FHCA 2019 Annual Conference & Trade Show

CE Session #9 – Linking ICD-10 to PDPM
Monday, August 5 – 10:00 to 11:30 a.m.
Celebration 5-6 – Finance/Development

Upon completion of this presentation, the learner will be able to:

- State requirements related to ICD-10 coding and reconciliation
- Discuss ICD-10 coding systematic processes to increase accuracy
- Define PDPM and its linkage to ICD-10 for appropriate and effective outcomes

Seminar Description:

This session will provide the understanding of key elements to ICD-10 coding and its critical linkage to the October 1, 2019, implementation of the Patient Driven Payment Model (PDPM). Important considerations related to ICD-10 coding will be shared to assist operators and finance teams for better oversight and support to their teams while recognizing appropriate integration steps with finance to enhance interoperability.

Presenter Bio(s):

Robin Bleier, RN, LHRM, CLC is President of RB Health Partners, Inc., a clinical, risk, Medicare and operations consultancy firm. A featured state and national presenter, Robin is a special topics advisor to the FHCA Quality Cabinet, immediate past Chair of the FHCA Emergency Preparedness Committee, immediate past chair of the FHC PAC, past executive board member of FADONA, a vested long term care advocate through her volunteerism and affiliation with numerous state and national professional committees. Robin's firm, RB Health Partners, Inc. provides consulting services to the FHCA Quality Affairs Department.

Florida Health Care Association

Linking ICD-10 to PDPM

Presented by:
Robin A. Bleier
RB Health Partners, Inc.

www.fhca.org

RB Health Partners, Inc. The Premier LTC Consultancy Organization

Florida Health Care Association

Linking ICD-10 to PDPM

Monday, August 5 - 10:00 to 11:30 a.m.

www.fhca.org

RB Health Partners, Inc. The Premier LTC Consultancy Organization

Florida Health Care Association

Linking ICD-10 to PDPM

This session will provide the understanding of key elements to ICD-10 coding and its critical linkage to the October 1, 2019, PDPM. Important considerations related to ICD-10 coding will be shared to aid the operators and finance teams the in the ability to provide better oversight and support to their teams while recognizing appropriate integration steps with finance to enhance interoperability.

www.fhca.org

RB Health Partners, Inc. The Premier LTC Consultancy Organization

Principal Diagnosis Defined

"That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

- Expanded to include all inpatient settings.

Form Locator (FL) Box 67 (Principal Diagnosis) on the UB04

Selection of Principal Diagnosis

For residents admitted for short term rehabilitation:

- The principal and primary diagnosis are the same code. For long-term care residents, regardless of payer:
- The principal diagnosis is the reason for the continued need for long-term care
- The primary diagnosis is sequenced as the first additional diagnosis.

Selection of Principal Diagnosis

Example:

- A long-term care resident with Parkinson's disease returns after hospitalization for aspiration pneumonia under a new Medicare Part A stay. The Parkinson's disease is the reason for the continued stay and is sequenced as the Principal diagnosis. The aspiration pneumonia is the reason for the skilled Medicare stay and is the second listed diagnosis.

Selection of Principal Diagnosis

Admission/Encounter for Rehabilitation

- If the condition is still present, code the condition
- If the condition is no longer present, code the appropriate aftercare code
- If the admission is following active treatment of an injury or fracture, assign the injury/fracture code with the seventh character for the appropriate subsequent encounter

Primary Diagnosis Defined

The reason that the patient requires admission for skilled care.

For skilled stays under Medicare A:

- The condition for which the resident received inpatient hospital services or a condition that arose while receiving care in a SNF for the condition that the resident received inpatient hospital services.

FL box 69 (Admitting Diagnosis) on the UB04

Additional/Other Diagnoses

Conditions that coexist at the time of admission or develop during the resident's stay and affect resident care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extend the length of stay
- Increase nursing care and/or monitoring

Additional Diagnoses

Medicare Claims Processing Manual, Chapter Six, page 33, indicates the Principal Diagnosis and up to eight additional diagnosis codes are included in the claims review process.

- This makes it imperative to get the most pertinent diagnoses requiring skilled services in the top 8 boxes of this section.

FL box 67A-Q (Other Diagnosis) on the UB04.

Key Terms &

Definitions for Consideration

ICD-10-CM Conventions

General rules for the use of the classification system which are independent of the coding guidelines.

(Conventions always takes precedence over guidelines!)

Etiology/Manifestation Notes

"Code First"

- Identifies the underlying condition, or etiology
- Indicates proper sequencing order for codes
- Note would be found at the manifestation code to alert coder to an additional code
- When both conditions are listed in the Alphabetic Index, brackets [ ] around code to be sequenced second

www.fhca.org

Etiology/Manifestation Notes

"Use additional code"

- Identifies the manifestation code
- Indicates proper sequencing order for codes
- Note would be found at the etiology code to alert coder to an additional code
- Includes "in diseases classified elsewhere"
  - May never be listed as a principal or first listed diagnosis

www.fhca.org

Code Also

The term "**code also**" informs the coder that more than one code may be needed to fully describe a condition.

