2010 ICD-9-CM CODING FOR LTC

PRESENTED BY
ALABAMA HEALTH CARE ASSOCIATION
MAY 25, 2010
SPEAKER:
ANNE COOK, RHIA
HIM CONSULTANT

Introduction to ICD-9-CM

- ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification
- Published by WHO (World Health Organization)
- New codes each year must be used for billing starting in October
- Used internationally to communicate disease/procedure data

Introduction to ICD-10-CM

- FYI…10th Revision is used in most countries outside of USA
- Codes expand to seven digits (alpha/numeric)
- UB-04 form “paves the way” with expanded fields
- Implementation date in USA: October 2013

The Coding Book

- Different publishers have variations to color coding within the ICD-9-CM code book
- Codes and descriptions are standard regardless of publisher

Volume 1- Tabular List of Diseases and Injuries

- Numerical list of codes
- 17 Chapters – by body system or type of disease (e.g. infections)
- Supplementary classifications
  - V Codes (Health Care Factors)
  - E Codes (External Causes of Injury/ Poisoning)

Volume 2- Alphabetic Index to Diseases

- Alphabetical list of conditions
- Hypertension Table
- Neoplasm Table
- Table of Drugs and Chemicals
- Index to External Causes of Injury and Poisoning (E Codes)

Volume 3 – Index and Tabular List of Procedures

- ICD-9-CM procedure codes have 2 digits before the decimal point (xx.xx)
- Procedure codes are not used by LTC facilities (per direction from HIPAA Law)
- LTC facilities assign “Aftercare” codes to report surgical procedures

Coding Conventions and Formatting: Alphabetic Index

- Main Terms:
  - . Identify Disease, Condition
  - . Listed in bold type
- Additional Main Term headings:
  - . Complications
  - . Late Effects
  - . V codes: admission for, aftercare, history of, absence of, etc.

Coding Conventions and Formatting: Alphabetic Index

- Sub terms
  - . Describe essential differences in a disease or condition related to:
    - . Site
    - . Cause
    - . Clinical type
    - . Complications

Coding Conventions and Formatting: Alphabetic Index

- Eponyms:
  . Diseases or syndromes named for a person
  . Listed as main terms, in appropriate alphabetic sequence, under both name of person and under *Disease or Syndrome*
  . Examples: Alzheimer's Disease 331.0

Coding Conventions and Formatting: Alphabetic Index

- Hypertension Table:
  . Found under "Hypertension"
  . Listing of conditions due to or associated with hypertension
  . Classifies hypertension as: Malignant, Benign or Unspecified

Coding Conventions and Formatting:Alphabetic Index

- Neoplasm Table: Found under "Neoplasm"
- Anatomic site listed in left most column
- Six columns indicate behavior of neoplasm:
  . Malignant: primary, secondary, in-situ
  . Benign .Uncertain Behavior
  . Unspecified

Instructional Notations – Alphabetic Index and Tabular List

- Not Elsewhere Classified (NEC)
  . Coder **has** specific information but has determined that a code is not available that matches the information
  . Equivalent to "other specified"
- Not Otherwise Classified (NOS)
  . Coder **lacks** specific information in the medical record. Equivalent to "unspecified"

Instructional Notations – Alphabetic Index and Tabular List

- **Cross References:**
- **See**
- **See Also**

Instructional Notations: See

- An explicit direction to look elsewhere
- Example: Searching the alphabetic Index under the main term "Kidney" results in "Kidney – **See Condition**
- Search index using main term for condition or disease such as Stone, Kidney

Instructional Notations – See Also

- Instruction to review another main term if all needed information is not located under the first main term
- Example: Searching the alphabetic index for "Dementia, multi-infarct" results in the following direction:
- Dementia,multi-infarct (cerebrovascular) – **See Also** Dementia,arteriosclerotic

Instructional Notations – Includes

- Found in Tabular List
- Appear at Beginning of Chapter, Section or directly below category or subcategory . Example: Hypertension
- Lists synonyms or similar conditions classified to code number

