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

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Objectives

Review ICD-10-CM basics/best practices 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

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

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

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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.

Wound coding – Pressure ulcer documentation, stage, severity, etc.

OASIS versus ICD-10-CM coding – does clinical documentation reflect/support OASIS?

What documentation can we use to assign codes?

Who can document?

Physicians

Nurse Practitioner*

Clinical Nurse Specialist*

Physician Assistant*

* under physician supervision

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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

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.

Remember Aftercare as an Alphabetic Index entry.

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

Coding Rules

If both COPD and emphysema are documented, code only the emphysema. Emphysema is a form of chronic obstructive pulmonary disease.

If both COPD and asthma are documented, code to J44.89. There is a Code Also note for the type of asthma if applicable (J45.-). This is not for unspecified asthma or unspecified asthma in exacerbation.

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

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.

ICD-10 coding versus MDS “coding”

Who is assigning ICD-10-CM codes and who is “coding” the MDS? If they are not the same person/team, is there a line of communication established and used?

When are ICD-10-CM codes reviewed? At the time of assignment only? Is it part of the Triple Check process?

If clarification of conflicting documentation between MDS and provided clinical documentation is needed is there a process in place to establish responsibility?

Is there a coding policy/procedure in place? Do coders know what codes are expected to be assigned and what are not included (i.e. certain family history, allergies, etc.)?

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.

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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

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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.

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Case #1 Considerations

What is the primary diagnosis? Are we coding Aftercare?

What is the clinical category?

What conditions are being treated or monitored?

Is there a NTA or SLP comorbidity?

Other questions?

Case #1

S72.052D	Unspecified fracture of head of left femur, subsequent encounter for closed fracture with routine healing
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

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Case #2 Considerations

What is our primary diagnosis?

What is our clinical category?

What conditions are being treated or monitored?

Is there a NTA or SLP comorbidity?

Other questions?

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.

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Case #3 Considerations

What is our primary diagnosis?

What is our clinical category?

What conditions are being treated or monitored?

Is there a NTA or SLP comorbidity?

Other questions?

Case #3

I69.353	**Hemiplegia and hemiparesis following cerebral infarction affecting right 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.

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Case #4 Considerations

What is our primary diagnosis?

What is our clinical category?

What conditions are being treated or monitored?

Is there a NTA or SLP comorbidity?

Other questions?

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 Considerations

What is the primary diagnosis? Are we coding Aftercare?

What is the clinical category?

What conditions are being treated or monitored?

Is there a NTA or SLP comorbidity?

Other questions?

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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