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

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Objectives

Review PDPM and ICD-10-CM topics previously discussed

Discuss new topics including specifics on COVID and Parkinson's Disease

Apply coding guidelines to long term care specific coding scenarios to select appropriate diagnoses, comorbidities and mapping

Quick Review

True or False?

We can assign codes from the discharge summary, H&P and progress notes only.

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

The answer would be false.

True or False?

When a resident comes for care following a joint replacement, the principal (primary) diagnosis is always Z47.1.

Other Problematic Coding

Aftercare from surgery

Aftercare following a joint replacement versus post op injury coding with subsequent episode of care

The answer would be false. A resident who presents for care following a joint replacement as treatment for a fracture would have the fracture with the subsequent care 7th character assigned as the principal (primary) diagnosis.

When would we assign the Z47.1?

True or False?

Provider queries can be written or verbal.

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.

The answer would be true.

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True or False?

The correct code assignment for diabetes type 2, hypertension and chronic kidney disease, stage 3a would be:

E11.9

I12.9

N18.31

Other Problematic Coding

Diabetes

Hypertension

with chronic kidney disease (CKD)
with congestive heart failure (CHF)
with CKD and CHF

The correct code assignment would be:
E11.22
I12.9
N18.31

The answer would be false.

True or False?

It is not necessary to request the operative report in transfer documents since no ICD-10-PCS codes are assigned.

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

The answer would be false.

True or False?

The subsequent episode of care 7th character includes patients who have completed active treatment and are in the healing or recovery phase of care.

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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.

The answer would be true.

True or False?

The correct code assignment for oropharyngeal phase dysphagia following CVA would be:

R13.12

Z86.73

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

The correct code assignment for oropharyngeal phase dysphagia following CVA:

I69.391

R13.12

The answer would be false.

True or False?

Any diagnosis listed on the problem list can be coded as an active diagnosis.

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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

The answer would be false.

True or False?

If a resident has type 2 diabetes and neuropathy, the correct code assignment would be E11.40 – unless the provider notes the neuropathy is due to something other than the type 2 diabetes.

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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.

The answer would be true.

True or False?

I feel more confident about ICD-10-CM coding.

The answer is hopefully YES!

Continuing topics for discussion:

Coding Clinic specific guidance for Long Term Care

COVID

Parkinson's Disease codes

ICD-10 coding versus MDS "coding"

Additional scenario coding practice

Coding Clinic Guidance

Guidance from Coding Clinic 4Q 2012 p. 90 addresses several Long Term Care coding issues. Subsequent issues provide additional guidance. Review of this important reference is recommended.

Guidance included there also provides clarification of the first listed or primary diagnosis. It notes:

The "first listed diagnosis" is the diagnosis which is chiefly responsible for the admission to, or continued residence in the nursing facility and should be sequenced first. For example, when coding an admission to the facility, the "first listed diagnosis" is the condition chiefly responsible for the admission to the facility. If coding diagnoses during the resident's stay, it is the condition chiefly responsible for the continued stay in the facility.

Coding Clinic Guidance

Guidance from Coding Clinic 4Q 2012 p. 90

Question:

A patient is discharged from the hospital and admitted to a long-term care facility (LTC) with a diagnosis of acute cerebral infarction with left-sided hemiparesis and dysphagia. The diagnosis on admission to the LTC is documented as acute CVA. What is the appropriated code assignment to describe this patient's condition?

Coding Clinic Guidance

Guidance from Coding Clinic 4Q 2012 p. 90

Answer:

Assign code I69.354, Hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, and code I69.321, Dysphasia following cerebral infarction, to completely describe the patient's condition. The hemiparesis and dysphasia are considered sequelae of the acute CVA for this LTC admission. Coding guidelines state that these "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. Codes from I60-I67 are reserved for the initial (first) episode of care for the acute cerebrovascular disease.

Coding Clinic Guidance

Guidance from Coding Clinic 3Q 2016 p. 16

Question:

A patient is admitted to an acute rehab facility for physical and occupational therapy following a total hip replacement (THR) due to a right intertrochanteric femur fracture. Since the hip joint was removed and replaced with a prosthetic, would the femoral fracture still be coded?

Coding Clinic Guidance

Guidance from Coding Clinic 3Q 2016 p. 16

Answer:

In this case, a total hip replacement was done to treat the traumatic fracture of the hip. The fracture is now in the healing and recovery phase after surgical treatment. Assign code S72.141D, Displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing, as principal diagnosis. Assign also code Z96.641, Presence of right artificial hip joint.