Instructional Notations - Excludes

- Found in Tabular List
- Appear at beginning of a chapter, section,below a category, subcategory or sub classification
- Guidance to select another code
- Example: Diabetes Mellitus: **Excludes** secondary diabetes (249)

Instructional Notations – Etiology and Manifestations

- Etiology – cause or underlying disease
- Manifestation – symptom or condition related to disease
- Example: Diabetic Retinopathy
  Etiology: Diabetes Mellitus 250.5x
  Manifestation: Retinopathy 362.0x
- Code BOTH etiology and manifestation
- Manifestation code is "blue" highlighted in Tabular List and may not be used alone

Instructional Notations – Disease Etiology

- Alphabetic Index lists etiology code followed by the manifestation code in slanted brackets
- Tabular listing includes **Use additional code** notation to identify disease manifestation
- Etiology codes are listed before the associated manifestation code when sequencing diagnoses

Structure of Codes

- Sections are groups of 3 digit codes
- Categories are 3 digit codes
- Subcategories are 4 digit codes
- Sub classifications are 5th digit of code
- ICD-9-CM codes should be used at their highest level of specificity (highest number of digits available)
- Observe symbols used by publisher to indicate need for 4th or 5th digits

Instructional Notations – Disease Manifestation

- Alphabetic index lists etiology code followed by the manifestation code in slanted brackets
- Tabular listing includes **"code first"** notation to identify underlying disease
- Manifestation codes are listed after the associated etiology code when sequencing diagnoses

How to Assign a Code

- Review the diagnostic statement
- Identify the main terms which are diseases or conditions and are often **nouns**
- Do not start with **anatomical site**
- Generally, review diagnostic statement from right to left
- Capture all components of diagnosis when possible

How to Assign a Code

- Example: COPD
- Chronic Obstructive Pulmonary Disease
- Start with **Disease**
- Then, **Pulmonary**
- Next, **Obstructive**
- Last, **Chronic**

Steps to Accurate Coding

- Locate the main term in the diagnostic statement
- Locate that same main term in the Alphabetic Index
- Refer to all notes under the main term
- Examine any modifiers in parentheses
- Carefully follow the sub terms indented under the main term

Steps to Accurate Coding

- Follow any cross reference instructions
- Confirm the code in the Tabular List
- Read and be guided by instructions in the Tabular List (includes and excludes notes)
- Assign code number to the highest level of specificity

Neoplasm Table

- Malignant: Primary, Secondary, In-situ
- Benign
- Uncertain Behavior
- Unspecified
- Unknown Site
- Multiple Sites

Neoplasm Table (140-239)

- To ensure accurate code assignment,begin looking for specific neoplasm in the Disease Index Example: Adenoma, Adenocarcinoma, Sarcoma
- Instructions will usually lead you to the Neoplasm Table- “See also Neoplasm, by site, malignant”

Neoplasm Table (140-239)

- Primary site: Where the cancer originates
- May code multiple primary sites if specified
- Code each site rather than code for multiple sites
- Primary is assumed whenever the diagnostic statement does not specify. Example: Carcinoma of breast

Neoplasm Table (140-239)

- Secondary Site: Where the cancer spreads or metastasizes to.
- May state breast cancer spread to lungs (Breast primary, Lungs secondary)
- Use a V code for a site that was surgically removed with no further treatment (V10)

Neoplasm Table (140-239)

- Carcinoma In-Situ:
- Atypical malignancy; does not spread;is encapsulated; at point of origin
- May be described as “non-invasive, pre-invasive, non-infiltrating, intraepithelial
- Do not assign “in situ” code unless physician specifically states

Neoplasm Table (140-239)

- Uncertain Behavior:
- Index instructions will sometimes refer you to this column (Ex: villous adenoma)
- Diagnosis must clearly state that the neoplasm is of uncertain behavior
- If needed, contact transferring hospital for clarification

Neoplasm Table (140-239)

- Unspecified:
- Neoplasms that have not been specified as malignant or benign Ex: Tumor
- Unspecified neoplasm codes should seldom if ever be used
- “Carcinoid” tumors are a special category (209)

