MASTERING ICD-10-CM TO ATTAIN THE GOLD

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LEARNING OBJECTIVES

- History and What’s New for 2017
- Official Coding Conventions and Guidelines
- Diagnosis Coding in SNF/LTC
- Billing Components
- Risk and Compliance
- Future Implications

HISTORY

ICD-10-CM
- International Classification of Diseases, 10th revision, Clinical Modification
- Used World-Wide for many years
- United States last to implement October 1, 2015
- Increased diagnosis code specificity from ICD-9-CM
  - From < 20,000 codes to > 65,000 codes
- WHO expects ICD-11 by 2018
NEW ICD-10-CM FOR 2017
- Code freeze of past five years is over
  - Increased specificity required
  - 1,974 New codes
  - 425 Revised codes
  - 311 Deleted codes
  - Additional 300 pages in ICD-10-CM Code Book
- One-year Medicare grace period for denial or auditing Part B claims solely on ICD-10-CM codes specificity provided a code from the appropriate family of codes has been submitted, is scheduled to end on Sept. 30, 2016

NEW ICD-10-PCS FOR 2017
- 3,827 New ICD-10-PCS codes
- Increased potential for principal diagnosis coding error impacting MS-DRG Grouping
  - Presence or absence of a major complication or co-morbidity (MCC) or complication or co-morbidity (CC) as a secondary diagnosis changes the MS-DRG
- CJR, BPCI, ACO statistical analysis
- ICD-10-PCS Coding Impacts
  - Hospital reimbursement
  - Rehospitalization rates (RTH%)
  - ELOS rates

HIPAA AND ICD-10-CM

HIPAA requires that healthcare providers, including LTC facilities, follow the guidance and direction in the ICD-10-CM code system and the “ICD-10-CM Official Guidelines for Coding and Reporting.”
AHIMA Practice Brief, March 2015
SNF/LTC ICD-10-CM GUIDANCE

- The Coding Clinic
  - Quarterly guidance publication by the American Hospital Association (AHA)
  - Assists LTC facilities on interpretation and application of ICD-10-CM Official Guidelines for Coding and Reporting in the LTC setting
  - Established in order to standardize data collection and assist coders in LTC facilities

ICD-10-CM CODE BOOK 2017

- Alphabetic Index
  - Index of Diseases and Injuries
    - List of terms and corresponding codes
  - Neoplasm Table
  - Table of Drugs and Chemicals
  - Index to External Causes
  - Tabular List of Diseases and Injuries
    - A structured list of codes divided into chapters based on body system or condition

It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code.

CONVENTIONS

Not just a bunch of people gathered for a meeting in Las Vegas!!

The Conventions and Instructions of the Classification take precedence over Guidelines.
SECTION 1.A. CONVENTIONS

Format and Structure
- A valid code can be 3 to 7 characters
- Starts with an Alpha character, except "U"
- Second character is always a Number
- Characters 3-7 can be Alpha or Numeric
- A period follows the third character
- X is used as placeholder
- 7th character must be in the 7th position

CODING AND SEVENTH CHARACTER

1.B. GENERAL CODING GUIDELINES

Sequela
- Late Effects
  - Scar formation resulting from a burn
  - Deviated septum due to nasal fracture
- Laterality
  - If laterality indicated, code as stated (right, left, bilateral)
  - If bilateral condition and bilateral is not an option, assign a code for the left and a code for the right
  - If laterality is not indicated, code as unspecified
1.B. GENERAL CODING GUIDELINES CONT.

