TEXAS LTC
VIRTUAL SYMPOSIUM

Trends, challenges and solutions in Texas skilled nursing

SEP 15-16, 2020

SESSION 8

ICD-10-CM Coding Challenges, Pitfalls and Solutions

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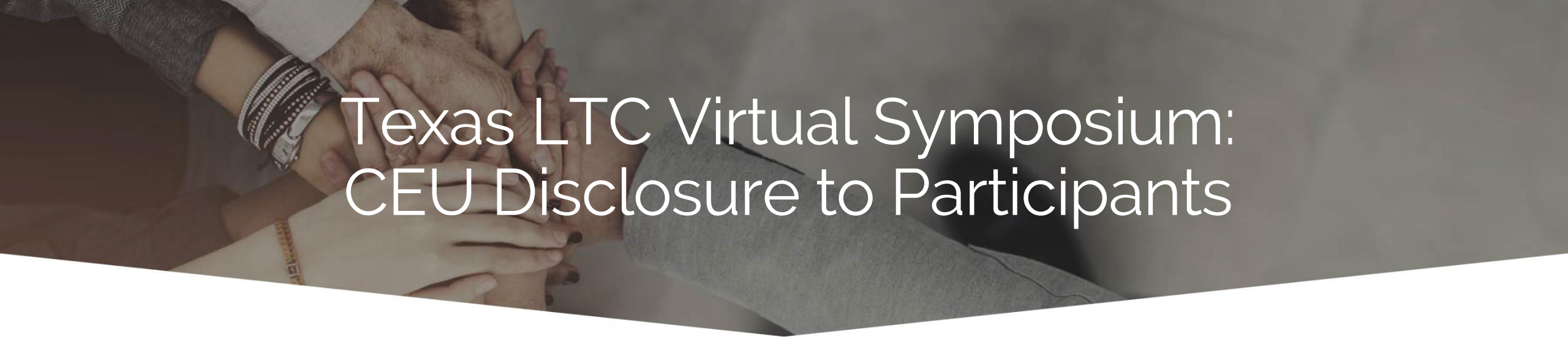

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Who Establishes Diagnoses?

- Excerpts from Coding Guidelines
- **Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).**
- **Meaning physicians, PAs, ANPs and CNS when allowed by their practice act to diagnose.**

Who Establishes Diagnoses?

Documentation of Complications of Care

- Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in.

Who Establishes Diagnoses?

- The listing of the diagnoses in the patient record is the responsibility of the attending provider.
- If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded.
- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance.

Diagnoses based on information from physician (provider—expanded definition)

- Is there verification of diagnoses before they are assigned to the claim?
  - Medicare expects communication with the physician with verification of diagnoses.
- Once diagnoses are placed on the claim, what are we doing with them?

Diagnoses based on information from physician (provider)

- Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician.
- Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment.

Diagnoses based on information from physician (provider)

- Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information.
- It would be appropriate to use the health record documentation of other providers, such as nurse practitioners and physician assistants as the basis for code assignment to report new diagnoses, if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility. The Official Guidelines for Coding and Reporting define a provider as the individual legally accountable for establishing a diagnosis. (CC 1st Quarter 2014)

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.

Admission Process in PDPM

It is extremely important to notate if the resident had a **major surgery** during the 100 days **prior to admission**.

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code	Did the resident have major surgery during the **100 days prior to admission**?
☐	0. **No** 1. **Yes** 8. **Unknown**

Definition of Major Surgery

- the resident was an *inpatient in an acute care hospital* for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF),

and

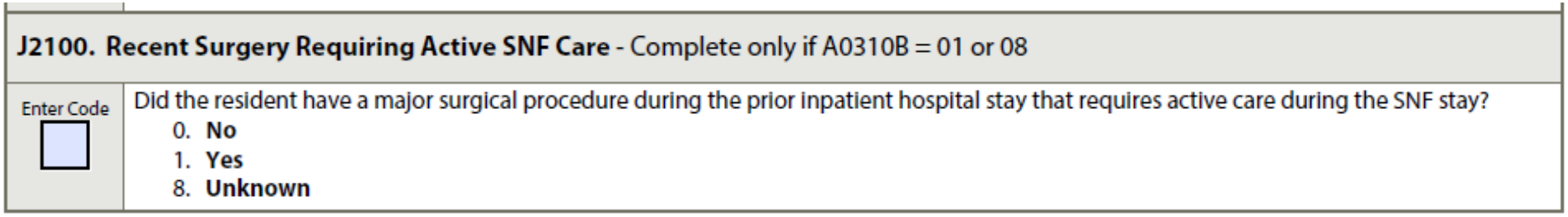
- the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Major Surgery during the 100 days prior to admission – J2000

This item identifies whether the resident has had major surgery during the 100 days prior to *the start of the Medicare Part A stay*. A recent history of major surgery can affect a resident's recovery.

