WEBINAR SERIES (PART THREE)

PDPM coding:

Avoid these common traps

Lisa Selman-Holman
and Mary Madison

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Number 3 The Use of Symptom Codes

- Symptom codes are NOT used when the definitive condition is known if that symptom is routinely associated with the definitive condition.

Symptoms, Signs and Ill-Defined Conditions

Code the Symptoms

- When that's all we have
- When the patient has a symptom not routinely associated with the condition
  - Pneumonia with *Hemoptysis*
- When there is an instruction to code the symptoms (N40.1-)

Coded

Do not code the symptoms

- When the patient has a symptom that IS routinely associated with the condition
  - Pneumonia with *dyspnea*

Not coded

Physical Therapists and Symptoms

- The guidelines in Section I, Conventions, General Coding Guidelines and Chapter Specific Guidelines, apply to all providers, including physical therapists. If the symptom is integral to the diagnosis it would not be separately coded.

More examples from the Coding Clinic

Question

- A patient with a known diagnosis of Parkinson's disease with frequent falls and lack of coordination is referred by the physician for physical therapy for fall prevention. What diagnosis codes should be reported for the physical therapy visit?

Answer

- G20, Parkinson's disease, as the first- listed diagnosis.
- R29.6, Repeated falls, should be assigned as an additional diagnosis since falls are not integral to Parkinson's disease.

More examples from the Coding Clinic

Question

- A patient with low back pain and sciatica with left lower extremity pain radiating to the knee and difficulty walking was seen by an orthopedist and referred to physical therapy (PT). The primary reason that PT is involved is to resolve the pain and improve mobility. What diagnosis codes should be reported for the physical therapy visit?

Answer

- M54.42, Lumbago with sciatica, left side, for the low back pain and sciatica.
- R26.2, Difficulty in walking, not elsewhere classified, as an additional diagnosis, since it is not integral to sciatica or lumbago.

When presented with just symptoms/signs…

- Even symptoms and signs MUST be documented/verified with the physician.
- Referring physicians'/consulting physicians' notes
- To confirm definitive diagnoses, look for indications of other illnesses:
  - Medications
  - Treatments
  - Interview of patient/caregiver
  - ***And verifying those findings with the physician*** and/or medical director

R Codes as Primary in PDPM (Examples)

- R09.89 Cardiac signs MM
- R25.8 Abn invol movement MM
- R26.0 ataxic gait MM
- R26.1 paralytic gait MM
- R04.81 idiopathic hem in infants
- R04.89 hem other spec resp passage
- R04.9 hem unspec resp passage
- R27.0 Ataxia Acute Neuro
- R27.8 Other lack of coord Acute N
- R29.1 Meningismus Acute Neuro
- R4020 Coma and several coma scale codes MM
- R40.3 PVS MM
- R41.4 Neurologic neglect AN
- R41.842 Visuospatial deficit MM
- R47.01 Aphasia AN
- R47.02 Dysphasia MM
- R47.1 Dysarthria and anarthria MM
- R48.2 Apraxia MM

Q and A Joint Replacements and Fractures

- What is an appropriate code to use for PT/OT?
- **K. Admissions/Encounters for Rehabilitation**
- When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.
- If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. *If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.*

A vs D as the 7th character

If a resident is here (SNF) for IVs for the infection of the prosthesis, would we use A as it is active treatment?

Can you please repeat the statement about using "A" with a "T", complication code? We normally use the D once they come to us with an antibiotic spacer.

So if a resident is here (SNF) for IVs for the infection of the prosthesis, would we use A as it is active treatment?

If a pt. is on a wound vac for a prosthetic knee infection; can you tell me what ICD-10 code I will use for the wound vac if not Zcode?

Answer

- Antibiotics are considered “active” treatment of the infection so the correct 7th character is A.
  - Example given by Coding Clinic for active treatment was antibiotics and wound vac treatment. Scenario was IV antibiotics.
- Does not have to be IV antibiotics to be active treatment.
- Patient admitted to SNF for IV antibiotics x 7 more days for infected right hip prosthesis. The prosthesis has been removed and an antibiotic spacer has been placed.
- T84.51xA Infection and inflammatory reaction due to internal r hip prosthetic
- Z89.621 Acquired absence of right hip joint

The coding would be the same for the condition requiring wound vac.

When would S be used?

- If the new joint replacement gets infected would that not be S? If S is used sometimes then when do you use it?
- S is for sequela. Sequela means that the original injury or illness is resolved and there is a condition “left over.”

