GREATER NY HEALTHCARE FACILITIES ASSOCIATION

THE PROOF IS IN THE ~~pudding~~

CODING:

ICD-10 CODING & UB-04 CODING FOR PDPM

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CMS's MESSAGE:
"If you do not like change, you are in the WRONG BUSINESS"

"THE MIND IS LIKE A PARACHUTE……IT ONLY WORKS WHEN IT IS OPEN"

DEFINITION: MEDICAL CODING (AAPC)

- Medical coding is the **transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes**.
- The diagnoses and procedure codes are taken from **medical record documentation**, such as transcription of physician's notes, laboratory and radiologic results, etc.
- Medical coding professionals help ensure the codes are applied correctly during the medical billing process, which includes **abstracting the information from documentation, assigning the appropriate codes, and creating a claim to be paid by insurance carriers.**

ICD-10-CM DIAGNOSIS CODING: A QUICK REVIEW

"We need to focus & understand this. This will be our "niche" to success."

TEST: DIAGNOSE YOURSELF

(My "updated" Favorite ICD-10 Codes)

- ❑ **Z62.1:** *Parental Overprotection*
- ❑ **Z63.1:** *Problems with the in-laws*
- ❑ **R46.1:** *Bizarre Personal Appearance*
- ❑ **Y93.84:** *Injured while Sleeping*
- ❑ **Y93.D1:** *Injured while Knitting or Crocheting*
- ❑ **X981.XXA:** *Assault by Hot Tap Water, Initial Encounter*
- ❑ **V94.31XA:** *Injury to Rider of (Inflatable) Recreational Watercraft being pulled behind other watercraft, Initial Encounter*
- ❑ **W22.02xD:** *Walked into a lamp post, Subsequent Encounter (Lesson: Don't Text while walking)*

- MUST CODE 7TH CHARACTER (A; D; or S); e.g. W04.xxxD:
- Use as Secondary to a Code from another Chapter indicating the nature of the condition: Means that this should never be used as a Principal Diagnosis Code

DIAGNOSIS CODES – ICD-10 IMPLICATIONS

- Reimbursement/Compliance Logic tests
- ***Heightened Emphasis on UB Coding: Transitions of Care, Medical necessity of services due to Medical Complexity, Appropriateness of Placement***
- Track Patient Recovery ***("Post-acute nature of ICD-10 codes in LTC ")***
- Increase the accuracy of "Predictive Analysis"
- Measure Acuity at different points along the continuum

Who Must Complete the ICD-10-CM Coding in the SNF?

From SNF PPS FY2019 Final Rule:

"…we do not believe it would be appropriate for CMS, in this instance, to specifically identify the type of staff that providers must employ to ensure accurate coding, as **this is a decision best left to the provider.**

- ***With regard to the potential consequences of ICD-10 coding errors on RAC audits, as under the current payment system, the information reported to CMS must be accurate.***
- ***Inaccuracies in the data reported to CMS, or a failure to document the basis for such data, will necessitate the same types of administrative actions as occur today."***

DIAGNOSIS CODES – ICD-10 IMPLICATIONS

Who Can Diagnose?

- ❑ Physicians (Attending physician, covering physicians, Radiologists, Specialists, etc.)
- ❑ Nurse Practitioners
- ❑ Clinical Nurse Specialists
- ❑ Physician Assistants

DIAGNOSIS CODES – ICD-10 IMPLICATIONS

- ❑ Diagnoses Must be Written by the Physician (Physician Extender)
- ❑ Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up
- ❑ Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up

DIAGNOSIS CODES – ICD-10 IMPLICATIONS

Where Can I Find Diagnoses?

- ❑ History and Physicals
- ❑ ER records and other hospital records
- ❑ Discharge summaries
- ❑ X-ray reports
- ❑ Surgical reports
- ❑ Transfer records
- ❑ Physician progress notes

Determining the ICD-10 CODE

- Use an ICD-10 coding Manual, do **NOT code from the internet, your phone, or code from a list!**
- You must **buy new books every October 1st!**
- Identify the Main term of the diagnosis
- If the diagnosis is not clear, **query the physician**

DO NOT…..!!!

- **DO NOT** Try to code from the Internet/website
- **DO NOT** Ask Siri, Alexa or "Hey, Google"
- **DO NOT** Use a list of commonly used codes
- **DO NOT** Copy from the hospital records
- **DO NOT** Code from previous year's code book(s)
- **DO NOT** Code symptoms you see in the licensed nursing notes
- **DO NOT** Code a diagnosis unless the physician has documented the diagnosis in the medical record

DO NOT…..!!!

- **DO NOT** code diagnoses added by therapists unless signed by the physician
- **DO NOT** code symptoms that you see in an IDT note but not documented by the physician
- **DO NOT** code diagnoses the physician has documented as "resolved"
- **DO NOT** guess, assume, or extrapolate what you think the physician meant without asking the physician to clarify the diagnosis

IMPORTANT: Always query the physician when the diagnosis is not clear.

ICD-10-CM Manual

- Be sure that you purchase the **ICD-10-CM Coding Manual**
  - Do not purchase an ICD-10-PCS Manual
  - While all ICD-10-CM Manuals will contain the same ICD-10 codes, **the layout of the manual can affect your ability to find the correct code** (Choose a User-friendly Manual)

DOCUMENTATION TO SUPPORT CODING AND CLAIM

- **Medical Records Must support codes**
  - Review all available records to determine appropriate assignment of ICD-10-CM Codes.
    - Hospital H&P
    - Discharge Summary
    - Physician/NP Progress Notes
    - Consultation Notes
    - Physician/NP Orders

SELECTION OF PRINCIPAL AND ADMITTING DIAGNOSIS

- Diagnoses: When, Who, and How Communicated? – ***Recommend to discuss in UR***
- **Definition of Principal/Primary Diagnosis in SNF: Condition chiefly responsible for the resident's admission to SNF (Field 67 on the UB-04)**
- **Diagnosis Codes on the UB-04 should:**
  - Support services provided during claim dates of service
  - Describe the conditions that qualify for payment
  - Support medical necessity
- Team determines Primary and Secondary

