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ICD-10-CM CODING BASICS FOR LTC

PRESENTER:
HEATHER PY, RHIT, CCS, RAC-CT, CHPS

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1

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OBJECTIVES

2

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3

Upon completion of this program, participants will be able to:

1. Navigate ICD-10-CM to identify diagnosis codes
2. Understand coding conventions and guidelines
3. Accurately select a principal diagnosis
4. Accurately select and sequence additional diagnosis codes.

3

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NAVIGATING THE MANUAL

4

SECTIONS

5

- OFFICIAL CONVENTIONS & GUIDELINES
- ALPHABETIC INDEX TO DISEASES AND INJURIES
- APPENDIX FILES:
  - Neoplasm Table
  - Table of Drugs and Chemicals
  - External Causes Index
- TABULAR LIST OF DISEASES AND INJURIES
- ILLUSTRATIONS

5

CONVENTIONS

6

- Coding Conventions are the general rules for classification and are independent of the guidelines.
- Conventions take precedence's over guidelines

6

CONVENTIONS

7

- Abbreviations
  - **NEC** = "Not elsewhere classified" or "other specified" – used when a specific code is not available
  - **NOS** = "Not otherwise specified" or "unspecified" - used when information in record is insufficient to assign a more specific code
- **"And"** - read as "and/or"

7

CONVENTIONS

8

- **"With"** Should be interpreted as "associated with" or "due to" when it appears under a main term, subterm, or as an instructional note in the Tabular Index.
  - A causal relationship is presumed between the two conditions linked by the term in either the Alphabetic or Tabular Index.
    - Code the terms as related, unless provider documentation specifically states that the two conditions are unrelated.

8

CONVENTIONS

9

- Punctuation
  - [ ] **Brackets**
    - Identify manifestation codes in Alphabetic index
      - Example:
        Alzheimer's G30.9 [F02.80]
    - Lists synonyms, alternate wording or explanatory phrases in Tabular List
      - Example:
        R79.82 Elevated C-reactive protein[CRP]

9

CONVENTIONS

10

- Punctuation
  - ( ) **Parentheses** – indicate supplementary words that don't affect the code assigned
    - Example:
      - Hypertension (benign)(essential)(malignant)

10

CONVENTIONS

11

- Instructional Notes
  - "**Code First**" / "**Use additional code**" - used to indicate underlying conditions & manifestations - indicates proper sequencing
  - Example:

Chapter 10. Diseases of the Respiratory System (J00-J99)

Use additional code, where applicable, to identify:

history of tobacco dependence (Z87.891)

tobacco dependence (F17.-)

tobacco use (Z72.0)

11

CONVENTIONS

12

- Instructional Notes
  - "**Code also**" - alerts coder that more than one code may be required to describe the condition - does not provide sequencing directions
  - Example:

N39.3 Stress incontinence (female)(male)

Code also any associated overactive bladder (N32.81)

12

CONVENTIONS

13

- **Inclusion Notes**
  - Used to further define, clarify, or give examples
  - Not an exhaustive list
  - Example:

B20 Human immunodeficiency virus [HIV] disease

INCLUDES acquired immune deficiency syndrome [AIDS]
AIDS-related complex [ARC]
HIV infection, symptomatic

13

CONVENTIONS

14

- **Excludes Notes**
  - Excludes 1 = "Not coded here" - used when two conditions **cannot** occur together
  - Example:

I69 Sequelae of cerebrovascular disease

EXCLUDES 1 *personal history of cerebral infarction without residual deficit (Z86.73)*

14

CONVENTIONS

15

- **Excludes Notes**
  - Excludes 2 = "Not included here" - indicates the condition isn't part of the diagnosis represented by the code, both conditions may be coded together
  - Example:

Chapter 1. Certain infectious and Parasitic Diseases (A00-B99)

EXCLUDES 2 *carrier or suspected carrier of infectious disease (Z22.-)*

15

GUIDELINES

16

Guidelines are: rules that accompany and complement the official conventions

- They are approved by CMS, NCHS, AHA and AHIMA.
- Adherence is required under HIPAA, under the correct coding initiative.
- General guidelines are divided into four sections.

16

GUIDELINES

17

- Section I - General and chapter specific; applicable in all health care settings unless otherwise indicated
- Section II - Selection of Principal Diagnosis; applicable in inpatient and outpatient settings
- Section III - Reporting Additional Diagnoses
- Section IV –Guidelines for Outpatient Services

17

ALPHABETIC INDEX

18

- Alphabetic list of terms with associated code
- Identifies general conditions
- Further divided by additional terms, descriptors and anatomical site
- Does not always provide the full code
  - A (-) dash at the end of an entry indicates that additional characters are required.

18

ALPHABETIC INDEX

19

Example:

Failure, failed
heart (acute)(senile)(sudden) I50.9
with
diastolic (congestive) I50.30

19

ALPHABETIC INDEX

20

- Aftercare (*see also* care)
  - Following surgery (for)(on)
    - Joint replacement Z47.1
  - Specified body system
    - Circulatory system Z48.812
- Attention (to)
  - Artificial opening (of) Z43.9
    - Urinary tract Z43.6
    - Cystostomy Z43.5
    - Gastrostomy Z43.1

20

ALPHABETIC INDEX

21

- Complication(s)(from)(of)
  - Joint prosthesis, internal T84.9-
  - Infection or inflammation T84.50-
  - Surgical procedure (on) T81.9-
  - Wound infection T81.4-
- Infection, infected, infective
  - Urinary (tract) N39.0
  - Escherichia (E.) coli NEC A49.8
    - As the cause of disease classified elsewhere (see also Escherichia coli) B96.20

21

ALPHABETIC INDEX

22

- Disease, diseased (*see also* Syndrome)
  - Pulmonary
    - Obstructive, Chronic J44.9
- Late Effect(s) – *see* Sequelae
- Presence (of)
  - Joint Z96.60-
    - Hip Z96.64-
  - Cardiac
    - Pacemaker Z95.0

22

ALPHABETIC INDEX

23

- Sequelae(of)(*see also* condition)
  - Stroke NOS I69.30-
- Status (post)(*see also* Presence (of))
  - Renal dialysis (hemodialysis) (peritoneal) Z99.2
  - Artificial opening (of)
    - Gastrointestinal tract Z93.4

23

ALPHABETIC INDEX

24

- NEVER CODE DIRECTLY FROM THE ALPHABETIC INDEX!
- Both the alphabetic index and tabular list should be utilized to identify codes and complete sequencing of conditions/diagnoses.

24

APPENDICES

25

- Table of Neoplasms
  - Sorted by anatomical site
  - Includes six columns of codes for each site depending on behavior/nature

25

APPENDICES

26

	Malignant Primary	Malignant Secondary	Ca in Situ	Benign	Uncertain Behavior	Unspecified Behavior
- lung	C34.9-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - azygos lobe	C34.1-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - carina	C34.0-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - hilus	C34.0-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - lingula	C34.1-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - lobe NEC	C34.9-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - lower lobe	C34.3-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - main bronchus	C34.0-	C78.0-	DO2.2-	D14.3-	D38.1	D49.1
- - mesothelioma - see Mesothelioma						
- - middle lobe	C34.2	C78.0-	DO2.21	D14.31	D38.1	D49.1
- - overlapping lesion	C34.8-					
- - upper lobe	C34.1-	C78.0-	DO2.2-	DI4.3-	D38.1	D49.1

26

APPENDICES

27

- Table of Drugs and Chemicals
  - Divided by drug or chemical classification or name
  - Includes columns of codes depending on poisoning state or adverse effect.