Neoplasm Table (140-239)

- Morphology codes (M-codes) are not used in LTC
- Morphology means study of cellular structure
- M-codes are listed in Disease Index under the specific neoplasm
- Example: Carcinoma, Liver Cell (M8170/3)

Neoplasm Table (140-239)

- If a neoplasm has been surgically removed yet resident is still receiving chemotherapy, radiotherapy or aftercare following surgery, code the neoplasm as a current condition.
- When a neoplasm has been surgically removed and/or treated without recurrence, code to personal history of neoplasm (V10)
- Never assign family history of neoplasm code (V16)

Coding Exercises for Neoplasms

- Breast Cancer with metastasis to brain
- Melanoma of neck
- Carcinoid Tumor of Lung
- Adenoma of Thyroid

Hypertension Table (401-405)

- Malignant
- Benign
- Unspecified
- Code hypertension to unspecified column unless specifically documented that condition is malignant or benign

Hypertension Table (401-405)

- Hypertension with heart disease – Use category 402 when a causal relationship is stated (due to hypertension) or implied (Hypertensive heart disease)
- Hypertension with chronic kidney disease- Use category 403 when any condition coded to 585-587 is present in a resident with hypertension

Coding Exercises for Hypertension

- Hypertensive crisis
- Uncontrolled hypertension
- Accelerated hypertension
- Hypertensive heart disease

Drugs and Chemicals Table

- Adverse effects of drugs and poisonings
- E-codes never used as **principal diagnosis**
- E-codes **may not stand alone**
- Poisoning agents (960-989)
- Accidents (minimum of 3 codes)
- Therapeutic use (minimum of 2 codes)
- Suicide attempt (minimum of 3codes)
- Assault (minimum of 3 codes)

Coding Exercises for Adverse Effects of Drugs and Chemicals

- Digitalis toxicity
- Dermatitis secondary to allergic reaction to Ampicillin
- Uncontrolled vomiting secondary to ingestion of Bengay ointment

ICD-9-CM CHAPTERS: Infections and Parasitic Diseases (001-139)

- Code first to the site or type of infection
- Go to “Infection” in alphabetic index
- Infection codes may combine disease process with organism in one code: Example: Pneumonia due to staphylococcus aureus 482.41

ICD-9-CM Chapters: Infections and Parasitic Diseases (001-139)

- Code organism separately if it is not included with the diagnosis description (UTI with E.Coli 599.0, 041.4)
- **MRSA** is coded 041.12
- Do not assign a code from subcategory V09.0 Infection with microorganism resistant to penicillin as an additional dx

Sepsis

- Code underlying infection first (Ex:UTI 599.0) followed by 995.91 for Sepsis
- Severe Sepsis: Change 5th digit to indicate organ dysfunction 995.92
- Codes for organ dysfunction must be assigned also.
  - * Acute respiratory failure: 518.81
  - * Septic shock: 785.52:Code may not stand alone
  - * Acute renal failure 584.5- 584.9

Coding Exercises for Infections

- Clostridium difficile diarrhea
- UTI with MRSA
- Sepsis secondary to pneumonia
- Sepsis secondary to Septicemia with acute renal failure

ICD-9-CM Chapters: HIV AND AIDS

- Use category 042 for confirmed HIV or AIDS
- Use V08 for HIV positive results with **no symptoms and no previous HIV illness**
- Sequencing HIV and related manifestations- Code HIV/AIDS first and related illness/condition second

Increased Revenue for treatment of AIDS residents

- If a resident has a physician documented diagnosis of HIV or AIDS with an infection, check the box on the MDS (12d), but also add the diagnosis code of 042 to UB-04 bill
- If the above resident is on Medicare Part A, the RUG rate will be increased by 128%
- If the resident has a positive lab test indicating HIV, but no associated infection,the proper code is V08

Coding Diabetes Mellitus/Complications

- Diabetes fifth digit assignment:
- 0 Type II or unspecified type, not stated as uncontrolled
- 1 Type I (Juvenile) not stated as uncontrolled
- 2 Type II or unspecified type, uncontrolled ***(Documentation must indicate widely fluctuating blood sugars; taking sliding scale insulin)***
- 3 Type I (Juvenile), uncontrolled