ICD-10 CONCLUSION

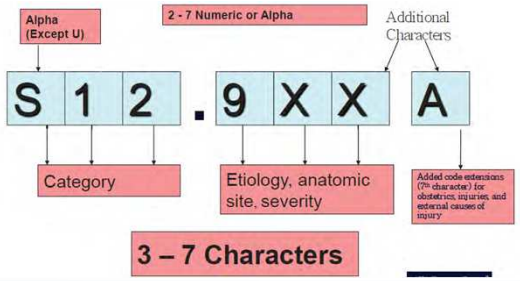
- ❑ Care Team Communication with Billing - My Personal Recommendation
  - o MDS Coordinator should utilize a form that is completed upon every admission listing Principal, Admitting and supporting secondary diagnosis codes
  - o The form should be completed by the appropriate clinical personnel and provided to the Business Office Manager for inclusion on the UB-04 in preparation for TRIPLE CHECK.

ANATOMY OF AN ICD-10-CM CODE

CODING CONVENTIONS AND TERMS

ICD-10: Up to Seven Digits

1st Digit = Always Alpha
2nd Digit = Always Numeric
3rd, 4th, 5th, 6th & 7th Digits = Maybe Combination



ICD-10-CM CODING

- Codes with **three characters are included in ICD-10-CM as the heading of a category of codes** that may be further subdivided by the use of any or all of the 4th, 5th, and 6th characters.
- Digits **4-6 provide greater detail of etiology, anatomical site, and severity.**
- A code using only the first three digits is to be used only if it is not further subdivided.

7th CHARACTER

The "seventh character" of code

- Adds additional information to describe encounter
  - A = Initial Encounter
  - D = Subsequent Encounter
  - S = Sequela
- Must be used if applicable

Example:

- S32.9XXD – Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing

ICD-10-CM CODING

- A code is invalid if it has not been coded to the full number of characters required. This does **not** mean that all ICD-10 codes must have 7 characters.
- The 7th character is only used in certain chapters to provide data about the characteristic of the encounter.

CODING CONVENTIONS AND TERMS

ICD-10 CODING: Coding Conventions and Terms

Default Code:

- Listed next to a Main Term in the ICD-10-CM-Alphabetic Index. The default code represents that **condition that is most commonly associated with the main term, or is the unspecified code for the condition**
- If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned

ICD-10 CODING: Coding Conventions and Terms

- **Family of Codes**: Refers to codes that have the same digits for the 1st 3 characters before the decimal.
  - Use codes from the same family. For example, if using E11 for Type 2 DM, pick combinations from this family of codes. Do not use coded from E11 (Type 2) on the same Diagnosis list/claim with with codes from E10 (Type 1 DM)

ICD-10 CODING: Coding Conventions and Terms

- **Placeholder Character (x)**: USED FOR FUTURE EXPANSION
- **7th Character:** ENCOUNTER CODES
  - SUBSEQUENT ENCOUNTER (D):
    - After completion of active treatment during healing & recovery phase/frequently used in LTC
- **COMBINATION CODES:** A single code used to classify
  - 2 Diagnoses
  - A diagnosis with a secondary process (Manifestation)
  - A diagnosis with a complication

ICD-10 CODING: Coding Conventions and Terms

- **Laterality:** Specify Left, Right or Bilateral for Certain codes. If no Bilateral Code is provided and the condition is bilateral, assign separate codes for both the Left and the Right Side.
- **Excludes Notes:** Exclude notes tell you that the code you are looking up excludes a certain diagnosis
  - TYPE 1 and Type 2
  - Each type has different definition for use but similar in that codes excluded from each other are independent of each other.

ICD-10 CODING: Coding Conventions and Terms

- **Excludes TYPE 1:** Excludes 1 NOTE is a pure excludes note.
  - It means **"NOT CODED HERE!"**
  - EXCLUDES NOTE TELLS YOU THAT THE **EXCLUDED DIAGNOSIS SHOULD NEVER BE USED WITH THE CODE YOU ARE LOOKING UP.**
  - Means that these codes are mutually exclusive so they are NEVER used together (e.g. Congenital versus Acquired)

ICD-10 CODING: Coding Conventions and Terms

- **Excludes TYPE 2:** Excludes 2 NOTE means **"NOT INCLUDED HERE"!**
  - Indicates although the excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time.
  - May be acceptable to use both the code and the excluded code together if supported by medical record documentation.

ICD-10 CODING: Coding Conventions and Terms

- **CODE ALSO NOTE:** Instructs that 2 codes may be required to fully describe a condition, but this note does not provide sequencing directions
- So if you are looking up a code and see "Code Also Note", you would also code any of these diagnosis listed in that note that the resident may have.

ICD-10 CODING: Coding Conventions and Terms

- "See" note in the Alphabetic Index main term is necessary to go to the main term referenced for the correct code
- "See also" note may be useful, but is not necessary to follow the reference when the original main term provides the necessary code

KEY POINTS TO REMEMBER REGARDING ICD-10-CM IN LTC

KEY POINTS TO REMEMBER REGARDING ICD-10-CM IN LTC

- ICD-10-CM is unique in Long-term Care Facilities because of the **"post-acute nature"** of the conditions that are being treated in the SNF.
- **Principal diagnosis is generally the reason for Skilled Medicare Coverage in a SNF.**
- **Main Goal:** To submit "Clean Claims" and get appropriately paid by (Medicare or other payer source) for services rendered for each beneficiary.

PRINCIPAL DIAGNOSIS

- The principal diagnosis choice coded in MDS item I0020B will be used to map to the PT, OT and SLP components of PDPM
- CMS has stated that the primary diagnosis coded in **I0020B should usually match the primary diagnosis on the SNF claim.** They have also stated that presently no edits have been planned to report differences between I0020B and the SNF claims

PRINCIPAL DIAGNOSIS

- The principal diagnosis can change during a SNF stay. The change could occur related to a hospital stay during an interrupted stay or could occur during the SNF stay when no re-hospitalization occurred
- The choice of the principal diagnosis should be also be reviewed carefully when completing an IPA.