27

APPENDICES

28

	Poisoning, Accidental (unintentional)	Poisoning, Intentional Self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse effects	Underdosing
Anticoagulant NEC	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516
Antagonist	T45.7X1	T45.7X2	T45.7X3	T45.7X4	T45.7X5	T45.7X6
Anti-common-cold drug NEC	T48.5X1	T48.5X2	T48.5X3	T48.5X4	T48.5X5	T48.5X6
Anticonvulsant	T42.71	T42.72	T42.73	T42.74	T42.75	T42.76
barbiturate	T42.3X1	T42.3X1	T42.3X1	T42.3X1	T42.3X1	T42.3X1
combination (with barbiturate	T42.3X1	T42.3X1	T42.3X1	T42.3X1	T42.3X1	T42.3X1
hydantoin	T42.0X1	T42.0X2	T42.0X3	T42.0X4	T42.0X5	T42.0X6
hypnotic NEC	T42.6X1	T42.6X2	T42.6X3	T42.6X4	T42.6X5	T42.6X6

28

APPENDICES

29

- Table of External Causes
  - Lists causes of injury, fracture, or poisoning.
  - Captures information for statistical purposes including:
    - How the injury occurred (cause)
    - Reason or intent of the accident (accidental, intentional)
    - The location of where the accident occurred (home, park, etc.)
    - Patient's status at time of accident (occupation)

29

TABULAR LIST

30

- List of codes from A to Z
  - Divided into twenty-one chapters based on body system or condition
    - Codes are divided by category, subcategory, and codes
    - Codes may be three to seven characters long
  - Includes chapter specific guidelines

30

TABULAR LIST

31

Example

I50.3 Diastolic (congestive) heart failure

I50.30 Unspecified diastolic (congestive) heart failure

I50.31 Acute diastolic (congestive) heart failure

I50.32 Chronic diastolic (congestive) heart failure

I50.33 Acute on chronic diastolic (congestive) heart failure

31

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CODING AND SEQUENCING

32

IDENTIFYING A CODE

33

- The following steps should be utilized to find diagnosis codes within the code book:
  - Identify the main term of the diagnosis that you are coding
  - Look up the main term in the Alphabetic Index
  - Use any secondary terms to assist with selecting most specific code
  - Find the code in the Tabular List
  - Review all notes associated with the category & subcategory

33

When To Code

34

- Admission/readmission – each time a resident is admitted / readmitted, the physician documentation (H&P, hospital records, orders, 3008 transfer form, etc.) should be reviewed
- Quarterly / per MDS schedule – review progress notes, consultant reports and orders for new diagnoses or resolved diagnoses. Update records during Care plan meetings.

34

When To Code

35

- Concurrently –
  - As conditions arise or are resolved
  - When resident transitions to Long-Term Care
- Annual on or after October 1st , and prior to the billing for October dates of service

35

36

Never

Pull

Codes

Forward!

36

Inaccurate Coding

37

- Pulling diagnoses codes from a patient's previous stay(s) is inaccurate coding!
- Cannot assume the past medical diagnoses have a current affect on the current condition for which the patient is receiving treatment.
- Chronic conditions may be reported if treatment is on an ongoing basis.

37

Inaccurate Coding

38

- Risks include:
  - Non compliance with federal regulations
  - Incomplete or inaccurate data on MDS and UB
  - Impaired or delayed cash flow due to denied or delayed claims
  - Time consuming and inefficient use of staff time
  - Inaccurate legal health record

38

PRINCIPAL DIAGNOSIS

39

The Principal 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".

- This definition has been expanded to include ALL non-outpatient settings including SNFs / LTC facilities.

39

PRINCIPAL DIAGNOSIS

40

- When a patient is treated for an acute condition in the hospital and transferred to a SNF for rehab
  - The **acute condition**, if still present is coded as the first listed/principal diagnosis.
  - The **aftercare** is coded as the first listed/principal diagnosis, if the acute condition is no longer present.

40

PRINCIPAL DIAGNOSIS

41

- When a patient transitions to long term care or returns from hospital stay for continued long term care
  - The **chronic condition**, that requires continued stay for long term care is the first listed/principal diagnosis.
  - The **acute condition or aftercare** is sequenced as the first additional/secondary diagnosis.

41

PRIMARY DIAGNOSIS

42

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

- Per Chapter Eight of the Medicare Benefits Policy Manual related to the four factors required for coverage of SNF care.

42

ADDITIONAL DIAGNOSIS

43

- Secondary/Additional Diagnoses – conditions that coexist at the time of admission, that develop subsequently during the resident's stay or that affect the treatment the resident receives or the resident's length of stay.
- Diagnosis that support both the Principle Dx. This is where you would include the therapy treatment diagnosis codes as they support the Admit Dx

43

ADDITIONAL DIAGNOSIS

44

- Keep in mind that, according to the CMS Manual System, page 107, regarding Medicare claims processing and the UB-04, Medicare will ignore data submitted in 67I-Q. (Department of Health & Human Services; Centers for Medicare & Medicaid Services, 2006)
  - This makes it imperative to get the most pertinent diagnoses requiring skilled services in the top 8 boxes of this section.

44

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CODING BY CHAPTER

45

Chapter 1 (A00 – B99)

46

Common conditions found in this chapter:

Candidiasis	C-Diff (colitis)
HIV disease	Sepsis
Varicella (chickenpox)	Viral Hepatitis
Viral meningitis	Viral infection
Zoster (herpes zoster)	Streptococcus
Staphylococcus	E. Coli.

This section does not include certain localized infections, such as, Influenza, Pneumonia or other acute respiratory infections!

46

Chapter 1 (A00 – B99)

47

- Instructional notes for infections found in other chapters may advise that additional organism code is required. The following codes are used to identify the infectious agent:
  - B95 – Streptococcus, Staphylococcus, and Enterococcus as the cause of disease classified elsewhere
  - B96 – Other bacterial agents as the cause of diseases classified elsewhere
  - B97 – Viral agents as the cause of diseases classified elsewhere

47

Chapter 1 (A00 – B99)

48

- 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
  - 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

48

Chapter 1 (A00 – B99)

49

- For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection.
  - If the reason for admission is both sepsis and a localized infection (pneumonia, cellulitis), the systemic infection is coded first followed by the localized infection.

49

Chapter 1 (A00 – B99)

50

- Colonization (When documentation includes terms such as: MRSA screen positive or MRSA positive nasal swab)
  - Z22.322 – Carrier or suspected carrier of Methicillin resistant Staphylococcus Aureus
  - Z22.321 – Carrier or suspected carrier of Methicillin susceptible Staphylococcus Aureus
  - When documentation supports an active MRSA infection and MRSA colonization both codes may be assigned

50

Chapter 1 (A00 – B99)

51

CODING CHALLENGE:

- Long term care resident with Parkinson's is readmitted from hospital after 4 days with new diagnosis of UTI due to ESBL E.coli. New orders for antibiotic therapy for 14 days. Physical and Occupational Therapy to treat resident related to muscle weakness.

51

Chapter 1 (A00 – B99)

52

ANSWERS

- Principal Diagnosis:
  - G20 Parkinson's disease
    - *Disease; Parkinson's*
- Primary Diagnosis:
  - N39.0 Urinary tract infection, site not specified
    - *Infection; urinary tract*

52

Chapter 1 (A00 – B99)

53

ANSWERS

- Additional Diagnosis
  - B96.20 Unspecified Escherichia coli (E.coli) as the cause of diseases classified elsewhere
    - *Infection; Escherichia coli; as the cause of the disease classified elsewhere*
  - Z16.12 Extended spectrum beta lactamase (ESBL) resistance
    - *Resistance, resistant (to); drug; extended beta lactamase (ESBL)*

53

Chapter 1 (A00 – B99)

54

ANSWERS

- Additional Diagnosis
  - M62.81 Muscle weakness
    - *Weakness; muscle*

54

Chapter 1 (A00 – B99)

55

RATIONALE

- Parkinson's disease is the reason for the resident's return to the facility. The urinary tract is a new diagnosis for skilled care. Guidelines indicate to use additional codes to identify the type of infection if known. The therapy treatment code is added to support care delivered.

55

Chapter 2 (C00 – D49)

56

- Neoplasms
  - Common conditions found in this chapter:
    - Carcinoma
    - Leukemia
    - Myelodysplastic Syndrome
    - Lymphoma
  - This chapter contains codes for most benign and all malignant neoplasms

56

Chapter 2 (C00 – D49)

57

- To code a neoplasm to the highest specificity it is necessary to determine if the neoplasm is benign, in-situ, malignant, or of uncertain behavior.
- Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified.

57

Chapter 2 (C00 – D49)

58

- When a primary malignancy has been removed and there is no further treatment directed to that site or evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used.

58

Chapter 2 (C00 – D49)

59

CODING CHALLENGE:

- Resident was admitted from the hospital for skilled care related to newly diagnosed liver metastases. Provider documentation indicates primary site of neoplasm as the lung. Resident is status post lobectomy one year prior. Resident is to under go radiation therapy five days a week for 5 weeks for the liver metastases.

