified, intractable, without status epilepticus *NTA Comorbidity
I10	Essential (primary) hypertension

Questions????

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