- **Borderline Diagnosis**
  - “Borderline” diagnosis documented at discharge is coded as confirmed diagnosis
  - Borderline diagnosis with specific index entry is coded as such (borderline diabetes)

- **Uncertain Diagnosis**
  - Documented as “probable”, “suspected”, “likely”, “questionable”, “possible”, “still to be ruled out” or similar terms are conditions coded only in hospitals.
  - Not for SNF/LTC nursing facilities

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**DOCUMENTATION**

- Imperative to accurate coding
- Only Physician, or physician extender can diagnose
  - Diagnosis must be documented by physician in medical record
- Ask for hospital discharge summary, operation reports, and consultation reports
- Get detailed information

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**ICD-10-CM**

21 CHAPTERS WITH CHAPTER SPECIFIC GUIDELINES AND INSTRUCTIONS
HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTIONS

- Code only confirmed cases
- Selection and sequencing of HIV codes
  - Patient admitted for HIV-related condition
    - Principal diagnosis = B20, [HIV] disease
  - Patient with HIV disease admitted for unrelated condition
    - Principal diagnosis = unrelated condition
    - Then code B20, [HIV] disease and all HIV-related conditions

UROSEPSIS

Urosepsis is a nonspecific term and has been commonly miss-coded.
- Not synonymous with Sepsis
- Should a provider use this term, he/she must be queried for clarification
  - UTI?
  - Sepsis?
  - Cystitis?

DIABETES MELLITUS

- Combination codes that include
  - type of diabetes mellitus,
  - the body system affected, and
  - the complications affecting that body system
- May use as many codes needed to describe all of the complications of the disease
- Sequence based on the reason for a particular encounter
- Use Z79.4 code for long term use of insulin as applicable
PAIN

» May be used in conjunction with other codes to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated

» When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis

» No code from category G89 should be assigned

ACUTE MYOCARDIAL INFARCTION (AMI)

» Admission when the myocardial infarction is ≤ four weeks old, and the patient requires continued care for the myocardial infarction, codes from category I21 may be reported

» For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned

» For old or healed myocardial infarctions not requiring further care, assign code I25.2, Old myocardial infarction

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND ASTHMA

» Distinguish between uncomplicated cases and those in acute exacerbation

» An acute exacerbation is a worsening or a decompensation of a chronic condition

» An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection
PRESSURE ULCER STAGE CODES

- Pressure ulcer codes are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.
- The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage, and unstageable.
- Assign as many codes as needed to identify all the pressure ulcers the patient has.
- Code to highest stage of pressure injury.

SITE

- Site represents the bone, joint, or the muscle involved.
- There may be a “multiple sites” code available (i.e., Osteoarthritis).
- For categories where no multiple site code is provided and more than one bone, joint, or muscle is involved, multiple codes should be used to indicate the different sites involved.

SIGNS AND SYMPTOM CODES

- Used in addition to a related definitive diagnosis when not routinely associated with that diagnosis.
- Not assigned as additional codes if associated routinely with a disease process, unless otherwise instructed by the classification.
- When using a combination code, an additional code should not be assigned for the symptom.
FALLS

- Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.
- Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls.
- When appropriate, both codes R29.6 and Z91.81 may be assigned together.

PATHOLOGIC FRACTURES

- Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected.
  - M81.-, Osteoporosis without current pathological fracture
  - For history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow the code from M81.-
  - M80.-, Osteoporosis with current pathological fracture
  - Coded to identify the site of the fracture, not the osteoporosis
  - 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.

TRAUMATIC FRACTURES

- Per Coding Clinic, "when a patient is admitted to the long term care facility specifically for rehab following an injury, assign the acute injury code with the appropriate 7th character (i.e., "D" for subsequent encounter) as the first-listed diagnosis."
TRAUMATIC FRACTURES

- Categories for traumatic fractures have additional 7th character values
  - A, initial encounter (active treatment)
  - D, subsequent encounter (healing or recovery)  
    - Almost always used in SNF/LTC setting
  - S, sequelae (complications or conditions that arise as a direct result)
    - Use both the injury code that precipitated the sequelae and the code for the sequelae itself

TRAUMATIC FRACTURES

- Fractures of specified sites are coded individually by site, sequenced by severity

- Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes

TRAUMATIC FRACTURE CODING EXAMPLE

S72.111D, Traumatic greater trochanter fracture of right closed hip, subsequent episode of care, routine healing