J2100 – J5000 are the questions that increase the PDPM Score.

J2100



J2100. **Recent Surgery Requiring Active SNF Care** - Complete only if A0310B = 01 or 08	
Enter Code ☐	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**

Very Clear Instructions for this Question in the RAI Manual

Determine whether the surgeries require active care during the SNF stay: Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay**.** Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B.

I0020B

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

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**

I0020B. ICD Code

Fractures

NO Z CODES
OTHER COMPLICATIONS

Joint Replacements for Fractures

- A total hip replacement was done to treat a traumatic fracture of the hip. The fracture is now in the healing and recovery phase after surgical treatment. Assign code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as principal diagnosis. Assign also code Z96.641, Presence of right artificial hip joint.
- The intent of ICD-10-CM's seventh character for fracture and other injuries is to track treatment through the various stages, as well as to track resource utilization and outcomes. There are clinical differences in joint replacement surgery performed because of a traumatic fracture versus elective joint replacement surgery. For example, an injury resulting in unexpected surgery might require more intensive rehabilitation than a hip replacement due to degenerative osteoarthritis of the hip.
- See K of Section II of the Guidelines

Joint Replacements and Fractures

K. Admissions/Encounters for Rehabilitation

- 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. (Add the appropriate Z96.6- code)*

Fractures with ORIF

- Note the excludes 1 note at Z47
  - Aftercare for healing fracture—code to fracture with 7th character D
- Note that this excludes1 note includes all kinds of fractures, not just traumatic.

Impact

- Do not code Z47.1 for aftercare following a joint replacement when the patient needs a joint replacement to repair a fracture.
- Do not code Z47.89 for other orthopedic aftercare for a fracture which requires an ORIF to repair.
- Code the fracture, the Z96.6- code to indicate the presence of the prosthesis (if any) and check yes on J2000, J2100

A vs D as the 7th character

Common Questions:

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.

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 Z code?

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

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

T on TOP

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?
- 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).

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.

COVID 19

COVID-19 Sequencing

- When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

COVID-19 Respiratory Manifestations

- When the *reason for the encounter/admission* is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.
- The following conditions are examples of common respiratory manifestations of COVID-19.

COVID-19 (MMTA-Respiratory)

Pneumonia confirmed as due to COVID-19

- U07.1 COVID-19
- J12.89, Other viral pneumonia

Acute Bronchitis confirmed as due to COVID-19

- U07.1 COVID-19
- J20.8, Acute bronchitis due to other specified organisms

Bronchitis confirmed as due to COVID-19

- U07.1 COVID-19
- J40, Bronchitis, not specified as acute or chronic

Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020

Lower Respiratory Infection confirmed as due to COVID-19

- U07.1 COVID-19
- J22, Unspecified acute lower respiratory infection

Acute Respiratory Infection confirmed as due to COVID-19

- U07.1 COVID-19
- J98.8, Other specified respiratory disorders, with code (just respiratory infection)

ARDS confirmed as due to COVID-19

- U07.1 COVID-19
- J80, Acute Respiratory Distress Syndrome

COVID-19 Issues in SNF

- Weakness from COVID-19
- “Fully recovered” from COVID-19
- Residuals from COVID-19 but now negative
- If documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs a residual effect from a previous infection, query the provider. The provider’s statement that the patient has C-19 is enough to code it.

COVID-19 Issues in SNF

- Patient was hospitalized a few weeks ago for pneumonia due to C-19. He went back to the ER with SOB and was admitted. The DC diagnosis is pneumothorax due to a previous history of C-19.
- J93.83 Other pneumothorax
- B94.8 Sequelae of other specified infectious and parasitic diseases

The patient no longer has C-19 and the pneumothorax is a residual effect (sequelae). The personal history code is not correct because the patient is still receiving treatment for the residual effect.