Two or More Interrelated Conditions, each Potentially Meeting the Definition for PRINCIPAL DIAGNOSIS

- When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, **either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise**

Two or More Diagnoses that Equally Meet the Definition for Principal Diagnosis

- In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, **any one of the diagnoses may be sequenced first**

Two or More Comparative or Contrasting Conditions

- In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), **they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission**
- If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first

KEY POINTS TO REMEMBER REGARDING ICD-10-CM IN LTC

- **UB-04 is the ultimate end product that capitulates the patient's story during the "Dates of Service" billed.** The codes and entries in the UB-04 fields reflect the ff.:
- Patient meets all technical and clinical eligibility requirements for payment
- *More specifically, the ICD-10-CM codes support the ff.:*
  - ***Justify "Medical Necessity"** of the skilled services provided to the patient*
  - ***Justify why these services have to be rendered in a Skilled Nursing Facility** (support stay in the SNF to obtain those services)*

ICD-10-CM CODING GUIDELINES

- General Coding Guidelines must be followed in order to code correctly
- Chapter specific coding guidelines must also be followed
- Erroneous coding may not only result in "Rejected Claims" but may also be the **cause of a claim going into Medical Review Status.**

ICD-10-CM CODING GUIDELINES

- There are **general coding guidelines that assist the physician and coder. Adherence to these guidelines when assigning ICD-10 diagnosis codes is required under HIPAA**
- In addition to the general coding guidelines, there are **guidelines for specific diagnoses and/or conditions in the ICD-10-CM by chapter** that, unless otherwise indicated, apply to both inpatient and outpatient settings
- ICD-10-CM includes 21 different chapters

Conditions that are an Integral Part of the Disease Process

- ***Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes***, unless otherwise instructed by the classification

For Conditions that are NOT an Integral Part of the Disease Process: Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present (if documented by the physician as a diagnosis)

COMBINATION CODES

- The term represents **a single code used to classify: two diagnoses, either a diagnosis with an associated sign or symptom, or a diagnosis with an associated complication**
- ***Multiple codes should not be used when the classification provides a combination code*** that clearly identifies all of the elements documented in the diagnosis
- Combination codes allow fewer codes to be submitted while still explaining the residents' clinical condition

COMBINATION CODING EXAMPLES

- I25.110: Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- E11.311: Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
- K50.012: Crohn's disease of small intestine with intestinal obstruction

LATE EFFECTS (SEQUELA)

- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated
- There is no time limit when a sequela code can be used
- Coding of a sequela generally ***requires two codes: The condition or nature of the sequela is sequenced first and the sequela code is sequenced second***

EXAMPLES OF SEQUELA

1. Scar formation resulting from a burn,
2. Deviated septum due to a nasal fracture,

and

3. Infertility due to tubal occlusion from old tuberculosis

Documentation for BMI, Non-Pressure Ulcers and Pressure Ulcer Stages

- For BMI, depth of non-pressure chronic ulcers and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the resident's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the resident (e.g., a dietitian often documents the BMI and nurses often document the pressure ulcer stages)

Documentation for BMI, Non-Pressure Ulcers and Pressure Ulcer Stages

- ***However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the resident's provider***
- If there is conflicting medical record documentation, either from the same clinician or different clinicians, **the resident's attending provider should be queried for clarification**
- The BMI should only be reported as a secondary diagnosis

Reporting Same Diagnosis Code More than Once

- Each unique ICD-10-CM code may be reported only once for an encounter. This applies to **bilateral conditions when there are not distinct codes identifying laterality or two different conditions** classified to the same ICD-10-CM
- Example: Type 2 diabetes with Diabetic Nephropathy includes the code for Type 2 Diabetes. Do not also append the code for Type 2 Diabetes without complications

Importance of Accurate Coding

1. The diagnoses and ICD-10-CM codes are an important part of each residents' medical record

2. ICD-10-CM codes must be accurate or billing issues can occur. Edits can prevent billing for inaccurate or unspecified codes that do not support skilled services

3. The new payment system (PDPM) focuses on resident characteristics including diagnoses

4. Future regulatory changes will be based on ICD-10-CM codes submitted on claims and MDS assessments

USING THE ICD-10-CM MANUAL

Using ICD-10 Manual

LOCATING A CODE:

1. Always locate **Main Term first in Alphabetic Index**
2. Then **verify Code in Tabular List**
3. Follow **Instructional Notations that appear in both Alphabetic Index & Tabular List**
4. Alpha Index does not always provide Full Code
   - **Laterality & 7th Character assigned in Tabular List**
   - A Dash at end of Alpha Index Code may indicate additional characters are required

ICD-10-CM Manual

Coding Guidelines

- **Alphabetic Index** (starting point for all diagnoses other than cancer)
- Neoplasm Table (starting point for cancer coding)
- Table of Drugs and Chemicals (use when a medication has been identified as a cause of symptoms/problems)
- **Tabular list (Must be used to determine the final code)**
- External Causes Index (Used to identify locations/causes of accidents. Not required in SNF setting)

Step One: Start with Alphabetic Index

- Find the main term in the Alphabetical Index list of terms and their corresponding codes
- Review indented sub-terms that appear under main terms
  - Same structure as ICD-9-CM Alphabetic Index of Diseases and Injuries
  - Alphabetic Index of External Causes
  - Table of Neoplasms
  - Table of Drugs and Chemicals
- Identify the code that seems most appropriate then move to step 2

Step Two: Tabular List

- Look up the code suggested from the Alphabetic Index **beginning with the first 3 characters of the code**
- Tabular List is a chronological list of codes divided into chapters based on body system or condition
- **Read all instructions** with the code to determine the next steps
- Code to the **highest degree of specificity**