- In ICD-10-CM, there are no Z code aftercare codes for traumatic fracture

- Assign the traumatic fracture code with the appropriate, subsequent encounter 7th character – “D” in the SNF/LTC setting
EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

- Not generally used in SNF or LTC setting
- Never sequenced as the first-listed or principal diagnosis
- Intended to provide data for injury research and evaluation of injury prevention strategies

Z CODES

- May be principal or primary code
- Multiple Categories
  - Contact/Exposure
  - Inoculations/Vaccinations
  - Status
    - Carrier of a disease or has sequelae or residual of past disease or condition
    - Includes prosthetic or mechanical devises
  - History (of) – personal and family
- Aftercare codes

USE OF Z CODES IN LTC FACILITIES

- The ICD-10-CM code set and the official guidelines provide specific instruction and guidance to both the coding and billing staff for appropriate use of Z codes in LTC facilities
- There is no code in ICD-10-CM for “Admission for, Encounter for, or Care involving rehabilitation procedures.”
  - Remember V57.89 in ICD-9-CM?
- Z codes will frequently be assigned for aftercare following surgical procedures performed in the hospital for which the patient is sent to the LTC facility to recover
STATUS Z CODES

- Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare.
  - Example: a patient had a coronary artery bypass graft (CABG) at the hospital immediately preceding being sent to the SNF for rehab. The codes for this patient would be:
    - Z48.812 Aftercare following surgery on the circulatory system
    - Z91.1 Presence of CABG

PRINCIPAL DIAGNOSIS

PRINCIPAL DIAGNOSIS DEFINITION & GUIDANCE

- Conflicts in requirements and terminology
  - Term “principal diagnosis” is interchangeable with primary and first listed diagnosis
    - Often used to indicate the reason for skilled Medicare services
    - May not be the same reason for the resident’s continued stay
The Uniform Hospital Discharge Data Set defines principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The AHA, Coding Clinic further states that for residents who continue to stay in LTC facilities, the condition requiring the resident to stay should be sequenced first.

In determining the principal diagnosis, coding conventions in ICD-10-CM, the Tabular List, and the Alphabetic Index take precedence over these official coding guidelines.

Current LTC resident transfers to the hospital to receive treatment for acute condition (i.e. pneumonia) and return to the facility for further care of their chronic condition (i.e. COPD) may continue to receive care for the acute condition if unresolved.
PRINCIPAL DIAGNOSIS CODING LTC EXAMPLE CONT.

- The principal diagnosis (first listed) is the reason for the continued stay (i.e. COPD) in the nursing facility
- A newly diagnosed condition will be listed after the principal diagnosis to reflect new conditions that affect the resident
- The principal diagnosis may or may not be the reason for Medicare skilled services

ICD-10-CM IN SNF/LTC SETTINGS

CODING ACUTE CONDITIONS IN SNF/LTC SETTING

- An acute condition treated at the hospital that continues to require follow up or ongoing monitoring should be coded with an acute diagnosis code as long as the condition persists and requires continuing treatment or follow-up (i.e. Pneumonia with nebulizers and antibiotics)
- The status of the acute condition would be assessed whenever the MDS is updated or in clinical review meetings, (i.e. 24 hour report, PPS, or weekly Medicare meeting, etc.)
CODING ACUTE CONDITIONS IN SNF/LTC SETTING

- Codes for the acute medical condition treated and resolved in the hospital are not coded or reported in the LTC facility
  - It is inaccurate to report an acute code for a resolved condition on the health record or claim because it directly contradicts the Official Guidelines for Coding and Reporting and is non-compliant with HIPAA regulations
- The facility would use a Z code for the aftercare

SNF/LTC CODE ASSIGNMENT

- ICD-10-CM codes are assigned on admission and concurrently as diagnoses arise throughout a stay often when the minimum data set (MDS) is updated
- All diagnoses (i.e., additional diseases or conditions) that affect the resident’s care are coded per coding guidelines
- Diagnostic listing and sequencing will vary depending on the circumstances of the resident’s admission or continued stay in the facility.