- Does not provide guidance related to sequencing.

www.fhca.org

With

The term "**With**" should be interpreted as "associated with" or "due to" when it appears under a code title, Alphabetic Index or as an instructional note in the Tabular Index.

- Conditions should be coded as related, unless provider documentation specifically states that the two conditions are unrelated.

See

"**See**" indicates that another term should be referenced.

- The coder must go to the main term listed within the note to locate the correct code.

See Also

"**See also**" indicates that there is another main term that may also be referenced, which may provide additional entries

- The coder is not required to follow the note when the original main term provides the necessary code.

7th Characters

Utilized in

- Chapter 7 – Diseases of the Eye and Adnexa (H00-H59)
- Chapter 13 – Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
- Chapter 19 – Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

ICD-10-CM Guidelines

Rules that accompany and complement the coding conventions and instructions.

Adherence to guidelines is required under HIPAA!

Acute and Chronic

When a condition is documented as both acute and chronic it is acceptable to code both conditions when separate subentries are present at the same indention level without a combination code.

The acute condition is sequenced first.

Sequela (Late Effects)

Sequela is a residual effect/deficit after the acute phase of an illness or injury has ended.

Often requires two codes to fully identify the condition.

- Condition of sequela sequenced first, followed by the cause of the sequela

The acute phase of the condition which caused the sequela is not coded with the sequela code

Coding without Provider Documentation

Documentation from other clinicians may be used for coding of:

- Body Mass Index (BMI)
- Depth of Non-Pressure Chronic Ulcers
- Stage of Pressure Ulcers

The specific disease/condition must be documented by the provider

Selection and Sequencing of Diagnosis Codes

Principal, Primary, and Additional Codes

Additional/Other Diagnoses

Conditions that coexist at the time of admission or develop during the resident's stay and affect resident care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extend the length of stay
- Increase nursing care and/or monitoring

Additional Diagnoses

Medicare Claims Processing Manual, Chapter Six, page 33, indicates the Principal Diagnosis and up to eight additional diagnosis codes are included in the claims review process.

- This makes it imperative to get the most pertinent diagnoses requiring skilled services in the top 8 boxes of this section.

FL box 67A-Q (Other Diagnosis) on the UB04.

Chapter Specific Guidelines

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00 – B99)

Human Immunodeficiency Virus (HIV)

- Code only confirmed cases!
  - Confirmation may be in the form of documentation from provider of "HIV positive" or that the patient has an HIV-related illness. Positive test results are not required.

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00 – B99)

Human Immunodeficiency Virus (HIV)

- Z21 - Asymptomatic HIV infection status is assigned when the patient without documented symptoms is noted as HIV positive in provider documentation.
- Do not assign this code if provider documentation indicates patient has AIDS or if patient is treated for an HIV-related illness

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00 – B99)

Human Immunodeficiency Virus (HIV)

- B20 - HIV Disease is assigned when provider documentation states the patient has Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC), or symptomatic HIV
- Once a patient has developed an HIV-related illness B20 will always be assigned for each subsequent admission.

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00 – B99)

Antibiotic Resistance

- Do not use additional resistant code if the condition code includes "due to Methicillin resistant Staphylococcus Aureus"
  - Example: J15.212 – Pneumonia due to Methicillin resistant Staphylococcus Aureus

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00 – B99)

Antibiotic Resistance

- Do not assign additional resistance code when the code for the cause of infection includes the resistance
  - Example: B95.62 – Methicillin resistant Staphylococcus Aureus as the cause of diseases classified elsewhere

CHAPTER 2: Neoplasms (C00 – D49)

When the primary malignancy has been excised and further treatment (additional surgery, radiation or chemotherapy) is directed to that site the primary malignancy code is used.

CHAPTER 2: Neoplasms (C00 – D49)

When the primary malignancy has been excised and no further treatment is directed at the site, a code from category Z85- Personal history of malignancy is used.

- Subcategories Z85.0 – Z85.7 are only assigned for former primary malignancy sites, not the site of a secondary malignancy.

CHAPTER 3: Diseases of the Blood and Blood Forming Organs (D50-D89)

Also includes certain disorders involving the immune system.

CHAPTER 3: Diseases of the Blood and Blood Forming Organs (D50-D89)

The ICD-10 guideline for admission due to cancer related anemia the following guidelines apply:

- For care of anemia d/t malignancy, the malignancy is sequenced first followed by the anemia code
- For care of anemia d/t chemotherapy, the anemia is sequenced first followed by the adverse effect. The neoplasm would be an additional code.

CHAPTER 4: Endocrine, Nutritional, and Metabolic Diseases (E00 – E89)

Diabetes Mellitus (DM)

- E11.- (Type 2, DM) is the default, when provider documentation does not specify the type of Diabetes.
- A causal relationship between diabetes and complications listed after the term "with" may be assumed. Unless provider documentation specifically states otherwise.