An example would be:

- The patient with congenital hip dysplasia had his 6th joint replacement on his right hip. He has an infected prosthesis and osteomyelitis in the femur. After treatment with antibiotics, the physician surgically shortened the femur and then replaced the prosthesis. The surgery is healed but his right leg is shorter than the left.
- M21.751 Unequal limb length (acquired) right femur
- T84.51xS Infection and inflammatory reaction due to internal r hip prosthetic, sequela

Questions re: osteoporosis fractures

Should the physician make the determination as to whether the fracture is traumatic or pathologic or should the coder make that determination based on the diagnosis of osteoporosis?

How can we determine if a fall would not usually cause a break in circumstances when we would not have witnessed that fall- like prior to admission, etc?

Osteoporosis fractures

- The guideline regarding osteoporosis fractures is a default *if the physician does not document the type of fracture.*
- If the physician has documented a trauma fracture in a patient with osteoporosis, you would code a trauma fracture and the osteoporosis (without current fracture) (M81.0) to indicate the comorbidity impacting the healing.
- If the physician has not documented type and the patient has osteoporosis and the information in the H&P indicates that there was no trauma or minor trauma (fall from standing height or less) then code it as an osteoporosis fracture. (M80.0-)

If the fracture is a result of fall in the facility, sent to ER and found a fracture, still D? or A?

- Active treatment of the fracture is A. Whatever treatment was provided in ER would be considered active treatment. Your 7th character for the fracture is D (aftercare for a healing, resolving fracture)

Joint replacement

- We have a patient coming with a removal of prosthesis d/t non- union. NWB x8 weeks then possible surgery again. Has an antibiotic spacer. We are using S72.491K. Is this correct?
- If the joint replacement was because of a fracture, then your fracture code is correct.
- However, if the prosthesis was displaced and infected, you would need to code the complications first. If this was a right knee, then you would code:
- T84.124A Displacement of internal fixation device right femur
- T84.53xA Infection and inflammatory reaction due to internal right knee prosthesis
- S72.491K Fracture of right femur lower end, non-union
- Z89.521 Acquired absence of right knee

ICD-10-CM codes match?

- Should the icd-10 codes used in the MDS match icd-10 codes in the physician's progress notes?
- Not necessarily. Coding needs to be based on documentation, not the codes used. Each coder is required to follow coding guidelines and conventions so just copying someone else's codes is not a good idea.
- A medical reviewer will look for physician documentation of the diagnoses.

Z codes as primary

- Z96.641 is non billable. Is that okay to use for pdpm?
- It can be used in I8000 of the MDS if it is active diagnosis. Don't use in I0020B for the primary diagnosis as it is an RTP - Return to Provider code.
- Generally, Z40s codes are aftercare codes and can be used as primary.
- Generally, Z80s codes are history codes and are not used as primary.
- Generally, Z90s codes are status codes and are not used as primary. Status codes are for information only and do not indicate care being provided. For example, Z96.641 indicates that the patient has a prosthesis but does not indicate the care. Z95.0 indicates that the patient has a pacemaker.

Fractures

- How can I code a fracture ie, S72... and obtain an Ortho category in PDPM? All my fracture codes result in "Return to Provider" rating
- Remember that you must use the diagnosis code that is the primary reason for skilled care/services in your facility in I0020B. That code will map to the designated category and thus the assignment of your PDPM reimbursement.
- Fracture codes do place the patient into either the non-surgical Ortho or the surgical Ortho. If the patient required major surgery that can be indicated in the J section.
- The only fracture codes that are RTP are the unspecified laterality codes.

Fractures

- So if we don't use a Z or surgical code for fractures with surgery, we don't get a PDPM surgical classification - the pt falls into a NON-Surgical PDPM category which doesn't pay as much - how can this be?
- CMS was asked this question during the August 8, 2019 SNF/LTC Open Door Forum. Several providers spoke to this so you're in good company. The answer was very complex and not complete. I suggest that you email this question to: SNF_LTCODF-L@cms.hhs.gov. The overall answer to your question is that you must follow the ICD-10 coding rules regardless of payment category.
- Open fractures are in surgical Ortho
- Closed fractures are in non-surgical Ortho but if they required surgery that can be indicated in the J section.

Aftercare

How do we code laminectomies, fusions and kyphoplasty?

- Generally, because the conditions that require these types of surgeries are from the M chapter, you would use Z47.89 (NOT Z48.89)
- If they had to have the surgery because of an injury, you would need to code the injury with a D (to indicate aftercare of a resolving, healing injury).