ICD-10-CM Manual: FINDING THE CORRECT CODE

START WITH THE ALPHABETIC INDEX

ABCDE

FGHIJK

LMNOP

QRSTU

VWXYZ

ICD-10-CM Manual: FINDING THE CORRECT CODE

MAIN TERM

- ❑ Don't use body site
- ❑ Look for the **disease, sign, symptom, etc.**
- ❑ You can find the body site as a sub-term
- ❑ For neoplasm diagnoses, review the Neoplasm
- ❑ Table for the appropriate diagnosis

ICD-10-CM Manual: FINDING THE CORRECT CODE

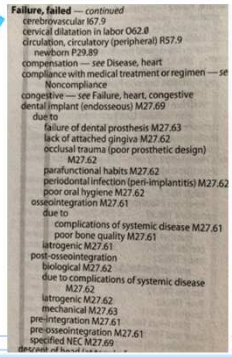
IDENTIFY THE MAIN TERM

CONGESTIVE HEART FAILURE

- ❑ Main Term = Failure
  - o Next = Heart
    - ➢ Then = Congestive

ICD-10-CM Manual: FINDING THE CORRECT CODE

MAIN TERM



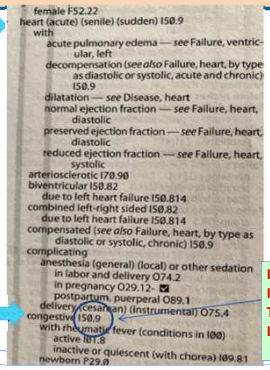
Failure, failed — *continued*
cerebrovascular I67.9
cervical dilatation in labor O62.8
circulation, circulatory (peripheral) R57.9
newborn P29.89
compensation — *see* Disease, heart
compliance with medical treatment or regimen — *see* Noncompliance
congestive — *see* Failure, heart, congestive
dental implant (endosseous) M27.69
due to
failure of dental prosthesis M27.63
lack of attached gingiva M27.62
occlusal trauma (poor prosthetic design) M27.62
parafunctional habits M27.62
periodontal infection (peri-implantitis) M27.62
poor oral hygiene M27.62
osseointegration M27.61
due to
complications of systemic disease M27.61
poor bone quality M27.61
iatrogenic M27.61
post-osseointegration
biological M27.62
due to complications of systemic disease M27.62
iatrogenic M27.62
mechanical M27.63
pre-integration M27.61
pre-osseointegration M27.61
specified NEC M27.69

ICD-10-CM Manual: FINDING THE CORRECT CODE

MUST TOUCH MOST LEFT VERTICAL LINE

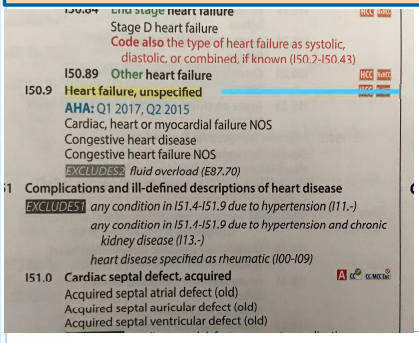
NEXT INDENT DRILLS DOWN TO MORE SPECIFIC CODE

LOOK FOR THIS IN THE TABULAR LIST



female F52.22
heart (acute) (senile) (sudden) I50.9
with
acute pulmonary edema — *see* Failure, ventricular, left
decompensation (*see also* Failure, heart, by type as diastolic or systolic, acute and chronic) I50.9
dilatation — *see* Disease, heart
normal ejection fraction — *see* Failure, heart, diastolic
preserved ejection fraction — *see* Failure, heart, diastolic
reduced ejection fraction — *see* Failure, heart, systolic
arteriosclerotic I70.90
biventricular I50.82
due to left heart failure I50.814
combined left-right sided I50.82
due to left heart failure I50.814
compensated (*see also* Failure, heart, by type as diastolic or systolic, chronic) I50.9
complicating
anesthesia (general) (local) or other sedation in labor and delivery O74.2
in pregnancy O29.12-
postpartum, puerperal O89.1
delivery (cesarean) (instrumental) O75.4
congestive I50.9
with rheumatic fever (conditions in I00)
active I01.8
inactive or quiescent (with chorea) I09.81
newborn P29.0

ICD-10-CM Manual: TABULAR LIST



Stage D heart failure
Code also the type of heart failure as systolic, diastolic, or combined, if known (I50.2-I50.43)
I50.89 **Other heart failure**
I50.9 **Heart failure, unspecified**
AHA: Q1 2017, Q2 2015
Cardiac, heart or myocardial failure NOS
Congestive heart disease
Congestive heart failure NOS
EXCLUDES2 *fluid overload (E87.70)*
Complications and ill-defined descriptions of heart disease
EXCLUDES1 *any condition in I51.4-I51.9 due to hypertension (I11.-)*
any condition in I51.4-I51.9 due to hypertension and chronic kidney disease (I13.-)
heart disease specified as rheumatic (I00-I09)
I51.0 **Cardiac septal defect, acquired**
Acquired septal atrial defect (old)
Acquired septal auricular defect (old)
Acquired septal ventricular defect (old)

Confirmed from the Tabular List

ICD-10-CM Manual: FINDING THE CORRECT CODE

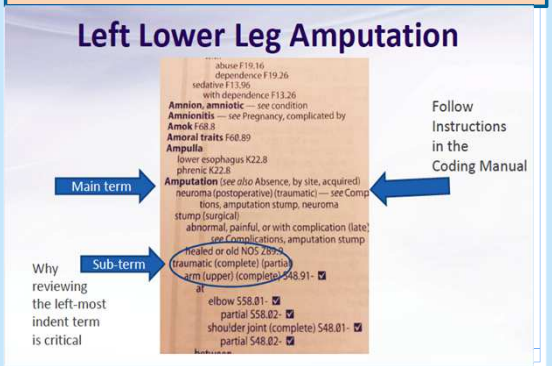
CONGESTIVE HEART FAILURE
ICD-10-CM CODE = 150.9

ICD-10-CM: LEFT LOWER LEG AMPUTATION

- **MAIN TERM: AMPUTATION** - Where does the Manual lead you?
- What would be the main sub-term?