CHAPTER 4: Endocrine, Nutritional, and Metabolic Diseases (E00 – E89)

Secondary DM

- E08 – DM due to underlying condition
- E09 – DM due to drug or chemical
- E13 – Other specified DM

CHAPTER 5: Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)

When provider documentation refers to use, abuse, and dependence of the same substance only one code is assigned based on the following hierarchy

- If Use and Abuse are documented, code abuse
- If Abuse and Dependence are documented, code dependence
- If all three are documented, code dependence

CHAPTER 6: Diseases of the Nervous System (G00 – G99)

When affected side is documented, but not specified as dominant or nondominant, without further direction under the category the following defaults are used:

- If patient is ambidextrous, code affect side as dominant
- If left side is affected, code as non-dominant
- If right side is affected, code as dominant

CHAPTER 6: Diseases of the Nervous System (G00 – G99)

Codes from G89 "Pain not elsewhere classified" may be used in conjunction with codes from other categories to provide additional information about acute, chronic, or neoplastic pain They should not be utilized when a definitive diagnosis is present, unless the reason for the admission is pain management.

CHAPTER 6: Diseases of the Nervous System (G00 – G99)

Postprocedural Pain

- Routine or expected postoperative pain immediately after surgery should not be coded.
- Post-thoracotomy and other post-procedural pain not specified as acute or chronic the default is the acute form.

CHAPTER 7: Diseases of the Eye and Adnexa (H00 – H59)

When "blindness" or "low vision", but the visual impairment is not documented, assign codes as follows

- Both eyes affected: H54.3 (Unqualified visual loss, both eyes)
- One eye affected: H54.6- (Unqualified visual loss, one eye)
- Unknown whether one or both eyes affected: H54.7 (Unspecified visual loss).

CHAPTER 8: Diseases of the Ear and Mastoid Process (H60 – H95)

Divided into the following subcategories:

- H60-H62: Disease of external ear
- H65-H75: Disease of middle ear and mastoid
- H80-H83: Diseases of inner ear
- H90-H94: Other disorders of ear
- H95: Intraoperative and postprocedural complications and disorders of ear and mastoid process, NEC

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Hypertension (HTN)

- Classification presumes casual relationship between hypertension and heart involvement and hypertension and kidney involvement, because the two terms are linked by the term "with" in the Alphabetic Index.
- The conditions should be coded as related, unless provider documentation states they are unrelated.

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

HTN with Heart Disease code to I11 Hypertensive heart disease

Includes Heart Conditions classified to:

- I50.- Heart Failure
- I51.4-I51.7 Complications and ill-defined descriptions of heart disease
- I51.89 Other ill-defined heart disease
- I51.9 Heart disease, unspecified

Use additional code for the type of heart failure

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

HTN with Chronic Kidney Disease (CKD) code to I12 Hypertensive chronic kidney disease

Includes conditions classified to:

- N18.- Chronic kidney disease

Use additional code for stage of chronic kidney disease

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

HTN with Heart Disease and CKD code to I13 Hypertensive heart and chronic kidney disease

Use additional codes for:

- Type of heart failure
- Stage of chronic kidney disease

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Atherosclerotic coronary artery disease, ASHD, or CAD with angina pectoris is coded utilizing a combination code

- I25.11 (ASHD of native coronary artery w/ angina pectoris)
- I25.7 (Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart w/ angina pectoris)
- A causal relationship is presumed.
- No additional code is used for the angina pectoris

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Category I69 is used to identify conditions classifiable to categories I60 – I67 as the cause of the sequela.

For sequelae that specify hemiplegia, hemiparesis or monoplegia the same defaults from Chapter 6 apply

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Type 1 ST elevated myocardial infarctions (STEMI) or Non-ST elevated myocardial infarctions (NSTEMI) are coded I21.0 – I21.4 or I21.9

- When admission occurs while the acute myocardial infarction is equal to or less than 4 weeks (28 days). Regardless of transfers to other acute or post acute settings.

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Coding Practice:

A. Resident admitted after hospitalization for an acute myocardial infarction of the left anterior descending wall

B. Resident admitted to hospital with hypertensive urgency. Resolved after administration of diuretics. Discharging diagnoses are Diastolic CHF and Hypertension

CHAPTER 9: Diseases of the Circulatory System (I00 – I99)

Coding Practice Answers:

A. I21.02 ST elevated (STEMI) myocardial infarction involving left anterior descending coronary artery

B. I11.0 Hypertensive heart disease with heart failure I50.30 Unspecified diastolic (congestive) heart failure

CHAPTER 10: Diseases of the Respiratory System (J00 – J99)

Chronic Obstructive Pulmonary Disease (COPD) and Asthma are divided between uncomplicated cases and those with acute exacerbation.

- Code J44.0 COPD with acute lower respiratory infection for a resident with diagnosis of COPD and pneumonia or other lower respiratory infection.