Coding Diabetes Mellitus/Complications

- Use additional code to identify specific diabetic complications or manifestations
- Always follow “Code Also”instructions
- Use additional code, if applicable for long-term or current use of Insulin V58.67
- ***Never assign uncomplicated diabetic code 250.0x with a complicated diabetic code 250.1x-250.9x***
- ***Uncomplicated diabetic code 250.0x is a poor choice for principal diagnosis***

Coding Exercises for Diabetes Mellitus

- Diabetic ulcer with gangrene of lower extremity secondary to PVD: S/P BKA
- Type II Diabetes with neuropathy
- Diabetes mellitus (long-term use of Insulin)

Secondary Diabetes Mellitus

- Fifth-digit identifies controlled or uncontrolled.
- Routine use of Insulin, Assign code V58.67
- Sequencing Secondary Diabetes Mellitus and Associated Conditions (e.g. renal manifestations). Category 249 sequenced before associated condition.
- Sequencing Secondary Diabetes Mellitus and its causes: Condition that caused Secondary Diabetes (e.g. malignant neoplasm of Pancreas) is sequenced first followed by code from Category 249.

Coding Wounds

- 879.8 Open wound (injury)
- 998.59 Postoperative wound infection
- 707.0x Pressure ulcer
- 454.0 Stasis ulcer of leg
- 707.1x Chronic ulcer secondary to diabetes

Pressure Ulcer Stage Codes

- Two codes needed to completely describe pressure ulcer.
- 707.0 Location 707.2 Stage
- Pressure ulcer stage code may not be listed as principal diagnosis
- Unstageable 707.25 should not be confused with 707.20 Unspecified

Pressure Ulcer Stage Codes

- Bilateral pressure ulcers with same stage: Only one code for location and one code for stage.
- Bilateral pressure ulcers with different stages: One code for location and two codes for stages.
- Multiple pressure ulcers of different sites and stages: Code for each location and code for each different stage.

Circulatory Disorders (390-459)

- Acute CVA: Cerebrovascular Accident 434.91
- Resident who has an acute CVA at nursing facility and DOES NOT go to hospital or ER for care or treatment (i.e. treated only at nursing facility) is assigned this code. This illustrates that the NF is providing initial episode of care

Late Effects of Cerebrovascular Disease

- 438.xx: assigned when a resident has completed the initial treatment for any condition between 430-437 at the hospital and admitted to the NF for subsequent treatment of the residuals.
- 438.xx is a combination code with dual meanings: the resident had an acute cerebrovascular incident and there are residuals which require further treatment.
- Example: 438.11 Late Effects of CVA, Aphasia

Late Effects of Cerebrovascular Disease (438)

- Multiple 438 codes may be assigned to illustrate all residual conditions treated at NF
- 438 codes may be assigned for both medical and treatment diagnoses for therapy services
- 438.89 is assigned for a residual condition that is not specifically listed. Ex: Left/Right sided weakness 438.89/728.87

Myocardial Infarction (Heart Attack)

- 410 category assigned when MI is acute with duration of less than 8 weeks
- Select appropriate 4th digit for wall involvement Ex: Subendocardial 410.7
- Select appropriate 5th digit for initial or subsequent episode of care – usually 2 for NF
- 414.8 assigned for MI with symptoms after 8 weeks
- 412 category is assigned when MI is old, healed with no current symptoms

History of CVA

- V12.54 Personal history of CVA/TIA should be assigned (and not a code from 438) when there is a diagnosis or history of cerebrovascular disease but no neurological deficits are present

Coding Exercises for Late Effects of Cerebrovascular Disease

- Right sided weakness secondary to CVA
- Cerebral embolism with Dysphagia and Dysphasia
- Subdural hemorrhage with hemiparesis