ICD-10-CM: LEFT LOWER LEG AMPUTATION

Left Lower Leg Amputation



ICD-10-CM Manual: FINDING THE CORRECT CODE

DX: LEFT LOWER LEG AMPUTATION
Issue: Not specific enough?

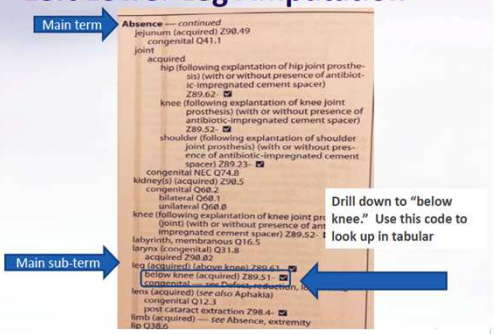
↓

Nurse queried MD for further SPECIFICITY: *AKA OR BKA?*

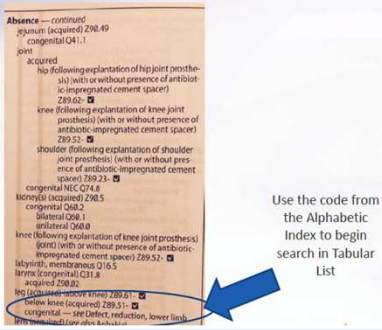
↓

MD documented DX:
BELOW THE KNEE AMPUTATION OF LEFT LOWER LEG, ACQUIRED

Left Lower Leg Amputation

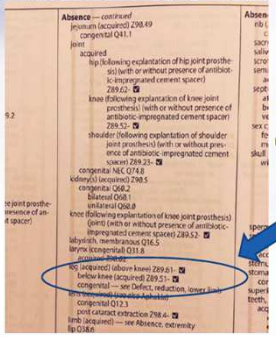


Next Step—Use code from Alphabetic to find code in Tabular List



Use the code from the Alphabetic Index to begin search in Tabular List

First 3 Characters of Z89.51 Code= Z89



Use the code from the Alphabetic Index to begin search in Tabular List

ICD-10-CM Manual: TABULAR LIST

4th **Z89 Acquired absence of limb**

INCLUDES *amputation status*
postprocedural loss of limb
post-traumatic loss of limb

EXCLUDES1 *acquired deformities of limbs (M20-M21)*
congenital absence of limbs (Q71-Q73)

5th **Z89.0 Acquired absence of thumb and other finger(s)**

Left Lower Leg Amputation

Final code includes the correct laterality of the limb amputated

Stay away from the **unspecified** codes as much as possible

Requirement!!!

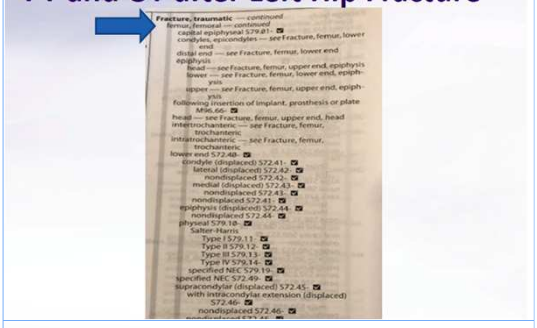
- ❑ You must always take the code from the Alphabetic Index and follow through in the Tabular List
- ❑ Begin by finding the first 3 characters of the identified code in the Tabular List
- ❑ Review all of the instructions found under that 3 Character Code
- ❑ Then proceed to finding the correct code from the Tabular List

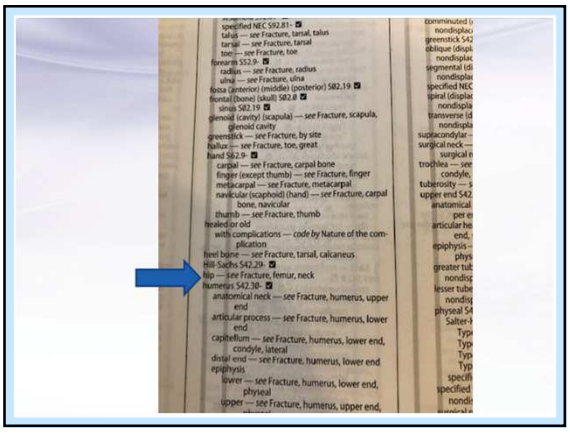
Physician's Note:

"Admission to SNF for physical and occupational therapy following hospitalization for a left hip (femoral neck) fracture"

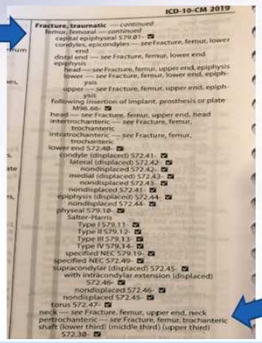
- ❑ What is the main term?
- ❑ What is the main sub-term?

PT and OT after Left Hip Fracture

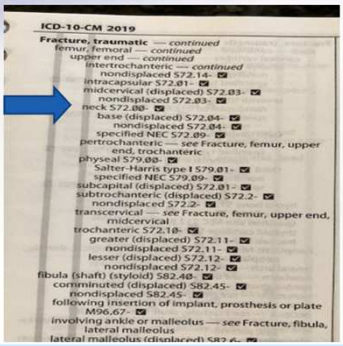




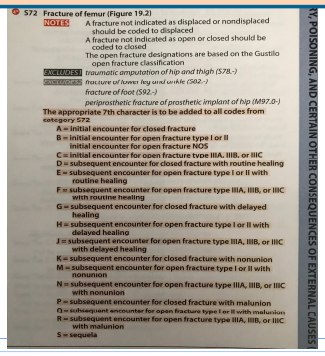
PT and OT after Left Hip Fracture



PT and OT for Left Hip Fracture



ICD-10-CM Manual: TABULAR LIST



S72 Fracture of femur (Figure 19.2)