59

Chapter 2 (C00 – D49)

60

ANSWERS:

- Principal Diagnosis:
  - C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct
    - *Neoplasm Table; Liver; Secondary malignancy*
- Primary Diagnosis:
  - C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct
    - *Neoplasm Table; Liver; Secondary malignancy*

60

Chapter 2 (C00 – D49)

61

ANSWERS:

- Additional Diagnoses:
  - Z90.2 Acquired absence of lung
    - Absence (of) (organ or part)(complete or partial); lung (fissure)(lobe)(bilateral)(unilateral)(congenital); acquired (any part)
  - Z85.118 Personal history of other malignant neoplasm of bronchus and lung
    - *History; personal; malignant neoplasm; lung*

61

Chapter 2 (C00 – D49)

62

RATIONALE:

- Resident's reason for admission was the newly diagnosed liver cancer. The lung cancer is coded as a history of since it is no longer present and no care is direct towards it.

62

Chapter 3 (D50 – D89)

63

- Diseases of the Blood and Blood-forming Organs and Certain Disorders involving the Immune Mechanism
  - Common conditions found in this chapter:
    - Anemia
    - Pancytopenia
    - Thrombocytopenia
    - Sickle cell disease

63

Chapter 3 (D50 – D89)

64

- The ICD-10 guideline for admission due to cancer related anemia the following guidelines apply:
  - Resident admitted for care of anemia d/t malignancy, the malignancy is sequenced first followed by the anemia code.
  - Resident admitted for care of anemia d/t chemotherapy, the anemia is sequenced first followed by the adverse effect. The neoplasm would be an additional code.

64

Chapter 3 (D50 – D89)

65

CODING CHALLENGE

- Resident is a long term care resident with dementia. Lab work during annual review indicated low hemoglobin and hematocrit. Her physician documents that she has anemia in chronic illness and orders Ferrous sulfate.

65

Chapter 3 (D50 – D89)

66

ANSWERS

- Principal Diagnosis:
  - F03.90 Unspecified dementia without behavioral disturbance
    - *Dementia (degenerative (primary))(old age) (persisting)*
- Additional Diagnosis:
  - D63.8 Anemia in other chronic disease classified elsewhere
    - *Anemia; due to; chronic disease*

66

Chapter 3 (D50 – D89)

67

RATIONALE

- Dementia is the principal diagnosis as it is the reason the for the resident's continued long term care stay. The anemia is an additional active diagnosis based on physician documentation and treatment with new medication order.

67

Chapter 4 (E00 – E89)

68

- Endocrine, Nutritional and Metabolic Diseases
  - Common conditions found in this chapter:
    - Diabetes mellitus
    - Hypothyroidism
    - Protein-calorie malnutrition
    - Volume depletion
    - Obesity
    - Vitamin deficiencies

68

Chapter 4 (E00 – E89)

69

- Diabetes (DM)
  - Assign as many codes from this section as necessary to describe ALL the complications of DM. The sequencing should be based on the reason for that particular admission/visit.
  - If the type of DM is not documented, the default is E11.- (Type 2 DM)

69

Chapter 4 (E00 – E89)

70

- Diabetes (DM)
  - Coders may assume a causal relationship between Diabetes and its complications that are listed directly under the term "with" in the alphabetic listing.
    - Terms such as "due to", "secondary to", or "diabetic" are not required to be documented by the provider to link the complications and diabetes.
  - Use Z79.4 if the patient uses insulin.

70

Chapter 4 (E00 – E89)

71

- CODING CHALLENGE
  - Resident was admitted from the hospital for skilled care with a diagnosis of chronic diabetic ulcer of the left heel. Observation of ulcer shows exposed fat tissue. Physician also documents diabetic neuropathy and chronic insulin usage.

71

Chapter 4 (E00 – E89)

72

ANSWER

- Principal Diagnosis:
  - E11.621 Type 2 Diabetes with foot ulcer
    - *Diabetes, diabetic (mellitus); Type 2; with; foot ulcer*
- Primary Diagnosis:
  - E11.621 Type 2 Diabetes with foot ulcer
    - *Diabetes, diabetic (mellitus); Type 2; with; foot ulcer*

72

Chapter 4 (E00 – E89)

73

ANSWER

- Additional Diagnoses:
  - L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
    - *Ulcer, ulcerated, ulcerating, ulceration, ulcerative; lower limb; heel; left; with; exposed fat layer*

73

Chapter 4 (E00 – E89)

74

ANSWERS

- Additional Diagnoses:
  - E11.40 Type 2 Diabetes mellitus with diabetic neuropathy, unspecified
    - *Diabetes; diabetic (mellitus) (sugar); Type 2; with; neuropathy*
  - Z79.4 Long-term (current) use of insulin
    - *Long-term drug therapy (use of); insulin*

74

Chapter 4 (E00 – E89)

75

- RATIONALE
  - Resident was admitted to SNF for chronic diabetic ulcer of the left heel. Resident also has neuropathy due to diabetes and receives insulin injections daily. There is a note to use an additional code to identify site of ulcer in the tabular index under E11.621. There is an additional instruction to “use additional code to identify any insulin use” at the beginning of E11 in the tabular index.

75

Chapter 5 (F01 – F99)

76

- Mental, Behavioral, and Neurodevelopmental Disorders
  - Common conditions found in this chapter:
    - Anxiety
    - Depression
    - Schizophrenia
    - Psychosis
    - Dementia

76

Chapter 5 (F01 – F99)

77

- Anxiety may be associated with depression. If both are documented by a physician, assign codes for both. However, if the physician links the two conditions, use F41.8, Anxiety depression

77

Chapter 5 (F01 – F99)

78

CODING CHALLENGE:

- Resident admitted to long term care after admission to hospital for altered mental status and weakness. Discharge Summary lists Senile psychosis with behaviors and recurrent depression.

78

Chapter 5 (F01 – F99)

79

ANSWERS:

- Principal Diagnosis:
  - F03.91 Unspecified dementia with behavioral disturbance
    - *Psychosis; senile*

79

Chapter 5 (F01 – F99)

80

ANSWERS:

- Additional Diagnosis:
  - R53.1 Weakness
    - *Weak, weakening, weakness (generalized)*
  - F33.9 Major depressive disorder, recurrent, unspecified
    - *Depression – see Disorder, depressive*
    - *Disorder; depressive; recurrent*

80

Chapter 5 (F01 – F99)

81

RATIONALE:

- Senile psychosis is the reason for admission and codes out to the F03 category. The documentation indicated the psychosis was with behaviors. The additional diagnosis of depression is specified as recurrent. Weakness is also coded as an additional diagnosis. The AMS is not coded as a definitive diagnosis was documented.

81

Chapter 6 (G00 – G99)

82

- Diseases of the Nervous System
  - Common conditions found in this chapter:
    - Alzheimer's disease
    - Parkinson's disease
    - Encephalopathy
    - Insomnia
    - Chronic Pain
    - Polyneuropathy

82

Chapter 6 (G00 – G99)

83

- Some codes from this chapter identify dominant side and non-dominant side. If the side is documented (left or right) , but not specified as dominant or non-dominant code as follows:
  - Ambidextrous = dominant
  - Left side affected = non-dominant
  - Right side affected = dominant

83

Chapter 6 (G00 – G99)

84

- Hemiplegia, hemiparesis, paraplegia and quadriplegia should only be coded from this chapter if stated as old or longstanding with unspecified cause. Paralytic sequelae of infarct/stroke are in Chapter 9.

84

Chapter 6 (G00 – G99)

85

- Pain may be:
  - Acute or Chronic
  - Related to neoplasm
  - Post procedural, post-thoracotomy, or post-traumatic
- Should not be coded when a definitive diagnosis for the pain is present.
- Expected post operative pain should not be coded

85

Chapter 6 (G00 – G99)

86

- Central pain syndrome and chronic pain syndrome are not the same as “chronic pain” and should only be coded when specifically documented by the provider.

86

Chapter 6 (G00 – G99)

87

CODING CHALLENGE:

- Resident was transferred from the hospital for skilled care with lumbar spinal stenosis. Hospital history and physical also indicates resident has Parkinson’s disease and chronic pain syndrome.