CHAPTER 10: Diseases of the Respiratory System (J00 – J99)

Coding Practice:

A. Resident admitted for skilled care related to bacterial pneumonia. Sputum culture is positive for Streptococcus pneumoniae

B. Long-term care resident with COPD returns to facility after hospitalization for aspiration pneumonia

CHAPTER 10: Diseases of the Respiratory System (J00 – J99)

Coding Practice Answers:

A. J13 Pneumonia due to streptococcus pneumoniae

B. J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection J69.0 Pneumonitis due to inhalation of food and vomit

CHAPTER 11: Diseases of the Digestive System (K00 – K95)

Divided into the following subcategories:

- K00-K14: Diseases of oral cavity and salivary glands
- K20-K31: Diseases of esophagus, stomach, and duodenum
- K35-K38: Diseases of appendix
- K40-K46: Hernia
- K50-K52: Noninfective enteritis and colitis

CHAPTER 11: Diseases of the Digestive System (K00 – K95)

Divided into the following subcategories:

- K55-K64: Other diseases of intestines
- K65-K68: Diseases of peritoneum and retroperitoneum
- K70-K77: Diseases of liver
- K80-K87: Disorders of gallbladder, biliary tract and pancreas
- K90-K95: Other disease of the digestive system

CHAPTER 12: Diseases of the Skin and Subcutaneous Tissue (L00 – L99)

Utilize as many codes from the L89 category as necessary to identify all pressure ulcers

Unstageable pressure ulcers should be assigned when:

- Stage of pressure ulcer cannot be determined due to eschar, slough, etc.
- Pressure ulcer is documented as a deep tissue injury without documentation as due to trauma.

CHAPTER 12: Diseases of the Skin and Subcutaneous Tissue (L00 – L99)

Documentation from clinicians other than physicians or physician extenders (APRN or PA) may be used for coding

- Stage of pressure ulcers
- Severity of non-pressure ulcers

CHAPTER 12: Diseases of the Skin and Subcutaneous Tissue (L00 – L99)

Coding Practice:

- Resident admitted for skilled nursing care related to chronic non-pressure ulcer of the left calf. Nursing documentation states muscle can be seen in the wound. Physician documentation lists diabetes as an additional diagnosis.

CHAPTER 12: Diseases of the Skin and Subcutaneous Tissue (L00 – L99)

Coding Practice Answer:

- E11.622 Type 2 Diabetes Mellitus with other skin ulcer
- L97.225 Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)

When multiple sites of bone, joint or muscle are affected by the same condition use a code for "multiple sites" when available.

Bone, joint or muscle conditions that are a result of a healed injury are usually found in this chapter

- Acute injuries should be coded to Chapter 19

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)

Coding of pathologic fracture requires use of a seventh character to identify the encounter type.

- Assignment is based on whether the resident is undergoing active treatment
  - Not on whether it is the providers first encounter with the resident.

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)

Osteoporosis with current pathological fracture (M80.-) should be coded when a resident with known osteoporosis suffers a fracture, even if the resident had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)

Coding Practice

- Resident admitted for skilled care post hospitalization for a periprosthetic fracture of right hip.
- Long-term care resident with osteoporosis treated conservatively in facility for fracture of L5 vertebra following fall from wheelchair

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00 – M99)

Coding Practice Answers:

A. M97.01XD Periprosthetic fracture around internal prosthetic right hip joint

B. M80.08XA Age-related osteoporosis with current pathologic fracture, vertebra(e), initial encounter for fracture

CHAPTER 14: Diseases of the Genitourinary System (N00 – N99)

Chronic kidney disease (CKD) is divided by stage:

- Stage 1
- Stage 2 or Mild
- Stage 3 or Moderate
- Stage 4 or Severe
- Stage 5
- End-stage renal disease

If both a stage of CKD and ESRD are both documented, assigned code N18.6 End-stage renal disease

CHAPTER 15: Pregnancy, Childbirth and the Puerperium (O00 – O9A)

Not typically assigned for stays in Skilled Nursing Facilities

Diagnosis code from this chapter are often selected in error when attempting to code a condition from another chapter.

CHAPTER 16: Certain Conditions Originating in the Perinatal Period (P00 – P96)

Not typically assigned for stays in Skilled Nursing Facilities
Diagnosis code from this chapter are often selected in error when attempting to code a condition from another chapter.

www.fhca.org

CHAPTER 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

When the malformation/deformation or chromosomal abnormality code does not have a unique code assignment, additional codes for manifestations may be used.

Do not use additional codes when manifestations are included in the condition code or are inherent components of the underline condition.

www.fhca.org

CHAPTER 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the condition.

www.fhca.org

CHAPTER 18: Symptoms, Signs and Abnormal Clinical/Lab Findings, NEC (R00 – R99)

Codes for symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been identified.

- Unless the signs or symptoms are not routinely associated with the definitive diagnosis
- The definitive diagnosis should be sequenced before the symptom

CHAPTER 18: Symptoms, Signs and Abnormal Clinical/Lab Findings, NEC (R00 – R99)

R29.6 – Repeated falls

- Used for encounters when a resident has recently had multiple falls and the cause for the falls is under investigation.