NOTES
A fracture not indicated as displaced or nondisplaced should be coded to displaced
A fracture not indicated as open or closed should be coded to closed
The open fracture designations are based on the Gustilo open fracture classification

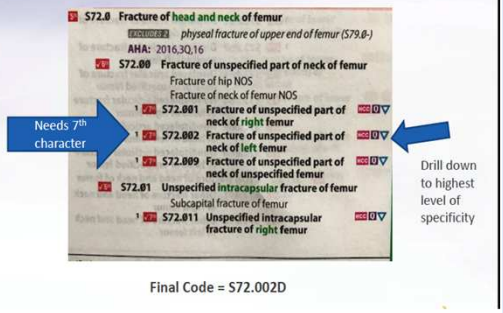
EXCLUDES1 *traumatic amputation of hip and thigh (S78.-)*

EXCLUDES2 *fracture of lower leg and ankle (S82.-)*
fracture of foot (S92.-)
periprosthetic fracture of prosthetic implant of hip (M97.0-)

The appropriate 7th character is to be added to all codes from category S72
A = initial encounter for closed fracture
B = initial encounter for open fracture type I or II
initial encounter for open fracture NOS
C = initial encounter for open fracture type IIIA, IIIB, or IIIC
D = subsequent encounter for closed fracture with routine healing
E = subsequent encounter for open fracture type I or II with routine healing
F = subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
G = subsequent encounter for closed fracture with delayed healing
H = subsequent encounter for open fracture type I or II with delayed healing
J = subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
K = subsequent encounter for closed fracture with nonunion
M = subsequent encounter for open fracture type I or II with nonunion
N = subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
P = subsequent encounter for closed fracture with malunion
Q = subsequent encounter for open fracture type I or II with malunion
R = subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
S = sequela

XIX. POISONING, AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (

PT and OT for Left Hip Fracture



S72.0 Fracture of head and neck of femur
EXCLUDES2 *physeal fracture of upper end of femur (S79.8-)*
AHA: 2016,3Q,16
S72.00 Fracture of unspecified part of neck of femur
Fracture of hip NOS
Fracture of neck of femur NOS
1 S72.001 Fracture of unspecified part of neck of right femur
1 S72.002 Fracture of unspecified part of neck of left femur
1 S72.009 Fracture of unspecified part of neck of unspecified femur
S72.01 Unspecified intracapsular fracture of femur
Subcapital fracture of femur
1 S72.011 Unspecified intracapsular fracture of right femur

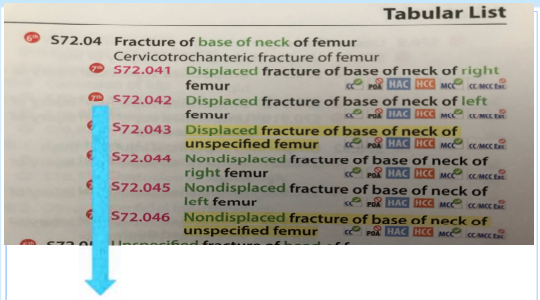
Needs 7th character

Drill down to highest level of specificity

Final Code = S72.002D

AFTER PHYSICIAN QUERY

- ❑MDS Coordinator queried Physician
- ❑Upon review of DOCUMENTATION based on Hospital Records (including O.R. Notes, Orthopedic Surgeon's Notes, etc.), MD documented the following diagnosis: ***Displaced Fracture of Base of the Neck of the Left Femur***



REQUIRES a 7th CHARACTER (ENCOUNTER CODE)
"Subsequent Encounter" = D

FINAL PRINCIPAL DIAGNOSIS CODE

Documentation: Displaced Fracture of Base of the Neck of the Left Femur

PRINCIPAL DX (ICD-10-CM) CODE TO SUPPORT PT AND OT SERVICES = S72.042D

ICD-10-CM CODING of PRINCIPAL DIAGNOSIS in MDS 3.0

- Code Principal Diagnosis in MDS Item I0020B.
- Principal Diagnosis: Reason for admission to a SNF for Daily Skilled Services (Reason for Medicare A Coverage)

ICD-10-CM CODING of PRINCIPAL DIAGNOSIS in the UB-04 (Claim)

- Field 67 (Principal Diagnosis): Reason they are admitted for Daily Skilled Services
- If new patient – Fields 67 and 69 will usually be the same.
- Field 69 – Reason why admitted to facility

ICD-10 CODING: ADMISSIONS/ENCOUNTERS FOR REHABILITATION

- When the purpose for the admission/encounter is Rehab, sequence first the code for the condition for which service is being performed
- If the condition that 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 services is being provided following an injury.

ICD-10 CODING: ADMISSIONS/ENCOUNTERS FOR REHABILITATION

- For Rehabilitation Services following active treatment of an injury, assign the Injury Code with the appropriate 7th Character for Subsequent Encounter as the first-listed or ***PRINCIPAL DIAGNOSIS***.

ICD-10 CODING: ADMISSIONS/ENCOUNTERS FOR REHABILITATION

- 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 Principal Diagnosis.**
- **Coding Clinic advised Next Code to be Z96.641 to specify which joint has been replaced.**

SELECTION OF PRINCIPAL AND ADMITTING DIAGNOSIS

- Team determines Primary and Secondary Diagnoses: When, Who, and How Communicated? – ***Recommend to discuss in UR***
- **Definition of Principal/Primary Diagnosis in SNF: Condition chiefly responsible for the resident's admission to SNF OR continued SNF care (Field 67 on the UB-04)**
- **Diagnosis Codes on the UB-04 should:**
  - Support services provided during claim dates of service
  - Describe the conditions that qualify for payment
  - Support medical necessity

CONTINUED TREATMENT OF ACUTE CONDITIONS IN THE LTC FACILITY

- Any acute condition treated at the hospital that continues to require follow-up or on-going monitoring should be coded with an acute diagnosis code as long as the condition persists AND requires follow-up.
- In general, the status of the acute condition would be assessed whenever the MDS is updated – resident status change or at monthly review for billing.