87

Chapter 6 (G00 – G99)

88

ANSWERS:

- Principal Diagnosis
  - M48.061 Spinal Stenosis, lumbar region without neurogenic claudication
    - *Stenosis; spinal; lumbar region*
- Primary Diagnosis
  - M48.061 Spinal Stenosis, lumbar region without neurogenic claudication
    - *Stenosis; spinal; lumbar region*

88

Chapter 6 (G00 – G99)

89

ANSWERS:

- Additional Diagnosis
  - G20 Parkinson's disease
    - *Parkinsonism (idiopathic)(primary)*
  - G89.4 Chronic pain syndrome
    - *Syndrome; chronic; pain*

89

Chapter 6 (G00 – G99)

90

RATIONALE:

- The main reason for admission is the spinal stenosis. The additional diagnosis of chronic pain syndrome and Parkinson's are included due to impact on resident care needs.

90

Chapter 7 (H00 – H59)

91

- Diseases of the Eye and Adnexa
  - Common conditions found in this chapter:
    - Conjunctivitis
    - Cataracts
    - Glaucoma
    - Macular degeneration
    - Blindness

91

Chapter 7 (H00 – H59)

92

- Assign as many codes from category H40, Glaucoma as needed to identify the type, affected eye, and stage.
  - Only use a bilateral code when the type and stage are the same in both eyes.
- This chapter does NOT include DM related eye conditions!

92

Chapter 7 (H00 – H59)

93

CODING CHALLENGE:

- Long term care resident with Alzheimer's was seen by the ophthalmologist during quarterly assessment look back period. Notes indicate resident has chronic closed angle glaucoma of the right eye. It is also noted that the resident was treated for recurrent C.diff enteritis with medications ending on the assessment reference date.

93

Chapter 7 (H00 – H59)

94

ANSWERS:

- Principal Diagnosis
  - G30.9 Alzheimer's disease, unspecified
    - *Disease; Alzheimer's [F02.80]*
- Additional Diagnosis
  - F02.80 Dementia in diseases classified elsewhere without behavioral disturbance

94

Chapter 7 (H00 – H59)

95

ANSWERS:

- Additional Diagnosis
  - H40.2210 Chronic angle-closure glaucoma, right eye, stage unspecified
    - *Glaucoma; angle-closure; chronic*
  - A04.71 Enterocolitis due to Clostridium Difficile, recurrent
    - *Enteritis; Clostridium; difficile; recurrent*

95

Chapter 7 (H00 – H59)

96

RATIONALE:

- The main reason for the resident's continued stay at the facility is the Alzheimer's disease. There are brackets with F02.80 under the Alzheimer's code to indicate the additional code. There are notes in the tabular index that indicate the need for a seventh character for the glaucoma stage code.

96

Chapter 8 (H60 – H95)

97

- Diseases of the Ear and Mastoid Process
  - Common conditions found in this chapter:
    - Benign paroxysmal vertigo
    - Meniere's disease
    - Hearing loss/Deafness
    - Otitis media

97

Chapter 8 (H60 – H95)

98

- Diseases in this chapter have been arranged into blocks for easier identification (external, middle, inner, other, etc.)
- When coding otitis media, use an additional code for associated perforated tympanic membrane
- This chapter does NOT include injuries and certain other consequences of external causes

98

Chapter 8 (H60 – H95)

99

CODING CHALLENGE:

- Resident admitted from the hospital for skilled care after fall. Discharge summary indicates resident has benign paroxysmal vertigo

99

Chapter 8 (H60 – H95)

100

ANSWERS:

- Principal Diagnosis
  - H81.10 Benign paroxysmal vertigo, unspecified ear
    - *Vertigo; benign paroxysmal (positional)*
- Primary Diagnosis
  - H81.10 Benign paroxysmal vertigo, unspecified ear
    - *Vertigo; benign paroxysmal (positional)*

100

Chapter 8 (H60 – H95)

101

ANSWERS:

- Additional Diagnosis
  - Z91.81 History of falling
    - *History; personal; falling*

101

Chapter 8 (H60 – H95)

102

CHALLENGE ANSWER RATIONALE:

- Principal and primary diagnoses are vertigo. Physician documentation does not specify which ear is affected. Therefore, the code for unspecified benign paroxysmal vertigo is used.

102

Chapter 9 (I00 – I99)

103

- Diseases of the Circulatory System
  - Common conditions found in this chapter:
    - Atherosclerotic heart disease
    - Atrial fibrillation
    - Hypertension
    - Myocardial infarction
    - Stroke and sequelae
    - Endocarditis

103

Chapter 9 (I00 – I99)

104

- Classification presumes a causal relationship between
  - Hypertension and Chronic Kidney Disease (CKD) (I12.-)
  - Hypertension and Heart Disease (I11.-)
  - Hypertension with CKD and Heart disease (I13.-)

104

Chapter 9 (I00 – I99)

105

- Hypertension with Heart Disease
  - Assign code from I11 for heart conditions (codes from I50 or I51.4-I51.9)
  - Additional codes should be utilized from I50 to identify specific type of heart failure

105

Chapter 9 (I00 – I99)

106

- Hypertension and Chronic Kidney Disease (CKD)
  - Assign code from I12 – Hypertensive chronic kidney disease when HTN and CKD (codes from N18) are documented
  - Additional code should be utilized from N18 to identify the specific stage of CKD

106

Chapter 9 (I00 – I99)

107

- Hypertension with Heart Disease and CKD
  - Assign code from I13 for heart conditions (codes from I50 or I51.4-I51.9)
  - Additional codes should be utilized from I50 to identify specific type of heart failure
  - Additional code should be utilized from N18 to identify the specific stage of CKD

107

Chapter 9 (I00 – I99)

108

- Sequelae of Cerebrovascular Disease (Category I69)
  - Divided by type of CVA (infarct/stroke, non-traumatic hemorrhage, cerebrovascular disease)
  - Coded when resident has CVA w/ deficits
  - Used to identify conditions classifiable to Categories I60-I67 as the cause of late effects (neurological deficits), classified elsewhere

108

Chapter 9 (I00 – I99)

109

- Sequelae of Cerebrovascular Diseases (Category I69)
  - May use additional codes to identify specific deficit as indicated under subcategory notes
  - Use same guidelines for dominant vs. non-dominant as Chapter Six
  - If resident has CVA without neurologic deficits assign Z86.73 – Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

109

Chapter 9 (I00 – I99)

110

- Congestive Heart Failure (CHF)
  - Categories are divided by type:
    - Systolic, Diastolic, or Combined
    - Acute, Chronic, or Acute on Chronic
- Atherosclerotic Coronary Artery Disease
  - Includes combination codes for atherosclerotic heart disease with angina pectoris
  - A causal relation is assumed
  - Do not use additional code for angina pectoris

110

Chapter 9 (I00 – I99)

111

- Myocardial Infarction (MI)
  - Divided as to whether the MI is Acute or Old/Healing
  - Acute codes are used for encounter while the MI is less than or equal to four weeks old
    - This includes transfers between healthcare settings
  - Old or healing MI is coded after the 4 week timeframe when no further care is required.
    - Code I25.02 (Old myocardial infarction)

111

Chapter 9 (I00 – I99)

112

- Myocardial Infarction (AMI)
  - Acute MI
    - I21- Initial AMI – code used for entire 28 day period
    - I22 – Subsequent AMI – code is used when a subsequent AMI occurs during the 28 day period of the initial AMI. A code from this category MUST be used in conjunction with a code from category I21.