The intent of ICD-10-CM's seventh character for fracture and other injuries is to track treatment through the various stages, as well as to tract resource utilization and outcomes. There are critical differences in joint replacement surgery performed because of a traumatic fracture versus elective joint replacement surgery. For example, an injury resulting in an unexpected surgery might require more intensive rehabilitation than a hip replacement due to degenerative osteoarthritis of the hip.

COVID-19

U07.1 COVID-19

Z86.16 Personal history of COVID-19

Z20.822 Contact with and (suspected) exposure to COVID-19

COVID Pneumonia

J12.82 Pneumonia due to coronavirus disease 2019

There is a Code First instructional note:

Code first COVID-19 (U07.1)

Long COVID

U09.9 Post COVID-19 condition, unspecified

There is a code first instructional note:

Code first the specific condition related to COVID-19 if known, such as:

- Chronic respiratory failure (J96.1-)
- Loss of smell (R43.8)
- Loss of taste (R43.8)
- Multisystem inflammatory syndrome (M35.81)
- Pulmonary embolism (I26.-)
- Pulmonary fibrosis (J84.10)

Long COVID

U09.9 Post COVID-19 condition, unspecified

There is an additional note providing further guidance:

Note: This code enables establishment of a link with COVID-19. This code is not to be used in cases that are still presenting with active COVID-19. However, an exception is made in cases of re-infection with COVID-19, occurring with a condition related to prior COVID-19.

Parkinson's Disease

G20.A1 Parkinson's disease without dyskinesia, without mention of fluctuations

G20.A2 Parkinson's disease without dyskinesia, with fluctuations

G20.B1 Parkinson's disease with dyskinesia, without mention of fluctuations

G20.B2 Parkinson's disease with dyskinesia, with fluctuations

G20.C Parkinsonism, unspecified

Parkinson's Disease

Coding Clinic, Fourth Quarter 2023

"Parkinson's disease (PD) is a progressive neurodegenerative disease that presents with motor symptoms such as tremors of the hands, arms, legs, or head, as well as nonmotor symptoms such as depression, anxiety, and pain. Currently, there is no cure for PD, and treatment consists of the medication levodopa to relieve symptoms.

Dyskinesia is the involuntary movement of the face, arms, legs, or trunk. PD fluctuations refer to periods of ON episodes where there is a positive response to levodopa, followed by periods of OFF episodes where levodopa wears off and the PD symptoms reemerge."

ICD-10 coding versus MDS "coding"

Medicare Claims Processing Manual Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing Section 30 – Billing SNF PPS Services:

Principal Diagnosis Code – SNFs enter the ICD-CM code for the principal diagnosis in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA)…

Other Diagnosis Codes Required – The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf

ICD-10 coding versus MDS "coding"

ICD-10-CM Official Guidelines for Coding and Reporting, Section III. Reporting Additional Diagnoses;

"For reporting purposes, the definition for "other diagnoses"; is interpreted as additional **clinically significant** 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."

ICD-10 coding versus MDS "coding"

ICD-10-CM Official Guidelines for Coding and Reporting, Section III. Reporting Additional Diagnoses;

"The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that related 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."

"The UHDDS definitions also apply to hospice services (all levels of care)."

ICD-10 coding versus MDS "coding"

Coding Clinic Fourth Quarter 2012, Long Term Coding Issues

Question:

A resident in LTC facility develops a urinary tract infection (UTI), which is treated and resolved during the LTC stay. Should the UTI be coded?

Answer:

Assign code N39.0, Urinary tract infection, site not specified. The diagnosis would be part of the resident's active problem list until the infection is resolved, at which time it would no longer be coded and reported.

ICD-10 coding versus MDS "coding"

For the MDS – a diagnosis of UTI has a **30** day look back period. This is different from the 7 day look back period for active diagnoses.

You may encounter situations where you would "code" UTI on the MDS, but not assign the ICD-10-CM code (N39.0) for UTI as an active diagnosis.

If a UTI is documented in transfer documentation as having treatment completed in the hospital, you would not assign the ICD-10-CM code, but would "code" UTI on the MDS (within the 30 day look back period).