Z91.81 – History of falling

- Used when resident has fallen in the past and is at risk for future falls

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

In the absence of documentations the following defaults apply:

- Fracture not documented as open or closed, code to closed
- Fracture not documented as displaced or non-displaced, code to displaced

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Use of seventh characters for identifying encounter types

- Assignment is based on whether the resident is undergoing active treatment
  - Not on whether it is the provider's first encounter with the resident.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

For fracture and injuries the assignment of the 7th character:

- "A" Initial Encounter is used when the resident is receiving active treatment for the condition. (Active treatment includes splinting, casting, surgery, etc.)

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

For fracture and injuries the assignment of the 7th character:

- "D" Subsequent Encounter is used after the resident has received active treatment of the injury/fracture and is receiving care for the condition during the healing and recovery phase.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

For fracture and injuries the assignment of the 7th character:

- "S" Sequela is used when a complication or other condition arises as a result of the injury/fracture.
  - A code for the specific sequela must be used and sequenced first, followed by the injury/fracture code

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

For open fractures of the forearm, femur, and lower leg (including ankle) the assignment of the 7th character:

- Based on the Gustilo open fracture classification
  - If classification is not specified for an open fracture, type I or II should be assigned.

GUSTILO TYPE

GUSTILO TYPE	DEFINITION
I	Open fracture, clean wound, wound less than 1cm in length
II	Open fracture, wound greater than 1cm in length without extensive soft tissue damage, flaps, or avulsions
III	Open fracture with extensive soft tissue laceration, damage, or loss, or an open segmental fracture (Includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for eight hours prior to treatment)
IIIA	Type III fracture with adequate periosteal coverage of the fractured bone despite the extensive soft-tissue laceration or damage
IIIB	Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. (Usually associated with massive contamination. Will often need additional soft-tissue coverage procedure, such as a flap graft)
IIIC	Type III fracture associated with an arterial injury requiring repair, regardless of soft-tissue injury

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Z codes for aftercare should not be assigned for injuries and fractures, where the seventh character identifies the subsequent care.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

For complication codes the assignment of the 7th character:

- Refers to the treatment of the condition described by the code, even if related to an earlier precipitating problem.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Drug Toxicity

- Adverse effect: coded when drug was correctly prescribed and administered
  - Code the nature of the adverse effect (i.e. hypokalemia, coagulopathy, etc.) first. Followed by the appropriate code for the adverse effect of the drug (T36-T50)

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Drug Toxicity

- Poisoning: coded for poisoning or reaction to improper use of a medication
  - Overdose
  - Wrong medication administered
  - Wrong route of administration

www.fhca.org

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Complications of Care

- Pain due to medical devices, such as implants, prosthesis or grafts are coded to this chapter.
  - An additional code from category G89 may be used to identify acute or chronic pain due to the device, implant, or graft. (G89.18 or G89.28)

www.fhca.org

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Complications of Care

- Transplant complications (T86.-)
  - Used to identify complications and rejection of transplanted organs.
  - Coded only when the complication affects the function of the transplanted organ
  - May require two or more codes

www.fhca.org

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Coding Practice:

A. Resident admitted for skilled care following hospitalization for an open transverse fracture of the right fibula.

B. Long-term care resident treated for chronic pain in right ankle due to internal fixation device

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)

Coding Practice Answers:

A. S82.421E Displaced transverse fracture of shaft of right fibula, subsequent encounter for open fracture type I or II with routine healing

B. T84.84XD Pain d/t internal orthopedic prosthetic device, implant, and graft, subsequent encounter

G89.28 Other chronic postprocedural pain

CHAPTER 20: External Causes of Morbidity (V00 –Y99)

- Used to provide data for injury research and evaluation of injury prevention strategies.
- May never be sequenced as the principal or first listed diagnosis
- No national requirement for reporting. Unless required by state or payer mandate, reporting of external causes is not required.

CHAPTER 21: Factors Influencing Health Status & Contact with Health Services (Z00 – Z99)

May be used as principal or secondary code, depending on reason for encounter.

Certain Z codes may only be principal diagnoses. List of this codes may be found in the chapter specific guidelines.

CHAPTER 21: Factors Influencing Health Status & Contact with Health Services (Z00 – Z99)

Status codes should not be assigned when a diagnosis code from one of the body system chapters includes the information of the status code

- Example: Code Z94.1 Heart transplant status, is not coded with a code from T86.2 Complications of heart transplant.

CHAPTER 21: Factors Influencing Health Status & Contact with Health Services (Z00 – Z99)

Body Mass Index (BMI) codes should only be assigned when the associated diagnosis meets the definition of a reportable diagnosis under Section III – Reporting Additional Diagnoses.