VENOUS THROMBOSIS/EMBOLISM AND PULMONARY EMBOLISM

- "Acute" VTE is a new thrombosis that requires initiation of anticoagulant therapy.
- "Chronic" VTE in reference to these conditions describes an old or previously diagnosed thrombus that requires continuation of anticoagulant therapy.
- New codes were added in 2010 to identify "chronic" VTE. ***Use additional code V58.61, Long-term (current) use of anticoagulants.***
- Personal history of thrombosis (without anticoagulant therapy) is coded V12.51

Complications of Medical and Surgical Care

- Refer to keyword "Complications" in Disease Index
- Key indentions: Due to; Mechanical; surgical procedures; etc.
- Examples: Complication of Gastrostomy; Failure of prosthetic joint; Complication of vascular catheter; Postop. wound infection,etc.

Coding Exercises for Complications

- Complication of Gastrostomy
- Postoperative wound infection
- Failure of hip prosthesis

Who Can Assign a Diagnosis

- Physicians: Attending, Consulting
- Physician extenders (within their scope of practice): Nurse practitioners, physician assistants
- Therapists: May only assign treatment diagnoses
- Licensed Nurses: May only assign nursing diagnoses e.g. incontinence, pressure ulcer

Where to find diagnoses in Hospital Records

- History and Physical Exam
- Discharge Summary
- Transfer form/Transfer orders
- Therapy records
- Consultations
- Diagnostic test results (Tissue Report, EKG,)
- Operative Report
- Physician progress notes

Coding Process in LTC

- Admission
- Identify and sequence according to **acuity**
- Principal (first-listed) diagnosis relates to condition treated at hospital
- Assign ICD-9 codes within 24 hours
- Input into software and print for clinical record
- Discuss at weekly Medicare meeting

Coding assignment timeframes and triggers

- Upon admission and readmission
- When new diagnoses arise (consults, progress notes)
- Quarterly (with MDS schedule)
- Perform final review of codes each month prior to submission of Medicare claim
- Change, addition or discontinuation in therapy services

Sequencing ICD-9 Codes

- Principal diagnosis (first-listed) (field 67) must be related to condition treated at hospital
- Admission diagnosis (field 69) is same as principal diagnosis on initial encounter at SNF
- Principal diagnosis may be a V-code
- V57 category (Aftercare involving Rehab Services) may ***only be used as a principal diagnosis***

Sequencing ICD-9 Codes

- V57 Category is used when purpose for admission/encounter is rehabilitation. Code for condition for which the service is being performed should be reported as an additional diagnosis. Ex: Aftercare of healing hip fracture V54.13
- Only one code from Category V57 is required. Use V57.89 when multiple therapies are performed during a single encounter.

APPLICATIONS OF V57 CATEGORY

- Use V57 category as principal diagnosis when resident is considered ***"short-term Rehab"*** only.
- Continue use of V57 category as ***Principal Diagnosis*** to last day of month even though therapy may have been discontinued at an earlier date during billing cycle.
- When resident is classified as ***"long-term care"***, do not use V57 category as principal diagnosis.
- Example: Readmission from hospital after a 3-day qualifying hospital stay subsequent to conclusion of previous "spell of illness".

Sequencing ICD-9 Codes

- Diagnosis and V-codes that are interrelated are listed together Ex: Attention to Gastrostomy V55.1; Failure to Thrive 783.7
- Acute codes are listed before chronic codes Ex: Pneumonia 486; Hypertension 401.9
- UB-04 Bill will accommodate nine (16) ICD-9 codes

V-Codes

- Supplementary classification of factors influencing health status and contact with health services
- V-Code Table: 1st Dx.Only; 1st or Add'l Dx; Add'l Dx.Only

Key Words for Locating V-Codes

- Absence of (acquired)
- Admission for
- Aftercare
- Attention to
- Dependence
- Encounter for
- Fitting of

Key Words for Locating V-Codes

- History of
- Long-Term Use
- Non-Compliance
- Palliative Care
- Refusal of care
- Replacement
- Resistance
- Status Post