COVID-19 Issues in SNF

- Patient admitted from acute hospital due to sequelae of COVID-19, including critical illness myopathy and peroneal palsy in the right lower extremity. *The patient no longer has COVID-19.*
- G72.81 Critical illness myopathy
- G57.31 Lesion of popliteal nerve, r lower limb
- B94.8 Sequelae of other specified infectious and parasitic diseases

The ‘With’ Convention

Conventions—Relational Terms

- The word “with” **or “in”** should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, **(either under a main term or subterm)** or an instructional note in the Tabular List.

With

The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. *These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").*

"With" or "in"

For conditions not specifically linked by these relational terms in the classification ***or when a guideline requires that a linkage between two conditions be explicitly documented****, provider documentation must link the conditions in order to code them as related.*

If the condition is not specifically listed under with or in, then it cannot be linked without the physician's say-so.

Does a guideline say it requires physician documentation?

Examples of 'With'

- Reference diabetes in the index **AS AN EXAMPLE**
- Diabetes

  with

  amyotrophy

  arthropathy NEC

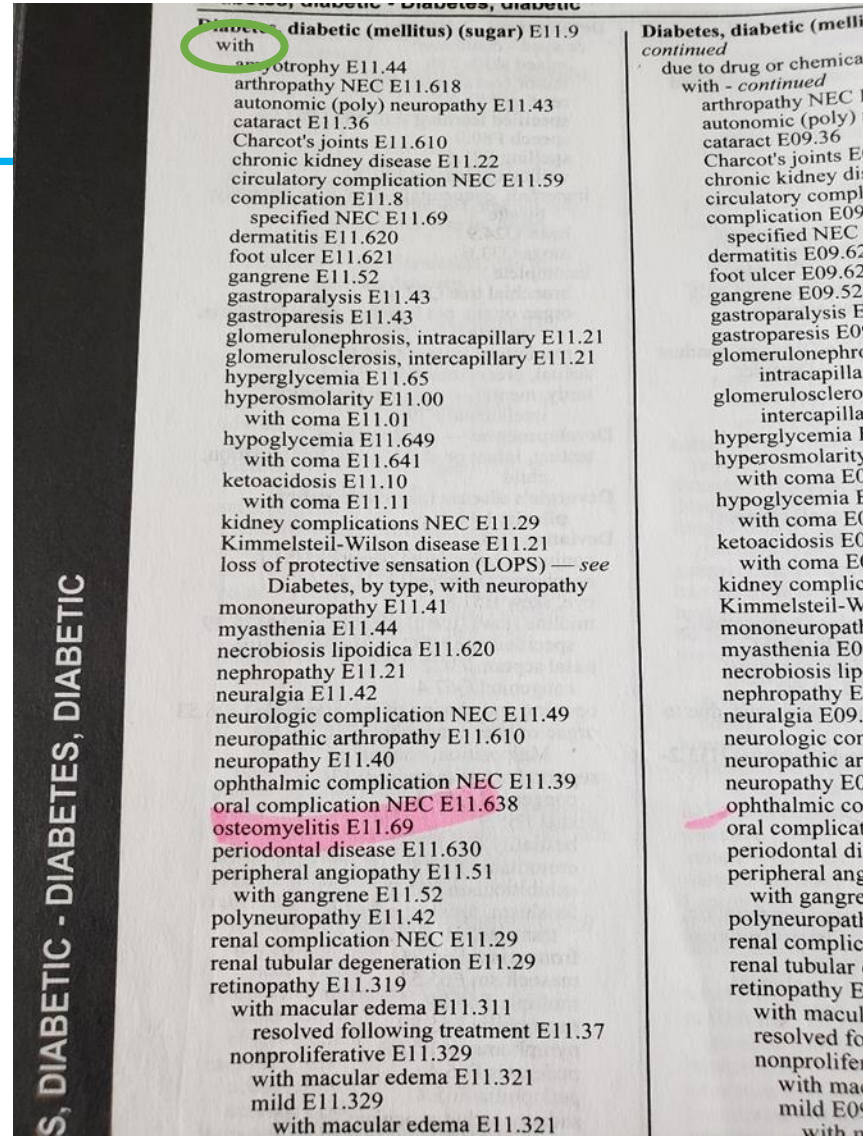
  autonomic (poly) neuropathy

  cataract (yes, even cataracts)

  Charcot's joints

  And so on…

- **Not limited to diabetes**…see dementia, with…
  - Dementia, with, Parkinson's
  - Anemia in…



Diabetic Manifestations (and Others)

- It's not the coder that assumes—the classification assumes a cause and effect relationship between diabetes and the listed manifestations
- The only time you do not code those manifestations specifically listed, as diabetic is if the physician has documented the conditions are *unrelated*.
  - It is imperative that all documentation be reviewed for indications that there is another cause or is unrelated before assigning the manifestation to diabetes.