CHAPTER 21: Factors Influencing Health Status & Contact with Health Services (Z00 – Z99)

Coding Practice:

A. Resident admitted after right total hip replacement due to a right intertrochanteric femur fracture
B. Resident admitted after right total hip replacement due to osteoarthritis of the right hip

CHAPTER 21: Factors Influencing Health Status & Contact with Health Services (Z00 – Z99)

Coding Practice:

A. S72.141D Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture w/ routine healing
   - Z96.641 Presence of right artificial hip joint
B. Z47.1 Aftercare following joint replacement surgery
   - Z96.641 Presence of right artificial hip joint

Patient Driven Payment Model (PDPM) and ICD-10-CM Coding

How ICD-10-CM Codes are utilized in the case mix groupings.

The Six Case Mix Components of PDPM

Physical Therapy (PT)
Occupational Therapy (OT)
Speech Language Pathology (SLP)
Nursing
Non-Therapy Ancillaries Services (NTA)
Non-Case Mix Component

www.fhca.org

Physical and Occupational Case Mix Component

Drivers of PT and OT component

- Primary reason for skilled stay
  - Utilizes diagnosis codes to classify residents into one of four PT and OT clinical categories
- Function Score based on coding from Section GG of the MDS

www.fhca.org

Physical and Occupational Case Mix Component

Selecting of the primary reason for skilled stay:

- Determine resident's primary diagnosis
  - This will determine which category is checked on item I0200B
- Some codes may map to more than one clinical category

www.fhca.org

Physical and Occupational Case Mix Component

Further delineation may be made into a surgical category based on specific procedures that occurred during inpatient hospitalization

- Surgical Procedure Category will be selected under new MDS items J2100 – J5000.
- These will be check boxes similar to the major condition categories in Section I.

www.fhca.org

Physical and Occupational Case Mix Component

Utilizing the primary diagnosis and any surgical procedure the resident will be categorized into one of the four clinical categories.

- Major joint replacement or spinal surgery
- Other orthopedic
- Non-orthopedic surgery
- Medical Management

www.fhca.org

Clinical Category

Clinical Category	Function Score	PT Case Mix Group	CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92
Other Orthopedic	0-5	TE	1.42
Other Orthopedic	6-9	TF	1.61
Other Orthopedic	10-23	TG	1.67
Other Orthopedic	24	TH	1.16
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

www.fhca.org

Speech Language Pathology (SLP) Case Mix Component

ST Case Mix utilizes diagnosis codes to classify residents into neurologic or non-neurologic clinical category

It also utilizes diagnosis coding to capture SLP related comorbidities.

Speech Language Pathology (SLP) Case Mix Component

Five Characteristics that will impact the SLP Component

- Acute Neurologic or Non-Neurologic
- SLP-Related Comorbidity
- Cognitive Impairment
- Mechanically Altered Diet
- Swallowing Disorder

Speech Language Pathology (SLP) Case Mix Component

The following comorbidities will be pulled from Section I – Active Conditions of the MDS

- Item I4300. Aphasia
- Item I4500. CVA, TIA, Stroke
- Item I4900. Hemiplegia or Hemiparesis
- Item I5500. Traumatic Brain Injury

Speech Language Pathology (SLP) Case Mix Component

The following comorbidities will be pulled from Section I – Active Conditions of the MDS, Item I8000:

- Laryngeal Cancer
- Apraxia
- Dysphagia
- ALS
- Oral Cancers
- Speech and Language Deficits

ICD-10-CM Codes

Condition	ICD-10-CM Code	Description
Speech and Language Deficits	I69.928	Other speech and language deficits following unspecified cerebrovascular disease
Speech and Language Deficits	I69.920	Aphasia following unspecified cerebrovascular disease
Speech and Language Deficits	I69.921	Dysphasia following unspecified cerebrovascular disease
Speech and Language Deficits	I69.922	Dysarthria following unspecified cerebrovascular disease
Speech and Language Deficits	I69.923	Fluency disorder following unspecified cerebrovascular disease
Speech and Language Deficits	I69.928	Other speech and language deficits following unspecified cerebrovascular disease

Speech Language Pathology (SLP) Case Mix Component

Additional factors utilized to adjust case mix index calculation

- Mechanically Altered Diet
  - Determined by K0510C2
- Swallowing Disorder
  - Determined by K0100
- Cognitive Impairment
  - Determined by C0500 or C1000

Neurologic Conditions

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

Nursing Case Mix Component

Utilizes modified version of the RUG-IV Nursing Categories

- Reduced to 25 PDPM RUGS from the original 43

Diagnosis codes are used to further classify residents into one of the 25 PDPM RUG groups.