V-CODE INSTRUCTIONS

- V54.1 Aftercare involving healing traumatic fracture ***Excludes Aftercare following joint replacement V54.81; Aftercare of amputation stump V54.89***
- V54.2 Aftercare involving healing pathological fracture ***Excludes Aftercare following joint replacement V54.81; Aftercare of amputation stump V54.89***
- V54.81 Aftercare following joint replacement ***Use additional code to identify site V43.60- V43.69***

V-CODE INSTRUCTIONS

- V58.4 Aftercare following surgery: ***Excludes Orthopedic Aftercare V54.0-V54.9***
- V58.43 Aftercare following surgery for injury (800-999) ***Excludes for healing traumatic fractures (V54.10-V54.19)***

V-CODE INSTRUCTIONS

- V58.78 Aftercare following surgery to musculoskeletal system (710-739) ***Excludes Orthopedic Aftercare V54.01 – V54.9***

Important V-Code Tips

- When using Aftercare following surgery V-code, do not code condition removed unless it is systemic or located in another part of the body Ex: Chronic ulcer of leg with BKA
- Acquired absence of organ/body part will provide specificity to Aftercare following surgery codes.
- Example Hysterectomy V58.76/V88.01
- Fracture codes (800 category) may only be used by facility that provided initial treatment.

Coding Exercise for V-Coding

- Colostomy Care
- History of colon cancer
- S/P BKA
- Admission for use of vascular catheter
- Dependence on oxygen

Hip Fracture Case

- Resident admitted to SNF for aftercare of healing traumatic hip fracture secondary to fall at home. ORIF surgery was performed. Resident is receiving PT and OT.
- V57.89 Aftercare involving multiple therapies
- V54.13 Aftercare of healing traumatic hip fracture
- V15.88 History of falling

Psychiatric Case

- Resident admitted to SNF for treatment of delirium, hallucinations and depression secondary to vascular dementia. Resident is also blind secondary to Diabetes and takes Insulin daily. Resident is receiving physical therapy for generalized weakness.
- V58.83 Admission for therapeutic drug monitoring
- V58.69 Long-term(current) use of high risk medications NEC
- 290.42 Vascular Dementia with depression
- 780.79 Generalized weakness
- 250.50 Diabetes with ophthalmic manifestation
- 369.4 Blindness
- V58.67 Current use of Insulin

Infection with antibiotics Case

- Resident admitted to SNF with diagnosis of aspiration pneumonia due to dysphagia secondary to Alzheimer's Dementia. Resident continued taking antibiotics and was receiving PT and OT for generalized weakness and dysphagia.
- 507.0 Aspiration pneumonia
- 787.20 Dysphagia
- 780.79 Generalized weakness
- V58.62 Current use of antibiotics
- 331.0 Alzheimer's disease
- 294.10 Dementia in condition classified elsewhere without behavioral disturbance

Infection without antibiotics Case

- Resident admitted to SNF with diagnosis of UTI but was not receiving antibiotics. Resident is receiving physical therapy secondary to generalized weakness.
- V13.01 History of UTI
- 780.79 Generalized weakness

Dehydration Case

- Resident admitted to SNF with diagnosis of dehydration and malnutrition. Gastrostomy tube was surgically inserted. Resident is receiving physical therapy for generalized weakness.
- V58.75 Aftercare following surgery, digestive system
- V55.1 Attention to Gastrostomy
- 263.9 Malnutrition
- 780.79 Generalized weakness

Official ICD-9 Coding Guidelines

- Developed by Centers for Medicare and Medicaid Services (CMS) and National Center for Health Statistics (NCHS)
- Approved by cooperating parties:
- CMS
- NCHS
- AHIMA (American Health Information Management Association)
- AHA (American Hospital Association)

Official ICD-9 Coding Guidelines

- Published on CDC Website (Centers for Disease Control)\ www.cdc.gov/nchs/data//icd9/icdguide.pdf
- Must be followed per HIPAA and per Section I of RAI Manual
- Developed to assist in coding and reporting situations where ICD-9-CM code book does not provide direction
- Instructions published in code book take precedence over any guidelines