112

Chapter 9 (I00 – I99)

113

CODING CHALLENGE

- Resident admitted to SNF for skilled care with dysphagia and right non-dominant hemiplegia following an acute embolic cerebral infarction. A PEG tube was placed and resident is currently NPO. ST is treating resident for pharyngeal dysphagia and cognitive deficits related to the stroke. PT is treating resident for abnormality of gait and OT for muscle weakness

113

Chapter 9 (I00 – I99)

114

ANSWERS

- Principal Diagnosis:
  - I69.391 Dysphagia following cerebral infarction
    - *Sequelae, infarction, cerebral, dysphagia*
- Primary Diagnosis:
  - I69.391 Dysphagia following cerebral infarction
    - *Sequelae, infarction, cerebral, dysphagia*

114

Chapter 9 (I00 – I99)

115

ANSWERS

- Additional Diagnoses:
  - R13.13 Dysphagia, pharyngeal phase
    - *Dysphagia, pharyngeal*
  - I69.353 Hemiplegia and hemiparesis following cerebral infarction affecting right nondominant side
    - *Sequelae, infarction NOS, hemiplegia*
  - R26.9 Unspecified abnormality of gait and mobility
    - *Gait; abnormal*

115

Chapter 9 (I00 – I99)

116

ANSWERS

- Additional Diagnoses:
  - M62.81 Muscle weakness
    - *Weakness; muscle*
  - Z43.1 Encounter for attention to gastrostomy
    - *Attention (to); artificial opening (of) digestive tract, stomach*

116

Chapter 9 (I00 – I99)

117

ANSWERS

- Additional Diagnoses:
  - I69.319 Unspecified symptoms and signs involving cognitive functions following cerebral infarction
    - *Sequela; infarction; cerebral; cognitive deficit*

117

Chapter 9 (I00 – I99)

118

RATIONALE

- Either sequela of the infarction could be listed as the principal diagnosis hemiplegia was chosen as it has the potential for requiring the most skilled care. There is a note in the tabular index that instructs coder to use an additional code to identify the type of dysphagia.

118

Chapter 10 (J00 – J99)

119

- Diseases of the Respiratory System
  - Common conditions found in this chapter:
    - Acute upper respiratory infection (URI)
    - COPD
    - Pneumonia
    - Influenza
    - Bronchitis
    - Asthma

119

Chapter 10 (J00 – J99)

120

- Chapter Specific Guidelines
  - For respiratory conditions occurring in more than one site not specifically indexed, code to the lowest anatomic site.
  - Many categories indicate to use additional codes to identify any tobacco use or exposure

120

Chapter 10 (J00 – J99)

121

- Influenza and Pneumonia (J10-J18)
  - Influenza due to Certain Identified Viruses (J09) should only be coded when diagnosis is confirmed based on provider documentation or positive laboratory results
- Asthma
  - Coding were expanded to include severity levels including: Intermittent, Mild Persistent, Moderate Persistent, Severe Persistent

121

Chapter 10 (J00 – J99)

122

- Respiratory Failure (code only if not resolved from acute care or if occurs after admission)
- Ventilator Associated Pneumonia (VAP) – J95.851
  - Must be documented by provider to code
  - Use additional code to identify organism, if documented
  - Do not assign an addition code to identify type of pneumonia

122

Chapter 10 (J00 – J99)

123

CODING CHALLENGE

- Resident admitted to the SNF from the hospital for skilled care with bacterial pneumonia due to Pseudomonas and COPD. H&P indicates a history of tobacco use.

123

Chapter 10 (J00 – J99)

124

ANSWERS

- Principal Diagnosis
  - J15.1 Pneumonia due to Pseudomonas
    - *Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved); in (due to); Pseudomonas NEC*
- Primary Diagnosis
  - J15.1 Pneumonia due to Pseudomonas
    - *Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved); in (due to); Pseudomonas NEC*

124

Chapter 10 (J00 – J99)

125

ANSWERS

- Additional Diagnoses
  - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
    - *Disease; Pulmonary; chronic obstructive; with; lower respiratory infection (acute)*
  - Z87.891 Personal history of tobacco dependence
    - *History; Personal; tobacco dependence*

125

Chapter 10 (J00 – J99)

126

RATIONALE

- The primary reason form admission to the facility is the acute bacterial pneumonia infection. The COPD is coded to with acute lower respiratory infection, due to the active pneumonia diagnosis. There is also a note in the tabular index to “use additional code” to identify the infection. There is a note at the beginning of the chapter to “use additional code” to identify any tobacco use.

126

Chapter 11 (K00 – K95)

127

- Diseases of the Digestive System
  - Common conditions found in this chapter:
    - Colitis
    - Crohn's disease
    - Diverticulitis
    - GERD
    - Pancreatitis
    - Hepatitis

127

Chapter 11 (K00 – K95)

128

- Chapter Specific Guidelines
  - Multiple categories include notes to use additional codes to identify any alcohol abuse or dependency
- Crohn's Disease
  - Codes include specific sites and complications

128

Chapter 11 (K00 – K95)

129

CODING CHALLENGE

- Resident admitted for skilled care peritonitis due to perforation of the colon. Studies indicate perforation was related diverticulitis of the colon with bleeding. History and Physical from the hospital also indicates resident has chronic blood loss anemia and GERD. Resident has orders for Antibiotics for peritonitis and ferrous sulfate for iron deficiency anemia.

129

Chapter 11 (K00 – K95)

130

ANSWERS

- Principal Diagnosis
  - K57.21 Diverticulitis of the large intestine with perforation or abscess with bleeding
    - *Diverticulitis; large intestine; with; abscess, perforation or peritonitis; with bleeding*
- Principal Diagnosis
  - K57.21 Diverticulitis of the large intestine without perforation or abscess with bleeding

130

Chapter 11 (K00 – K95)

131

ANSWERS

- Additional Diagnoses
  - D50.0 Iron deficiency anemia secondary to blood loss (chronic)
    - *Anemia; blood loss (chronic)*
  - K21.9 Gastro-esophageal reflux disease without esophagitis
    - *Reflux; gastroesophageal*

131

Chapter 11 (K00 – K95)

132

ANSWERS

- Additional Diagnoses
  - K65.9 Peritonitis, unspecified
    - *Peritonitis*

132

Chapter 11 (K00 – K95)

133

RATIONALE

- Resident is admitted with the diverticulitis of the colon, which is part of the large intestine. Documentation indicates perforation and bleeding. There is also a note that indicates to "Code also, if applicable peritonitis K65.-" to identify peritonitis. Documentation of GERD does not included esophagitis, therefore it is coded without.

133

Chapter 12 (L00 – L99)

134

- Diseases of the Skin and Subcutaneous Tissue
  - Common conditions found in this chapter:
    - Cellulitis
    - Pressure Ulcers
    - Non-pressure ulcers
    - Dermatitis
    - Abscess

134

Chapter 12 (L00 – L99)

135

- Chapter Specific Guidelines
  - Assign as many codes as necessary to identify all ulcers
- Cellulitis
  - More specific identification of site, including laterality for extremities
- Dermatitis and eczema are used synonyms

135

Chapter 12 (L00 – L99)

136

- Pressure Ulcers
  - Uses combination codes that include the site & stage of the ulcer
  - Coding may utilize clinical documentation to identify specific staging, if necessary
  - Staging may be coded per clinical documentation. However, the ulcer diagnosis itself must be documented by the physician, or extender.
  - There is no "reverse staging", "back staging", or "down-staging" of pressure ulcers!

136

Chapter 12 (L00 – L99)

137

- Non-pressure Ulcers (Vascular, DM, etc.)
  - Note at the beginning of the category to "Code first any associated underlying condition"
  - Codes have increased specificity including: site, laterality, and severity

137

Chapter 12 (L00 – L99)

138

CODING CHALLENGE

- A resident is discharged from the hospital with a diagnosis of cellulitis right arm are related to post mastectomy lymphedema. The patient also has a pressure ulcer of the coccyx. Nursing evaluation at time of admission documents coccyx as a stage 4.

138

Chapter 12 (L00 – L99)

139

ANSWERS

- Principal Diagnosis:
  - L03.113 Cellulitis of right upper limb
    - *Cellulitis; upper limb*
- Primary Diagnosis:
  - L03.113 Cellulitis of right upper limb
    - *Cellulitis; upper limb*

139

Chapter 12 (L00 – L99)

140

ANSWERS

- Additional Diagnosis:
  - I97.2 Postmastectomy lymphedema syndrome
    - *Lymphedema (acquired); postmastectomy*
  - Z90.11 Acquired absence of right breast and nipple
    - *Absence (of) (organ or part)(complete or partial); breast(s)(and nipple(s))(acquired)*
  - L89.154 Pressure ulcer of sacral region, stage 4
    - *Ulcer; pressure; coccyx*

140

Chapter 12 (L00 – L99)

141

RATIONALE

- Primary reason for resident's admission for skilled care is the acute infection of cellulitis. Guidelines in the coding manual indicate that the stage of the ulcer may be coded based on nursing documentation. However, physician documentation is necessary to code the pressure ulcer.