Nursing Case Mix Component

Nursing Function Score based on Section GG

- GG0130A1 – Self-care: Eating
- GG0130C1 – Self-care: Toileting Hygiene
- GG0170B1 – Mobility: Sit to Lying
- GG0170C1 – Mobility: Lying to Sitting on bedside
- GG0170D1 – Mobility: Sit to Stand
- GG0170E1 – Mobility: Chair/bed to chair/bed
- GG0170F1 – Mobility: Toilet Transfer

Nursing Case Mix Component

Further division is based on the presence of the following conditions or services:

- Tracheostomy and Ventilator/Respirator
- Infection Isolation
- Depression
- Restorative Nursing Services

Nursing Case Mix Component

RUGs are grouped into six categories

- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Cognitive Symptoms
- Reduced Physical Function

Nursing Case Mix Component

Special Care High

- Diagnosis Coding in from Section I
  - Septicemia (I2100)
  - Diabetes (I2900) with both of the following:
    - (N0350A) Insulin injections all 7 days
    - (N0350B) Insulin order changes on 2 or more days

Nursing Case Mix Component

Special Care High

- Diagnosis Coding in from Section I
  - Quadriplegia (I5100) with
    - Nursing Function Score greater than or equal to eleven (11)
  - COPD (I6200) and
    - J1100C SOB when lying flat

www.fhca.org

Nursing Case Mix Component

Special Care High

- Fever (J1550A) and one of the following:
  - Pneumonia (I2000)
  - Vomiting (J1550B)
  - Weight Loss (K0300, 1 or 2)
  - Feeding Tube (K0510B1 or K0510B2)

www.fhca.org

Nursing Case Mix Component

Special Care Low

- Diagnosis Coding
  - Cerebral palsy (I4400) and
    - Nursing Function Score of 11 or greater
  - Multiple Sclerosis (I5200) and
    - Nursing Function Score of 11 or greater

www.fhca.org

Nursing Case Mix Component

Special Care Low

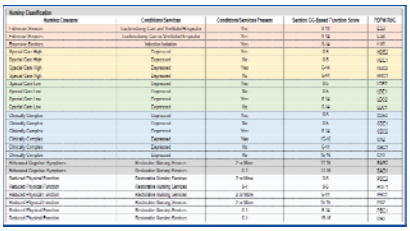
- Diagnosis Coding
  - Parkinson's (I5300) and
    - Nursing Function Score of 11 or greater
  - Respiratory Failure (I6300) and
    - Oxygen therapy while a resident (0100C2)

Nursing Case Mix Component

Clinically Complex

- Diagnosis Coding
  - Pneumonia (I2000) and
    - Nursing Function Score of 11 or greater

Nursing Classifications



Non-Therapy Ancillary (NTA) Case Mix Component

Utilizes 50 diagnosis codes and extensive services to identify additional comorbidities

Utilizes a points scale from 1 to 8 to calculate comorbidity score

- B20 (Human Immunodeficiency Virus [HIV] Disease) must be coded on the UB04
- All other diagnosis and special services are pulled from coding on the MDS

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS.

- Multiple Sclerosis (I5200)
- Asthma, COPD, Chronic Lung Disease (I6200)
- Wound Infections (I2500)
- Diabetes Mellitus (DM) (I2900)
- Multi-Drug Resistant Organism (MDRO) (I1700)
- Malnutrition (I5600)

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS.

- Multiple Sclerosis (I5200)
- Asthma, COPD, Chronic Lung Disease (I6200)
- Wound Infections (I2500)
- Diabetes Mellitus (DM) (I2900)
- Multi-Drug Resistant Organism (MDRO) (I1700)
- Malnutrition (I5600)

www.fhca.org

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS,

- I8000 – Additional Diagnoses
  - Lung Transplant Status
  - Major Organ Transplant Status, Except Lung
  - Opportunistic Infections
  - Bone, Joint, Muscle Infections/Necrosis, Except Aseptic Necrosis of Bone

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Chronic Myeloid Leukemia
  - Endocarditis
  - Immune Disorders
  - End-Stage Liver Disease
  - Narcolepsy and Cataplexy

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Cystic Fibrosis
  - Specified Hereditary Metabolic and Immune Disorders
  - Morbid Obesity
  - Chronic Pancreatitis

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Psoriatic Arthropathy and Systemic Sclerosis
  - Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
  - Complications of Specified Implanted Device or Graft

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Inflammatory Bowel Disease
  - Aseptic Necrosis of Bone
  - Cardio-Respiratory Failure and Shock
  - Myelodysplastic Syndromes and Myelofibrosis

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Hemorrhage
  - Severe Skin Burn or Condition

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Diabetic Retinopathy, Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
  - Intractable Epilepsy
  - Disorders of Immunity

Non-Therapy Ancillary (NTA) Case Mix Component

The following conditions will be pulled from Section I – Active Conditions of the MDS

- I8000 – Additional Diagnoses
  - Cirrhosis of Liver
  - Respiratory Arrest
  - Pulmonary Fibrosis & Other Lung Disorders

Comorbidity Descriptions

Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
Endocarditis	A0102	Typhoid fever with heart involvement
Endocarditis	A1884	Tuberculosis of heart
Endocarditis	A3282	Listerial endocarditis
Endocarditis	A3951	Meningococcal endocarditis
Endocarditis	A5203	Syphilitic endocarditis
Endocarditis	A78	Q fever
Endocarditis	B3321	Viral endocarditis
Endocarditis	B376	Candidal endocarditis
Endocarditis	I330	Acute and subacute infective endocarditis
Endocarditis	I339	Acute and subacute endocarditis, unspecified
Endocarditis	I38	Endocarditis, valve unspecified
Endocarditis	I39	Endocarditis and heart valve disorders in diseases classified elsewhere
Endocarditis	M3211	Endocarditis in systemic lupus erythematosus