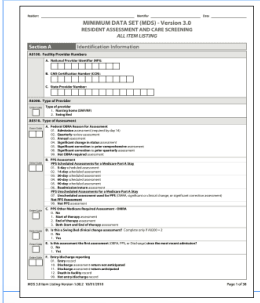
MDS ISSUES IDENTIFIED

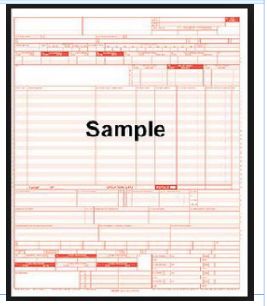
- ❑ Not including all diagnoses that should have been coded
- ❑ Not including more specific diagnosis with ICD-10-CM code in Section I1800
- ❑ Using incorrect codes not supported by Medical Records

THERAPY ISSUES IDENTIFIED

- ❑ THERAPY using whatever the facility used for the medical diagnosis regardless if that was the diagnosis that most supported their treatment plan or not
- ❑ You want to ensure that Billing is getting diagnosis codes from facility and not just from Therapy since Therapy Medical Diagnosis is NOT the same as the Principal Diagnosis for Continued Stay or for Medicare Part B.

MOST IMPORTANT DOCUMENTS FOR PAYMENT: MDS & UB-04


MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
ALL ITEM LISTING



SNF BILLING

UB-04 CODING

NELIA ADACI RN, BSN, CDONA, DNS-CT, RAC-CTA
VP, The CHARTS Group

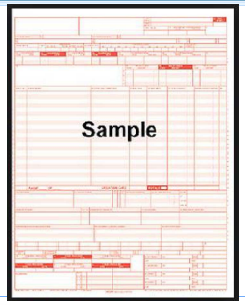
CMS UPDATES

CMS has implemented unprecedented TECHNOLOGICAL UPGRADES in Claims Processing & Management:

- ***Automatic Denials*** *due to increase in "EDITS" (NCCI Edits; Medically Unlikely Edits; MAC Medical Review Edits)*
- ***Enhanced Coordination of Benefits:*** *To detect overlapping of claims (sequencing), avoid duplication of services, follow the beneficiary across care settings*
- *Determine* ***compliance with Medicare regulations*** *via "data (e.g. Dates, Codes, Modifiers) in the UB-04 (electronic claims submitted as reflected in FISS)*

95

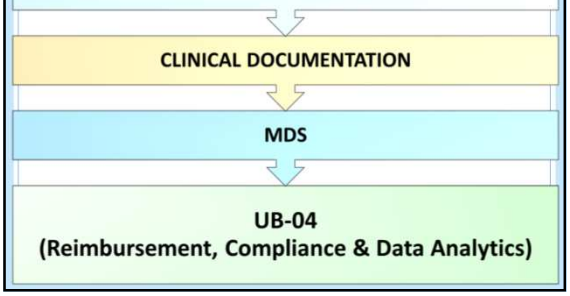
UB-04: FORM (Front)



UB-04: (Back) ATTESTATION

- *"The Submitter of this Form Understands That Misrepresentation or Falsification of Essential Information as Requested by this Form, May Serve as the Basis for Civil Monetary Penalties & Assessments and May Upon Conviction Include Fines and/or Imprisonment Under Federal and/or State Law(s)."*

UB-04: should tell the story of the beneficiary of care provided across settings



FOCUS ON ACCURACY OF CLAIMS (UB-04)

- ❑ **PAYMENT REFORM:**
  - ***Quality & Value is the new currency: It's all about DATA!***
  - ✧**Sources of Data? MDS 3.0 and UB-04**
- ❑ **CLAIM DENIALS/RECOVERIES:**
  - ***Billing errors submitted in FISS automatically generate denials in claims that go on medical review.***

WE KNOW THAT….

- ❑ *The claim form (UB04) communicates the type of care you are billing Medicare for.*
  - ❑ *The MDS and the medical record documentation must support the claim.*

5 STEP PROCESS FOR BILLING MEDICARE

1. Decide that the service is medically necessary.
2. Provide the best service to meet, but not exceed, the patient's need.
3. Document the service provided in the medical record.
4. Select the most appropriate coding for the services provided.
5. Submit your claim to Medicare.

"MUST HAVES" BEFORE BILLING

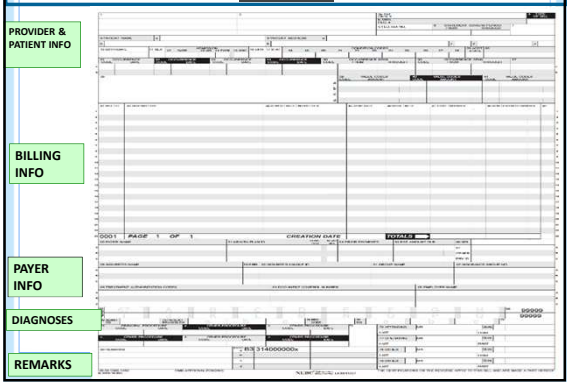
1. Technical Components meet:
   - ❑ 3-Day Qualifying Hospital Stay (unless there is a waiver)
   - ❑ Practical Matter (Why in a SNF?)
   - ❑ Daily Skilled Services
2. CWF/HETS
3. MSP
4. Assignment of Benefits
5. Release of Information

"MUST HAVES" BEFORE BILLING

6. Physician Certification
7. Validation Report – Proof of transmission and acceptance of MDS in the QIES-ASAP Server
8. Authorizations – if required
9. Signed and dated MD Orders
10. Signed and Dated Therapy POC
11. Diagnosis Validation
12. Beneficiary Notices – if appropriate

*** NOW YOU CAN BILL!!!!**

UB-04



CHECKLIST: UB-04

- ❑ Make sure that **all IDENTIFICATION INFORMATION IS ACCURATE (Name; HIC #; Date of Birth; Gender; etc.)**
- ❑ Facility Information is Accurate: Name; Address; NPI #; etc.
- ❑ **Field #4: TYPE OF BILL**
- ❑ **Field #6: Statement Covered period (From and Through)**
- ❑ **Field #12: Admission Date**

COMPLETING THE MEDICARE CLAIM

NOW EXTREMELY IMPORTANT TO BE ACCURATE!!!