Active Diagnoses (I8000) vs Claim

- On the slide about Mr. Perk, you said to code presence of artificial hip replacement on left hip. but that is not an active diagnosis. Please clarify.
- Active Diagnoses (I8000) requires you to make a decision whether the condition is active. One could argue that because Mr Perk also has a prosthesis on the left side, that will impact his rehab and count it as active. If Mr Perk has other comorbidities that meet the definition better, you would not want to take up those spaces with a status code.
- The claim requires that coding conventions and guidelines be followed with applying the ICD-10-CM. When providing the scenarios I am coding according to the guidelines and these codes are what should appear on your claim even if they do not appear in I8000.

RTP codes can be used as I8000 or on claim

- Can return to provider codes be used as treatment diagnosis codes? ie: dysphagia codes
- RTP or Return to Provider codes should not be used in I0020B but can be used in I8000.
- Many of the RTP codes are symptom codes and should not be coded according to coding guidelines.

Are Z57 or Z98 codes acceptable?

- Z57 Occupational exposure codes would not be used as primary.
- Z55-Z65 codes can be used without physician documentation.
- Z98 codes are acceptable as secondary codes. They are status codes.

Pre-Screening

- Are there any suggested methods to pre-screen SNF residents?
- You should pre-screen potential SNF residents - whenever possible! Utilize PDPM resources available at the PDPM website to develop your screening template: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MDS_Manual_Ch_6_PDPM_508.pdf.

Where can I purchase a coding manual?

- You can purchase it here: https://www.briggshealthcare.com/products/professional-resources/billing-coding-prof/icd-10-cm.You'll want to purchase the 2020 books which begin on 10/2/2019. Look for the coding resource (always purchase ICD-10-CM for diagnosis coding; ICD-10-PCS is used in the acute setting for procedures) that fits your setting, i.e. SNF. Remember you'll want/need to purchase a new ICD-10-CM coding reference each year as CMS updates that database annually.

Hypertension and heart failure

- If the resident is admitted with congestive heart failure exacerbation and also has hypertension, would you code the congestive heart failure as primary or the hypertension?
- I11.0 Hypertensive heart disease with heart failure
- I50.9 Congestive heart failure

- Sequencing is mandatory.

Physician documentation

- Can we use the Wound MD documentation for clarification of wound types for coding?
- Yes. Any consulting physician’s documentation can be used as long as it does not conflict with the admitting physician’s documentation.

CVA with hemiplegia

- IF a resident is admitted with a diagnosis of CVA unspecified, but therapy says she has left hemiplegia, can we code this as cva with left sided hemiplegia? no record of hemiplegia in hospital documentation.
- LTC facilities admit patients for treatment of the residuals of CVAs, not for the treatment of the CVA itself. Anytime a patient is being admitted after a CVA, the source should be queried for residual deficits. You cannot code the I69.35- code for hemiplegia as a sequela of CVA unless the physician documents the hemiplegia.

Pressure Ulcer

- So if a resident has a pressure ulcer that was not is the hospital records, do we have to wait until the facility physician sees it in order to code it? Wouldn't it then be considered a facility acquired pressure ulcer?
- If the pressure ulcer was found on admission, then the physician would have to be queried. We can identify a pressure ulcer based on NPUAP criteria, however the physician would have to agree for it to be coded.

Where do we look up the major surgery code J2599?

- J section of the MDS (provided as an extra handout)

Amputations

- Regarding the patient with a dx of diabetic ulcer to left 2nd that required an amputation, what should be the primary and admitting diagnosis for a skilled facility?
- Z47.81 Aftercare following amputation
- Z89 code for the missing part

Use additional code

- When they say use an additional code - must it IMMEDIATELY follow the initial code?
- If part of an etiology/ manifestation pair, yes.
  - Alzheimer's dementia
- If there is a corresponding 'Code first' note, yes.
  - Bladder infection says use additional code to identify infection
  - Infection codes say to code the infection (what is infected first)
- Otherwise, no.
  - Z47.1 states to use Z96.6 code to identify the joint.

Medical Review

- Will CMS or the MAC's have professional coders reviewing our UB-04's for coding errors? How will they know during the billing process if the codes are correct or not?
- Most MACs have someone on the staff that is a professional coder or knows something. They are required by the Program Integrity Manual to follow coding guidelines.

What questions do you have?

Lisa@selmanholman.com

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