141

Chapter 13 (M00 – M99)

142

- Diseases of the Musculoskeletal System and Connective Tissue
  - Common conditions found in this chapter:
    - Arthritis, Osteoarthritis, Rheumatoid Arthritis
    - Gout
    - Osteoporosis
    - Pathologic fractures
    - Lumbago

142

Chapter 13 (M00 – M99)

143

- Chapter Specific Guidelines
  - Most categories now include site and laterality
    - Sites identify whether bone, joint, or muscle is involved (some subcategories include a "multiple sites" code)
    - For subcategories where no multiple sited codes are available utilize as many codes as necessary to fully identify the different sites

143

Chapter 13 (M00 – M99)

144

- Chapter Specific Guidelines
  - Bone vs. Joint
    - In some conditions where the bone may be affected at the proximal or distal ends the site designation should be bone, not joint

144

Chapter 13 (M00 – M99)

145

- Osteoporosis
  - Use a code from M81 when coding osteoporosis without current pathological fracture
  - Use a code from M80 when coding osteoporosis with current pathological fracture

145

Chapter 13 (M00 – M99)

146

- Pathological fracture vs. traumatic fracture:
  - Official guidelines state: "A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone."

146

Chapter 13 (M00 – M99)

147

- Pathologic fractures
  - ICD-10-CM has 3 categories for pathologic fractures: neoplastic, osteoporotic, and other
  - Requires the use of 7th character designation
    - "A" used when receiving active treatment
    - "D" = subsequent encounter for fracture with healing
    - Other 7th characters (G, K, P, & S) identify subsequent encounters with complications or sequelae

147

Chapter 13 (M00 – M99)

148

- Arthritis & Osteoarthritis
  - Codes include type
    - Primary – caused by normal wear & tear
    - Secondary (Post-traumatic) – typically caused by injury, heredity, obesity, etc.
- Rheumatoid Arthritis
  - Codes now include site, laterality, complication and rheumatoid factor

148

Chapter 13 (M00 – M99)

149

CODING CHALLENGE

- Long term care resident with Parkinson's and osteoporosis, had fall from low bed onto bedside pads. Nursing evaluation indicates new complaint of right elbow pain. Physician ordered x-ray of RUE. X-ray results indicate presence of fracture of the humerus. Resident is sent to hospital for treatment and returns to facility four days later under skilled care.

149

Chapter 13 (M00 – M99)

150

ANSWERS

- Principal Diagnosis:
  - G20 Parkinson's disease
    - *Parkinsonism (idiopathic) (primary)*

150

Chapter 13 (M00 – M99)

151

ANSWERS

- Primary Diagnosis:
  - M80.021D Age-related osteoporosis with current pathological fracture, right humerus; subsequent encounter for fracture with routine healing
    - *Osteoporosis (female)(male); with current pathologic fracture; humerus*

151

Chapter 13 (M00 – M99)

152

ANSWERS

- Additional Diagnosis:
  - Z91.81 History of falling
    - *History; personal (of); fall, falling*

152

Chapter 13 (M00 – M99)

153

RATIONALE

- Because the resident was sent to a higher level of care for the initial active treatment of the fracture, the 7th character of "D" was utilized. The fractures were also code to pathologic, related to the type of fall and known history of osteoporosis.

153

Chapter 14 (N00 – N99)

154

- Diseases of the Genitourinary System
  - Common conditions found in this chapter:
    - Chronic kidney disease (CKD)
    - Benign prostatic hypertrophy (BPH)
    - Urinary tract infection (UTI)
    - Neurogenic bladder
    - Cystitis

154

Chapter 14 (N00 – N99)

155

- CKD is classified based on severity.
  - Mild = stage II
  - Moderate = stage III
  - Severe = stage IV
  - End stage is coded when documented by the physician
- If a patient is receiving dialysis, use Z99.2, Dependence of renal dialysis.

155

Chapter 14 (N00 – N99)

156

CODING CHALLENGE:

- Resident admitted after hospitalization for skilled care related to acute cystitis due to the indwelling urethral catheter. Additional diagnoses include HTN and ESRD. The resident will receive dialysis three times weekly.

156

Chapter 14 (N00 – N99)

157

ANSWERS:

- Principal Diagnosis:
  - T83.511A Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter
    - *Complication; catheter; urethral*
- Primary Diagnosis:
  - T83.511A Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter
    - *Complication; catheter; urethral*

157

Chapter 14 (N00 – N99)

158

ANSWERS:

- Additional Diagnoses:
  - N30.00 Acute cystitis without hematuria
    - *Cystitis; acute*
  - I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
    - *Hypertension, hypertensive; kidney; with stage 1 through stage 4 chronic kidney disease*

158

Chapter 14 (N00 – N99)

159

ANSWERS:

- Additional Diagnoses:
  - N18.6 End-stage renal disease
    - *Disease; renal; end-stage*
  - Z99.2 Dependence on renal dialysis
    - *Status (post); dialysis (hemodialysis) (peritoneal)*

159

Chapter 14 (N00 – N99)

160

RATIONALE:

- The primary and principal diagnosis is the acute cystitis due catheter. There is an instructional not to "Use additional code to identify infection" which indicate complication is coded first. Per guidelines the causal relationship between the HTN and ESRD is assumed. Additional notes in the tabular to use additional code to identify stage of chronic kidney disease and to identify dialysis status

160

Chapter 15 (O00 – O9A)

161

- Pregnancy, Childbirth, and the Puerperium
  - Common conditions found in this chapter:
    - Maternal disorders related to pregnancy
    - Encounter for delivery
    - Complications in pregnancy

161

Chapter 16 (P00 – P96)

162

- Certain Conditions originating in the Perinatal Period
  - Common conditions found in this chapter:
    - Pre-term (Premature) newborn
    - Birth trauma
    - Neonatal aspiration

162

Chapter 17 (Q00 – Q99)

163

- Congenital Malformations, Deformations, and Chromosomal Abnormalities
  - Common conditions found in this chapter:
    - Arteriovenous (AV) malformation
    - Spina bifida
    - Down syndrome
    - Septal heart defect
    - Cleft palate

163

Chapter 17 (Q00 – Q99)

164

- Congenital Malformations, Deformations, and Chromosomal Abnormalities
  - Common conditions found in this chapter:
    - Arteriovenous (AV) malformation
    - Spina bifida
    - Down syndrome
    - Septal heart defect
    - Cleft palate

164

Chapter 17 (Q00 – Q99)

165

- Codes from this chapter may be principal / first listed or secondary diagnoses.
- Although present a birth, malformation, deformation, or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by a physician, it is appropriate to assign a code from this chapter.
- If a congenital malformation has been corrected, use a personal history code

165

Chapter 17 (Q00 – Q99)

166

CODING CHALLENGE:

- During quarterly review of long term care resident with history of lumbosacral spina bifida a cardiology consult note, written within last 60-days, identifies a new diagnosis of atrial septal defect.

166

Chapter 17 (Q00 – Q99)

167

ANSWERS:

- Principal Diagnosis:
  - Q05.7 Lumbar spina bifida without hydrocephalus
    - *Spina bifida; lumbar*
- Additional Diagnosis:
  - Q21.1 Atrial septal defect
    - *Defect; septal; atrial*

167

Chapter 17 (Q00 – Q99)

168

RATIONALE:

- The reason for resident's continued long term stay is the lumbar spina bifida. The atrial septal defect is added as an additional diagnosis. The documentation does not indicate that the defect was acquired or due to an acute myocardial infarction, thus it is coded to Chapter 17 as a congenital malformation.

168

Chapter 18 (R00 – R99)

169

- Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, not elsewhere classified
  - Common conditions found in this chapter:
    - Alerted mental status (AMS)
    - Bacteremia
    - Chest pain
    - Nausea and Vomiting
    - Weakness

169

Chapter 18 (R00 – R99)

170

- Coding Guidelines
  - Symptom codes should only be used when no definitive diagnosis is provided or when the symptom is not typically associated with the definitive diagnosis
  - Always sequence the definitive diagnosis code first

170

Chapter 18 (R00 – R99)

171

- Falls
  - R29.2 – Repeated falls
    - Should be used when a resident has recent falls and reason is being determined
  - Z91.81 – History of falls
    - Should be used when resident has had past falls and is at risk of further falls.