Official Coding Guidelines

- Aftercare V-codes are used when:
- Initial treatment of disease or injury has been performed; ***and***
- Continued care is required during healing or recovery phase; ***or***
- Continued care is required for long-term consequences of the disease.
- ***DO NOT USE*** if treatment is directed at a current acute disease. Use diagnosis code. e.g. Pneumonia on antibiotics

Official Coding Guidelines for Aftercare involving Therapy (V57)

- First listed, or principal diagnosis if resident admitted primarily for therapy intervention.
- Condition related to need for therapy is listed as ***first secondary diagnosis then the treatment diagnosis.***
- ***If skilled nursing service(e.g. IV Antibiotics) is longer duration than Therapy, Do Not Use V57 as principal diagnosis.***

AHA Coding Clinic

- Published quarterly
- Provides guidance on use of ICD-9-CM codes
- Content approved by NCHS, CMS, AHIMA and AHA
- Coding Clinic, 4th quarter 1999 published rules for use of V-codes in LTC
- Coding Clinic, 4th quarter 2003 clarified coding fractures in healing phase
- Guidelines require use of aftercare (V) codes for all subsequent encounters after the initial treatment for care of fracture
- For statistical purposes, **acute fracture should only be coded once.**

AHA Coding Clinic

- Coding Clinic, 4th quarter of 2008 further clarified that aftercare involving Rehab (V57) services may only be used as principal diagnosis.
- Coding Clinic, Future issues will be published in 4th quarter of each year on new V codes and pertinent changes to existing V codes. No changes have been made in 2006-2008.

CMS Transmittal 437

- CMS Transmittal 437 for Medicare Claims Processing Manual published on 1/21/2005:
- Principal Diagnosis code must be reported according to Official Coding Guidelines, including proper use of V codes.
- Other Diagnosis Codes required: CMS does not have additional requirements regarding reporting or sequencing of codes.

Definition of Principal (Primary) Diagnosis in Federal Register

- Principal (Primary) diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. (Federal Register: July 21, 1985

Definition of Principal (Primary) diagnosis in Federal Register

- Since that time, the application of the UHDDS definition has been expanded to include all non-outpatient settings (Acute care, Short-term, Long-term and Psychiatric hospitals; Home health agencies; Rehab facilities; Nursing facilities, etc.)
- ***Principal diagnosis code may only be changed at beginning of each month or subsequent to an overnight hospital stay during "spell of illness" .***

Principal diagnosis for definition of SNF Medicare billing

- When it comes to the UB-04, Reference Section 50 of Medicare Claims Processing Manual defines Field 67 (Principal diagnosis) as the condition for which the resident was admitted or readmitted to a SNF to receive skilled services and must be one of the conditions or a related condition for which the resident received hospital care during the qualifying hospital stay.
- (CMS publication 100-04)

Billing Issues

- Assure all Medicare billing is accurate prior to transmission
- Maintain up-to-date coding libraries in computer
- Monitor Medicare publications for changes in coding
- Never add a digit to a code without verifying it is accurate
- Never delete a code because Medicare rejected

Billing Issues

- Inaccurate and incomplete ICD-9 codes can trigger a rejection of the claim
- Payment may be delayed
- Inaccurate or inappropriate codes can cause a medical review

Important factors about Section I of MDS

- As space permits, assign more specific ICD-9 codes for I3 for general disease categories listed under I1 and I2. Examples: Diabetes, Arthritis, Missing Limbs, Anemia, Dementia, Cancer and Wound Infection
- V-codes may be used if they affect current ADL status, mood and behavior, medical treatments, nursing monitoring or risk of death. Example: Aftercare following hip replacement V54.81, Replacement of hip joint V43.64

Anne Cook and Associates

- 2341 Monterey Drive, N.E.
- Marietta, Georgia 30068
- 770-578-9422 Office
- 404-597-6869 Cell
- acookassoc@att.net

References

- Coding instructions in ICD-9-CM Manual 2009
- Coding Clinic for ICD-9-CM
- ICD-9-CM Official Coding published by CMS and NCHS 4th quarter of 2003, 2005 and 2008