DIAGNOSIS CODING ON THE MDS

- The Resident Assessment Instrument (RAI) MDS 3.0 User’s Manual provides instructions for reporting diagnoses that have an impact upon the development of individualized care plans for residents
- The MDS contains common active diagnoses sets or groups that are to be checked on Section I if present in the resident record
DIAGNOSIS CODING ON THE MDS

- ICD-10-CM diagnosis codes may be listed individually on the MDS
  - If the diagnostic groups listed in Section I of the MDS do not identify a condition/diagnostic group meeting the criteria of impact on the resident’s current function
  - If more specificity is needed or provided

- Diagnoses on the MDS must meet additional timeframe requirements, therefore the documentation supporting the diagnoses must be current

PRIMARY DIAGNOSIS FOR THERAPY SERVICES

- Medicare Program Integrity Manual Definition
  - Refers to the term “primary diagnosis” as the diagnosis that is the reason for therapy services
  - This diagnosis is currently referred to as the “medical diagnosis” for the therapy evaluation and plan of care and may or may not be the principal, primary, or first-listed diagnosis

ICD-10-CM CODING FOR THERAPY SERVICES

- The Therapy Evaluation and Plan of Care for new Medicare Part A stays require the medical reason to support the therapy services as documented by the physician or qualified practitioner

- The diagnosis code representing the medical reason may be identified as “primary diagnosis” or “medical diagnosis” on the therapy plan
ICD-10-CM CODING FOR THERAPY SERVICES

- The medical diagnosis on the Therapy Evaluation or Therapy Plan of Care may be different than the diagnosis listed as the reason for the continued stay (principal, primary, or first-listed diagnosis) in the facility.

THERAPY SERVICES – LTC/SNF CODING EXAMPLE

- LTC patient with Parkinson’s disease returns after hospitalization for pneumonia with Medicare Part A stay
- Sequencing on UB-04 and in medical record
  - Parkinson’s Disease continues to be sequenced first
  - The reason for the new focus of care and Medicare Part A stay, pneumonia, is sequenced second

- Therapy Evaluation and Plan of Care diagnoses for skilled services
  - Medical Diagnosis = Pneumonia
  - Add appropriate therapy treatment diagnosis codes

MEDICARE PART B THERAPY SERVICES

- Medicare Part B therapy services require medical necessity for treatment and must be reasonable and necessary
- ICD-10-CM codes for chronic or other medical conditions that affect the resident’s progress, or need for treatment, may also be used to support therapy services
MEDICARE PART B - BILLING CLAIM

- The medical diagnosis that identifies the reason for the Part B therapy services should be listed on the UB-04 after the primary diagnosis for the LTC stay.

- Data fields on the UB-04 (bill type, specific line items for therapy services, and appropriate medical and treatment diagnoses) along with accurate and complete documentation in the health record will support appropriate reimbursement for Medicare Part B services.

SNF MEDICARE CLAIMS PROCESSING


- Chapter 23, Fee Schedule Administration and Coding Requirements (Rev. 1717, 04-26-08), Section 10, “Reporting ICD Diagnosis and Procedure Codes” (Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08), 10.2, “Relationship of ICD Codes and Date of Service.”
The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-CM diagnosis code, including up to seven characters in ICD-10-CM where applicable.

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows:

- Principal diagnosis code: SNFs enter the ICD-10-CM code for the principal diagnosis in the appropriate form locator on the UB-04 (67A and 69).
- Other diagnosis codes required: The SNF enters the full ICD-10-CM codes for additional conditions in the appropriate form locator.
- Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-10-CM guidelines.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD diagnosis codes are a medical code set, CMS does not provide any grace period for providers to use in billing discontinued diagnosis codes on Medicare claims.

What does this mean?