Examples

- The physician documents foot ulcer on a diabetic patient.
  - Diabetic ulcer
- The physician documents pressure ulcer on the right buttock on a diabetic patient.
  - Pressure ulcer
- The patient has diabetes and also has polyneuropathy.
  - Diabetic polyneuropathy
- The patient has diabetes and also has alcoholic polyneuropathy documented.
  - Alcoholic polyneuropathy
- The diabetic has a gangrenous pressure ulcer.
  - Not a pressure ulcer and not diabetic gangrene

Examples

- The diabetic patient has PVD
  - Diabetic PVD
- The diabetic patient has *arterial* ulcers.
  - Where are the ulcers?
- The diabetic has an ulcer

  on his lower *leg* associated

  with stasis dermatitis with

  hemosiderin staining and a

  beefy wet appearance.
  - Know when you should really

    ask

- Arthropathy NEC
- Circulatory complication NEC
- Complication, specified NEC
- Kidney complications NEC
- Neurologic complication NEC
- Oral complication NEC
- Skin complication NEC
- Skin ulcer NEC

- *For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.*

CC Q4 2017 Do NOT link conditions not specifically listed!

- The patient has diabetes and OA. Do we code that as diabetic arthropathy?
- What if the doctor documents diabetes and arteriosclerosis of the extremities?
- The patient has diabetes and CAD. Is that diabetic CAD? No, but…
  - (If diabetic CAD is documented: E11.59, I25.10)

Other diabetic noteables

- Do not use E11.8, DM with unspecified complications
- Do not use E11.9, DM without complications when there are manifestations

Chronic Kidney Disease

N18 Chronic kidney disease (CKD)

N18.3 Chronic kidney disease, stage 3 (moderate)

N18.30 Chronic kidney disease, stage 3 unspecified

N18.31 Chronic kidney disease, stage 3a

N18.32 Chronic kidney disease, stage 3b

Stage 3A eGFR 45-59

Stage 3B eGFR 30-44

Remember you cannot code based on lab data.

Questions & Answers

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Questions? Please contact Jill Miller at codeprou@selmanholman.com or 214-550-1477 ext 4.

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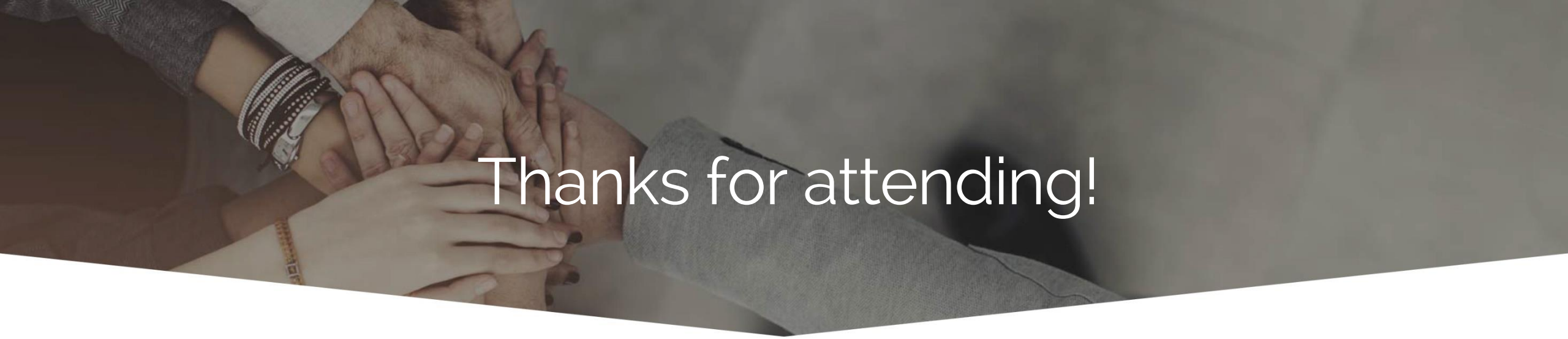

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