Non-Therapy Ancillary (NTA) Case Mix Component

HIV/AIDS add-on

- Applied based on the presence of ICD-10-CM code B20 on the SNF claim.
- Due to the significant increase in nursing cost to care for HIV/AIDS patients, the facility will get an 18% increase in NTA category.

www.fhca.org

NTA Comorbidity Score

NTA Comorbidity Score	NTA Case Mix Group	CMI
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

www.fhca.org

Physician Queries

Helping providers document the most specific diagnosis possible based on their notes, orders, and other findings within the medical records.

www.fhca.org

Querying a Provider

Requests to providers for further clarification of a diagnosis must be presented in a nonleading manner.

Forms of Query

- Yes/No: Often used to identify an underlying cause of a condition. Such as, complications of a surgical procedure.

Querying a Provider

Forms of Query

- Open-Ended: provides objective findings present in the medical record with an request for a diagnosis that represents the indicators presented.
- Multiple Choice: provides findings documented in the medical record with a list of specific conditions that may apply. Typically, includes an "Other" option.

Accurate Coding and Sequencing

Requirements

Under HIPAA healthcare providers that will be billing Medicare and/or Medicaid Services are required to follow the ICD-10-CM coding conventions and guidelines

Risks of Inaccurate Coding

- Inaccurate health record
- Incomplete or inaccurate data on the MDS
- Incomplete or inaccurate data on the UB04

Risks of Inaccurate Coding

Risk Management

- Diagnosis of osteoporosis in a resident that obtains a fracture after rolling out of the bed in lowest position onto fall mats.
- Coding guidelines indicate that the fracture may be coded as a pathologic fracture.

Risks of Inaccurate Coding

Quality Care

- Resident specific care based in part on their specific diagnoses and other care needs.
  - Resident with diagnosis of CVA versus CVA with right side nondominant hemiplegia
  - UTI vs. UTI due to ESBL E.coli

www.fhca.org

Risks of Inaccurate Coding

Care Planning

- Diagnoses aid in identification of problems and determination of interventions
  - Anemia vs. Anemia d/t Vitamin B12 deficiency
  - DM vs. DM with nephropathy

www.fhca.org

Risks of Inaccurate Coding

Quality Measures

- Percentage of Short Stay Residents with Pressure Ulcers that are New or Worsening
  - Includes Covariates related to diabetes or peripheral vascular disease coded in Section I

www.fhca.org

Risks of Inaccurate Coding

Quality Measures

- SNF Readmission Measure (SNFRM)
  - Exclusions include hospitalized for primary diagnosis related to medical (non-surgical) treatment of cancer

Risks of Inaccurate Coding

Quality Measures

- SNF Readmission Measure (SNFRM)
  - Exclusions include hospitalized for primary diagnosis related to medical (non-surgical) treatment of cancer

www.fhca.org

Risks of Inaccurate Coding

Claims Denials

- Remittance advice informs of invalid diagnosis, but does not typically specify which code or sequence

www.fhca.org

Avoiding Inaccurate Coding

Claims Denials

- Remittance advice informs of invalid diagnosis, but does not typically specify which code or sequence

www.fhca.org

Ensuring Compliance

Create a policy and procedure related to diagnosis coding

Maintain a current ICD-10-CM Coding Manual

- Use both the Alphabetic and Tabular Indices
  Always code each stay independently.
- Never pull diagnosis codes forward

www.fhca.org

Ensuring Compliance

Ensure that all disciplines are utilizing the same primary diagnosis

Review diagnosis coding during Triple Check (Pre-Bill) meeting

Review annual code updates effective October 1st and revise codes for current residents, as needed

www.fhca.org

Ensuring Compliance

Speak to your EHR/Billing System provider regarding how, or if, diagnosis information will pull into Section I of the MDS

References and Resources

Centers for Medicaid and Medicare Services (CMS), Patient Driven Payment Model, Background & Finalized Changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS); retrieved January 16, 2019 from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

References and Resources

Liebner, Carol S; Lowery, Amanda L; Maccariella-Hafey, Patricia C; Usher, Joan L; Ward, Maria; Young, Carol. "ICD-10-CM Coding Guidance for Long-Term Care Facilities". Journal of AHIMA 86, no.3 (March 2015): 46-50 [extended web version]. Retrieved March 5, 2019 from http://library.ahima.org

References and Resources

American Medical Association. “ICD-10-CM The Complete Official Codebook”. Optum360, LLC (2018).

Q & A

Questions???

Thank you for your participation

Please contact Robin A. Bleier with regards to services at robin@rbhealthpartners.com
or call us at 727.786.3032
Click HERE for more info about this Presenter