- New ICD-10-CM codes will be used for dates of service on, or after October 1, 2016.
The number of diagnoses listed can be extensive and may exceed current reporting capacity on the UB-04 (Universal Billing Form, version 5010), which only allows for 25 codes.

The principal diagnosis is located in fields 67A and 69 on the UB-04 with no strict hierarchy in the ICD-10-CM guidelines regarding the sequencing of secondary diagnosis codes. When diagnoses are sequenced together it is not required that the secondary diagnosis code be reported immediately following the code for the related condition. However, the sequencing of diagnoses should paint the picture of the need for skilled care.

Prior to submission of the UB-04 claim, facilities must validate that the ICD-10-CM diagnoses reported on the claim are consistent with the health record documentation and MDS information. The triple-check process ensures that the diagnosis data submitted for each payment mechanism is consistent.
Compliance and Audits

MEDICAL REVIEWS

With the increase in third-party audits from entities such as the Office of Inspector General (OIG), recovery auditors, and Medicaid Integrity Contractors, it is imperative that LTC facilities understand the ICD-10-CM guidelines for coding and reporting as required by HIPAA.

MEDICAL REVIEWS - OIG

The risk areas associated with billing and cost reporting have been among the most frequent subjects of investigations and audits by the OIG.
MEDICAL REVIEWS
➢ OIG Compliance Program Guidance for Nursing Facilities:
   ▶ A nursing facility should develop policies and procedures to ensure compliance with the federal healthcare programs when submitting information that affects reimbursement decisions.
   ▶ Proper and ongoing training and evaluation of the staff responsible for coding diagnoses, and
   ▶ Regular internal audits of coding policies and procedures

CODING COMPLIANCE
➢ Identify who is completing ICD-10 coding
➢ Provide ICD-10-CM coding training
➢ Develop coding policies and procedures
➢ Conduct internal compliance audits

FUTURE IMPLICATIONS
CMS FOCUS DIAGNOSES

- Heart Failure (CHF)
- COPD
- Pneumonia
- Acute Myocardial Infarction (AMI)
- Stroke (CVA)
- Total Hip Replacement (THA, THR)
- Total Knee Replacement (TKA, TKR)

Hospitals are being penalized for re-hospitalizations. SNFs will be penalized for avoidable returns to hospital starting in 2018.

VALUE BASED PURCHASING INITIATIVES

- Accountable Care Organizations (ACO)
  - Healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients
  - May be hospital or physician’s group
  - Choose post-acute care partners that meet certain criteria and metrics

- Comprehensive Care Joint Replacement Model (CJR)
  - Mandatory per CMS as of April 1, 2016
  - Participant hospitals are financially accountable for entire episode of care
  - Episode of care starts on day of admission to hospital and ends 90-days post discharge
  - Includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries
  - MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or
  - MS-DRG 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities)
VALUE BASED PURCHASING INITIATIVES

- Bundled Payments for Care Initiatives (BPCI)
  - Voluntary
  - Four Models
    - Model 1 - Hospital inpatient only - includes all DRGs
    - Model 2, 3, & 4 – Includes inpatient and post-acute care - 48 episodes participants can choose from with associated DRGs
      - [https://innovation.cms.gov/initiatives/bundled-payments/](https://innovation.cms.gov/initiatives/bundled-payments/)

Attain the Gold with Coding Accuracy

- Regulatory Compliance
- Appropriate Reimbursement
- Value-Based Purchasing Partnerships

QUESTIONS
OFFICIAL RESOURCES

2017 ICD-10-CM is available at
http://www.cdc.gov/nchs/icd/icd10cm.htm or
http://www.cms.hhs.gov/ICD10

- 2017 ICD-10-CM Index to Diseases and Injuries
- 2017 ICD-10-CM Tabular List of Diseases and Injuries
  - Instructional Notations
- FY2016 Official Guidelines for Coding and Reporting (no changes as of this date)
- 2017 Table of Drugs and Chemicals
- 2017 Neoplasm Table
- 2017 Index to External Causes

REFERENCES