171

Chapter 18 (R00 – R99)

172

CODING CHALLENGE:

- Resident admitted for skilled care following hospitalization for aspiration pneumonia. PT is treating the resident for difficulty walking. OT is treating the resident for weakness. ST is treating the resident for oral dysphagia

172

Chapter 18 (R00 – R99)

173

ANSWERS:

- Principal Diagnosis:
  - J69.0 Pneumonitis due to inhalation of food and vomit
    - *Pneumonia; aspiration*
- Primary Diagnosis:
  - J69.0 Pneumonitis due to inhalation of food and vomit
    - *Pneumonia; aspiration*

173

Chapter 18 (R00 – R99)

174

ANSWERS:

- Additional Diagnoses:
  - R26.2 Difficulty in walking, NEC
    - *Walking; difficulty*
  - R53.1 Weakness
    - *Weak, weakening, weakness (generalized)*
  - R13.11 Dysphagia, oral phase
    - *Dysphagia; oral phase*

174

Chapter 18 (R00 – R99)

175

RATIONALE:

- The primary reason for resident's stay at facility is for care and rehab services related to the aspiration pneumonia. The therapy treatment codes are added as additional diagnoses to support reason for skilled care.

175

Chapter 19 (S00 –T88)

176

- Injury, Poisoning, and Certain Other Consequences of External Causes
  - Common conditions found in this chapter:
    - Fracture
    - Sprain/Strain
    - Poisoning/Toxic effects
    - Abrasions/Burns/Wounds

176

Chapter 19 (S00 –T88)

177

- Coding Guidelines
  - 7th character extensions are required for most codes in this chapter.
    - A – Initial Encounter (Used during active treatment for injury. Such as, surgical intervention, ER visit, etc.)
    - D – Subsequent Encounter (Used for encounters during healing & recovery care, after active treatment)
    - S – Sequela (Used for identification of complication or other condition that occur due to the original injury)

177

Chapter 19 (S00 –T88)

178

- Not all categories have the same 7th character extension. Refer to the beginning of each category to determine extensions.
- The aftercare Z codes should NOT be coded with conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care

178

Chapter 19 (S00 –T88)

179

- Sequencing
  - Code most serious injury first (This is determined by major focus of care and physician documentation)
  - When coding an injury and fracture as a sequela, the sequela is coded 1st followed by the injury code with the 7th character for Sequela

179

Chapter 19 (S00 –T88)

180

- Traumatic fractures:
  - Organized and classified by:
    - Anatomical site and laterality
    - Type
    - Displaced vs. non-displaced
    - Type of encounter
  - Default Coding:
    - Not designated as displaced or non-displaced = displaced
    - Not designated as open or closed = closed

180

Chapter 19 (S00 –T88)

181

- Open Wounds
  - Not to be used for healing surgical wounds or complications of surgical wounds
  - Divided into subcategories for different wounds
    - Lacerations
    - Punctures
    - Open Bites
  - Subcategories are further divided by site & laterality

181

Chapter 19 (S00 –T88)

182

- Adverse Effects, Poisoning, Under-dosing, & Toxic Effects (T36-T50)
  - Definitions:
    - Adverse Effect: Medication was properly prescribed & correctly taken
    - Poisoning : Medication used improperly (overdose, taken in error, wrong route)
    - Under-dosing: Taking less that prescribed dose
    - Toxic Effects: Harmful substance ingested
  - Always refer to the Tabular List, before going to the Table of Drugs and Chemicals

182

Chapter 19 (S00 –T88)

183

CODING CHALLENGE:

- Resident admitted for therapy services following a left shoulder replacement due a fracture of the greater tuberosity of the left humerus. The resident also had nondisplaced fracture of the of the lateral condyle of the left femur. PT treatment diagnosis is difficulty walking and OT treatment diagnosis is muscle weakness.

183

Chapter 19 (S00 –T88)

184

ANSWERS:

- Principal Diagnosis:
  - S42.252D Displaced fracture of the greater tuberosity of the left humerus, subsequent encounter with routine healing
    - *Fracture; traumatic; humerus; tuberosity – see Fracture, humerus, upper end; greater tuberosity*
- Primary Diagnosis:
  - S42.252D Displaced fracture of the greater tuberosity of the left humerus, subsequent encounter with routine healing

184

Chapter 19 (S00 –T88)

185

ANSWERS:

- Additional Diagnosis:
  - Z96.612 Presence of left artificial shoulder joint
    - *Presence (of); implanted device; joint; shoulder*
  - S72.425D Nondisplaced fracture of lateral condyle of left femur, subsequent encounter with routine healing
    - *Fracture; traumatic; femur; condyle – see fracture, femur, lower end; condyle; lateral; nondisplaced*

185

Chapter 19 (S00 –T88)

186

ANSWERS:

- Additional Diagnoses:
  - M62.81 Muscle weakness (generalized)
    - *Weak, weakening, weakness (generalized); muscle*
  - R26.2 Difficulty in walking, not elsewhere classified
    - *Difficult, difficulty (in); walking*

186

Chapter 19 (S00 –T88)

187

RATIONALE:

- Either of the fractures code be listed as the principal diagnosis. It is important to determine which will require the most skilled care to determine primary reason for admission. Guidelines state that for rehab following active treatment for injuries, the injury code with the appropriate 7th character be utilized. The 7th character of "D" is utilized as encounter is during the healing and recovery phase, after initial (acute) care was delivered.

187

Chapter 20 (V00 – Y99)

188

- External Causes of Morbidity
  - Common conditions found in this chapter:
    - Exposure to forces of nature
    - Slipping, tripping, stumbling, falling
    - Transport accident

188

Chapter 20 (V00 – Y99)

189

- Codes from this chapter are NEVER a principal/first listed diagnosis.
- Used for diagnosis coding for trauma centers.
- They are used to provide additional information as to the cause of a condition.
- Most often the condition will be classifiable to Chapter 19 – Injury, Poisoning, and Certain Other Consequences of External Causes.

189

Chapter 21 (Z00 – Z99)

190

- Factors Influencing Health Status and Contact with Health Services
  - Common conditions found in this chapter:
    - Aftercare following joint replacement surgery
    - Artificial openings
    - Encounter for surgical after care
    - Personal history of…

190

Chapter 21 (Z00 – Z99)

191

- Z codes can be used in ANY healthcare setting. They are NOT procedure codes!
- Some Z codes may only be used as principal/first listed diagnosis only.
  - These codes are listed under the chapter specific guidelines

191

Chapter 21 (Z00 – Z99)

192

- Status Codes
  - Indicates either carrier of disease or sequela/residual of past disease/condition
  - Includes the presence of prosthetic/mechanical devices
  - Long-Term (current) drug therapy
    - (Do not use when medication is being used to temporarily treat acute illness)

192

Chapter 21 (Z00 – Z99)

193

- Status Codes
  - Should not be used with a code from another chapter, if the code includes the information from the status code
    - Example:
      - Z94.1 Heart transplant status would note be coded with T86.21 Heart transplant rejection.

193

Chapter 21 (Z00 – Z99)

194

- Aftercare
  - Used when initial active treatment is complete and resident requires continued care during the healing/recovery phase or for the long-term consequence of the condition
  - Do not use when treatment is directed at a current active disease
  - Codes should not be used for aftercare of injuries.
  - May require multiple codes from this chapter to fully describe the reason for the aftercare

194

Chapter 21 (Z00 – Z99)

195

- History of (Personal or Family medical condition)
  - Personal history codes provide information re: past medical conditions that are no longer treated, but could potential reoccur, affect current treatment, or require continued monitoring
  - Family history codes provide information regarding the increased potential for a resident to contract a specific disease

195

Chapter 21 (Z00 – Z99)

196

CODING CHALLENGE:

- Resident admitted for skilled care following elective bilateral knee replacement surgery due to osteoarthritis of the knees.

196

Chapter 21 (Z00 – Z99)

197

ANSWERS:

- Principal Diagnosis:
  - Z47.1 Aftercare following joint replacement surgery
    - *Aftercare; following surgery; joint replacement*
- Primary Diagnosis:
  - Z47.1 Aftercare following joint replacement surgery
    - *Aftercare; following surgery; joint replacement*

197

Chapter 21 (Z00 – Z99)

198

ANSWERS:

- Additional Diagnoses:
  - Z96.653 Presence of artificial knee joint, bilateral
    - *Presence (of); implanted device (artificial) (prosthesis) (prosthetic); joint; knee*

198

Chapter 21 (Z00 – Z99)

199

RATIONALE:

- The primary reason for admission is rehab following left total shoulder replacement surgery. The osteoarthritis is not coded as it is no longer present.