If a UTI is documented in transfer documentation as needing continuing treatment, you would assign the ICD-10-CM code AND would "code" UTI on the MDS (meets the criteria for active diagnosis and is within the 30 day look back period).

For UTI occurring in the LTC facility, ensure evidence based criteria is met (ie Loeb, McGeer, NHSN) when "coding" on the MDS.

Coding Exercises

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Case #1

Resident is a left handed 75 year old male who is receiving physical and occupational therapy for right sided hemiparesis following a nontraumatic intracerebral bleed. After noticing a fever and cough, he was sent to the hospital where he was treated for pneumonia due to Klebsiella pneumoniae. He is returning back to the facility with new orders to continue the last three days of antibiotic treatment for the pneumonia. Resident will also continue treatment for hypertension, narcolepsy and chronic systolic heart failure.

Case #1

I69.253	**Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side**
I11.0	Hypertensive heart disease with heart failure
I50.22	Chronic systolic (congestive) heart failure
G47.419	Narcolepsy without cataplexy *NTA Comorbidity
	MAPS TO ACUTE NEUROLOGIC

Case #2

Resident is a 67 year old female admitted for physical and occupational therapy following a left total hip replacement for advanced osteoarthritis. Patient was progressing well when she forgot to call for help and slipped and fell in the bathroom. She fell on her right side and immediately felt pain in her right leg. Radiology reports demonstrated a right fibula fracture. X-rays also showed no dislocation of the left hip prosthesis. Resident is also noted to be a type 2 diabetic well controlled with diet management.

Case #2

Z47.1	**Aftercare following joint replacement surgery**
Z96.642	Presence of left artificial hip joint
S82.401A	Unspecified fracture of shaft of right fibula, initial encounter for closed fracture
W01.0XXA	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter
Y92.121	Bathroom in nursing home as the place of occurrence of the external cause
E11.9	Type 2 diabetes mellitus without complications MAPS TO MAJOR JOINT REPLACEMENT OR SPINAL SURGERY

Case #3

Resident is a 81 year old male admitted from the hospital following admission for treatment of an infected gastrostomy. Resident will continue on antibiotic therapy for at least 10 days. Transfer documentation from the hospital physician documents an infected gastrostomy with abdominal wall cellulitis. In addition to the antibiotic administration, increased skin checks are also ordered. Resident is also noted to have plasma cell leukemia currently in remission following a stem cell transplant three years ago. Immediate dietary evaluation is required as the resident is noted to have a BMI documented as 17.8. Transfer documentation also notes the resident was noted to have had a COVID-19 infection in August 2020.

Case #3

K94.22	Gastrostomy infection
L03.311	Cellulitis of abdominal wall
C90.11	Plasma cell leukemia in remission
Z94.84	Stem cells transplant status *NTA Comorbidity
Z86.16	Personal history of COVID-19
	MAPS TO ACUTE INFECTIONS

Case #4

New resident is a 78 year old female. Transfer documentation is limited, but physician documents the patient needs skilled care including physical therapy for Bell's palsy. Resident history notes she is on Aricept for late onset Alzheimer's dementia, lisinopril for hypertension, metformin and Victoza for diabetes type 2. It also notes she should remain on a low protein diet because of her moderate chronic kidney disease. There is no documentation of behavior disturbances. Her diabetes is noted to be well controlled.

Case #4 – Query needed for clarification; Maps to Return to Provider

G51.0	Bell's palsy
G30.1	Alzheimer's disease with late onset
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
N18.30	Chronic kidney disease, stage 3 unspecified
Z79.84	Long term (current) use of oral hypoglycemic drugs
Z79.85	Long term (current) use of injectable non-insulin antidiabetic drugs

Case #5

New resident is a 76 year old male transferred from the acute care hospital. Transfer documentation from the hospital includes a discharge summary that documents the discharge diagnosis as follows:

Acute CVA with pharyngeal dysphagia and dysphasia

UTI, patient completed full course of antibiotics

Severe obesity with BMI of 49.8

Case #5

I69.391	Dysphagia following cerebral infarction
R13.13	Dysphagia, pharyngeal phase
I69.321	Dysphasia following cerebral infarction *SLP Comorbidity
E66.01	Morbid (severe) obesity due to excess calories *NTA Comorbidity
Z68.42	Body mass index [BMI] 45.0-49.9, adult *NTA Comorbidity
	MAPS TO ACUTE NEUROLOGIC

Questions????

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Thank You!!