199

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ICD-10 AND THE MDS

200

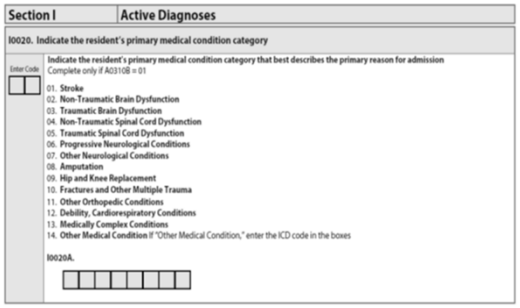
SECTION I (ACTIVE DIAGNOSES)

201

- The Importance of Section I:
  - Disease processes can have a significant adverse effect on a individual's health status and quality of life
  - This section identifies active diseases and infections that drive the resident's current plan of care

201

SECTION I (ACTIVE DIAGNOSES)



Section I	Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission
Complete only if A0310B = 01

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions
14. Other Medical Condition If "Other Medical Condition," enter the ICD code in the boxes

I0020A.

202

SECTION I (ACTIVE DIAGNOSES)

- Item I0020: The resident's primary medical category that best describes the primary reason for admission
  - If "14. Other Medical Conditions" is selected the diagnosis code must be entered into Item I0020A.
  - Joint replacements due to a fracture should be coded to "10. Fractures and Other Multiple Trauma"
  - Infections, open wounds, and ulcers should be coded to "13. Medically Complex Conditions"

203

SECTION I (ACTIVE DIAGNOSES)

204

- Conducting the Assessment:
  - Step 1: Identify diagnoses
    - Requires a documented diagnosis by authorized licensed staff as permitted by state law within the last 60 days
  - Step 2: Determine diagnosis status
    - Determine if the diagnosis is active or inactive in the 7-day look-back period

204

SECTION I (ACTIVE DIAGNOSES)

205

- Items in this section are intended to code diseases that have a relationship to the resident's current:
  - functional status
  - cognitive status
  - mood or behavior status
  - medical treatments
  - nursing monitoring
  - risk of death

205

SECTION I (ACTIVE DIAGNOSES)

206

- UTIs:
  - Code when both of the following criteria were met in the last 30 days:
    - Resident determined to have had a UTI using evidence-based criteria (McGeer, NHSN, or Loeb)
    - A physician (NP, PA, CNS) documented the UTI diagnosis

206

SECTION I (ACTIVE DIAGNOSES)

207

- UTIs:
  - When a UTI is diagnosed prior to admission, entry, or reentry, it is not necessary to obtain or evaluate the evidence-based criteria and coding may be based solely on the provider documentation
  - If the resident is transferred but not admitted to the hospital, the facility must meet both of the previously listed criteria.

207

SECTION I (ACTIVE DIAGNOSES)

208

DO LOOK FOR:	DON'T INCLUDE
• Recent onset, exacerbation, or change in therapy • New or worsening signs or symptoms attributed to a disease • Ongoing therapy with medication or other interventions	• Conditions that have been resolved • Conditions that no longer affect the resident functioning or plan of care • Diagnosis just because it is on the problem list.

208

SECTION I (ACTIVE DIAGNOSES)

209

- Entering Data:
  - Check off each / every active disease
    - Diagnoses are listed by major category
    - Examples are provided
    - Diseases to be coded aren't limited to examples
  - Add specific disease or condition codes into Item I8000 that are not listed in major categories or require further specification.

209

SECTION I (ACTIVE DIAGNOSES)

210

- While not required by the RAI manual guidelines. Best practice is to include the Principal/Skilling diagnosis in this section, even if it is checked under one of the major categories without code providing further specificity.

210

Section J (Health Conditions)

- Item J2000: Prior Surgery. Did resident have major surgery during the 100 days prior to admission
  - Major surgery refers to a procedure that meets all three (3) components to be considered major surgery:
    - Resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to SNF
    - Resident had general anesthesia during the procedure, and
    - Surgery carried some degree of risk to resident's life or potential severe disability.

211

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PAYMENT METHOD CHANGES

212

Patient Driven Payment Model (PDPM)

- Changes to the current prospective payment system (PPS)for SNFs.
  - New payment system is called the Patient Driven Payment Model (PDPM)
  - Changes are scheduled to go into effect on October 1, 2019
  - Decrease number of scheduled assessments to be completed

213

Patient Driven Payment Model (PDPM)

- Divided into six case mix categories
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Therapy (ST)/Speech Language Pathology (SLP)
  - Nursing
  - Non-Therapy Ancillary
  - Non Case Mix Adjusted Rate

214

PT and OT Components

- Utilizes ICD-10 diagnosis codes
  - PT and OT Case Mix utilizes the primary diagnosis code to classify residents into one of four clinical categories
    - Major joint replacement or spinal surgery
    - Other orthopedic
    - Non-orthopedic surgery
    - Medical Management

215

PT and OT Components

PT and OT Clinical Category	Primary Diagnosis Clinical Category
Major Joint Replacement or Spinal Surgery	• Major Joint Replacement • Spinal Surgery
Other Orthopedic	• Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) • Non-Surgical Orthopedic/Musculoskeletal

216

PT and OT Components

PT and OT Clinical Category	Primary Diagnosis Clinical Category
Non-Orthopedic Surgery and Acute Neurologic	• Non-Orthopedic Surgery • Acute Neurologic
Medical Management	• Acute Infections • Cardiovascular and Coagulations • Pulmonary • Cancer • Medical Management

217

ST Component

- Utilizes ICD-10 diagnosis and procedure codes
  - ST Case Mix utilizes diagnosis codes to classify residents into neurologic or non-neurologic clinical category
    - It also utilizes diagnosis codes to capture SLP related comorbidities.

218

ST 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

219

Nursing Component

- RUGs are grouped into six categories
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex
  - Behavioral Cognitive Symptoms
  - Reduced Physical Function
- Three categories utilize diagnosis and coding from section I of the MDS.

220

Nursing 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

221

Nursing 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

222

Nursing Component

- Special Care High
  - Diagnosis Coding in from Section I
    - Fever (J1550A) and one of the following:
      - Pneumonia (I2000)
      - Vomiting (J1550B)
      - Weight Loss (K0300, 1 or 2)
      - Feeding Tube (K0510B1 or K0510B2)

223

Nursing Component

- Special Care Low
  - Diagnosis Coding in from Section I
    - Cerebral palsy (I4400) and
      - Nursing Function Score of 11 or greater
    - Multiple Sclerosis (I5200) and
      - Nursing Function Score of 11 or greater
    - Parkinson's (I5300) and
      - Nursing Function Score of 11 or greater
    - Respiratory Failure (I6300) and
      - Oxygen therapy while a resident (0100C2)

224

Nursing Component

- Clinically Complex
  - Diagnosis Coding in from Section I
    - Pneumonia (I2000) and
      - Nursing Function Score of 11 or greater

225

Non-Therapy Ancillary (NTA) Component

- Utilizes 50 diagnosis codes and extensive services to identify additional comorbidities
  - Must be coded on the UB04 or MDS
  - Utilizes a points scale from 1 to 8 to calculate comorbidity score

226

Non-Therapy Ancillary (NTA) Component

Non-Therapy Ancillary Comorbidities		
Condition/Extensive Service	**MDS Item**	**Points**
HIV/AIDS	SNF Claim ICD-10 B20	8
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator Post-admit Code	O0100F2	4
Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2

227

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BILLING COMPLIANCE

228

Triple Check

- Triple check is a 3 point check system used to review each beneficiary's UB-04 claim prior to submission of the bill as part of a center's billing compliance program.
- Who attends:
  - MDS
  - Rehabilitation
  - Business Office

229

Triple Check

- What is reviewed:
  - MDS RUG codes and applicable billing days
  - MDS submission date and acceptance
  - ARD date and HIPPS code for accuracy and compliance
  - ICD-10 coding selection and ordering on the UB-04
- When is it conducted:
  - Monthly, prior to submission of bills

230

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SUMMARY

231

SUMMARY

232

- Identify diagnoses based on physician or physician extender documentation
- Code to highest level of specificity documented.
- Follow coding guidelines and conventions.
- Become familiar with PDPM clinical categories and those codes that are listed as return to provider

232

Q & A

233

Questions???

233

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234

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236