FL 17: Patient Status Codes- DISCHARGE STATUS.

- ❑ **01 – Discharged to Home or Self-Care (TOB = 211 or 214)**
- ❑ **03** – Discharged/Transferred to other SNF
- ❑ **06 – Discharged to home with HH**
- ❑ **07 – Left AMA**
- ❑ **20 – Expired**
- ❑ **30 – Still patient**
- ❑ **50 – Discharged to Hospice (Home)**
- ❑ **65 – Discharged to a Psych Hospital or Psych Unit of a Hospital**

17 STAT
30

COMPLETING THE MEDICARE CLAIM

FL 31-34: Occurrence Codes/Dates - Describe a particular condition or event that applies and the date.

- ❑ **22 – Date Skilled Care Ended (Part A)**
- ❑ 24 – Date Insurance Denied (MSP)
- ❑ **50 – ARD of Assessment (Part A)**
- ❑ A3 – Benefits Exhausted (Part A) – *Novitas states "Not necessary"*
- ❑ **55 - Date of Death (TOB: 214)**

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 CC
50	2/5/12	50	2/12/12	

COMPLETING THE MEDICARE CLAIM*

FL 35-36: Occurrence Span Code/Dates – A Code and the related dates that identify an event that relates to the payment of the claim.

- ❑ **70 – Qualifying Stay Dates (3-day QHS)**
- ❑ **74 – Non-covered Level of Care (SKIP DAY)**
- ❑ **78 – SNF Prior Stay Dates (Last 60 days)**

*If OC 70, OC 74 and/or OC 78 are not coded accurately & appropriately in FISS = AUTOMATIC DENIAL

COMPLETING THE MEDICARE CLAIM

FL 42: Revenue Codes - Identifies accommodations & charges for claim

- ❑**0022 – SNF PPS: HIPPS Code**
- ❑120 – Room & Board (Semi-Private)
- ❑180 **– Leave of Absence**
- ❑250 – Pharmacy
- ❑260 - IV Therapy
- ❑270 – Med/Surgical Supplies
- ❑274 – Prosthetic/Orthotic Supplies

42 REV. CD	43. DESCRIPTION
0022	PPS Medicare
0022	PPS Medicare
0022	PPS Medicare
0120	Semi Private
0250	Pharmacy
0300	Laboratory
0420	Physical Therapy
0430	Occupational Therapy

COMPLETING THE MEDICARE CLAIM

FL 67 AND 67A-67Q; FL 69:

- ❑**DIAGNOSIS CODES**
  - **67: Principal Diagnosis Code**
  - **67A – 67H: Other Diagnosis Codes**
    (Fields 67 "I" – 67 "Q" will be ignored)
  - **69 – Admitting Diagnosis**
- ❑**AIDS ADD-ON**
  - Ensure diagnosis code of **B20** is on claim
  - Use only for those with AIDS, Symptomatic HIV, ARC

SUBMITTING "CLEAN" CLAIMS

Clean Claim:

- ❑One that holds up to FI edits
- ❑Claims paid within 30 days, not before 14 days
- ❑Decrease claims Returned to Provider(RTP)
- ❑Reduces chance of Medical Review
- ❑Increases cash flow of facility

WHAT TO DO

"PRACTICAL STRATEGIES"

PRACTICAL STRATEGIES

1) Evaluate Current Processes:
- ❑Review your Pre-admission & Admission Process
  - oWho ensures that appropriate Hospital Records are obtained?
  - oHow soon does MD come in to do a Comprehensive H&P? Discuss establishment of a system with your Medical Director and MD's.
- ❑Evaluate your systems (including tools and forms) on how you obtain the necessary documentation to support MDS Coding.
- ❑Review efficiency and productivity of your Morning Meetings, IDCP Meetings, UR Meetings and Triple Check Meetings

PRACTICAL STRATEGIES

2) Review your Current Work Flow on MD Documentation and Diagnosis Coding.
- o Clean up all your Diagnosis codes in your systems (upon admission and throughout the stay).
- o Have MD review, verify and clarify appropriate DX Codes (especially the payment drivers).
- o How will your team work with MD's/NPP's to collect necessary diagnosis data if not originally provided?
- o Include discussion of the most appropriate ICD-10-CM codes for each resident in the UR meeting (Remember: You are justifying medical necessity and continued stay in a SNF).

PRACTICAL STRATEGIES

3) Generate Diagnosis Worksheets for each Medicare beneficiary & keep them up-to-date
4) Discuss Training Plan around new MDS changes and MDS items that will drive payment areas.
   - o Identify areas for improvement and establish a Plan of Action. Start by doing random audits on MDS Coding accuracy. Include review of Resident Interviews
   - o Review your forms and tools; Modify as necessary
   - o Review your Restorative Nursing Program

PRACTICAL STRATEGIES

5) Review your Triple Check Process to ensure accurate and documented MDS and Claims Coding. Make necessary changes if needed.
6) Ensure compliance with Official ICD-10-CM Coding and RAI Manual Guidelines
7) Collaboration is a "Must". WE ARE A TEAM! Start with how Section GG is supported by Documentation.
8) It is a "confusing world." Therefore, the key is to always go back to CMS's "Intent" behind the regulations.

AMIDST ALL THESE CHANGES AND CHALLENGES, LET US REMIND OURSELVES OF WHY WE WORK IN HEALTH CARE. WE WILL GET THROUGH THIS!
TO ALL SNF HEALTH CARE PERSONNEL – THE FUTURE CAN BE VERY BRIGHT FOR US!!!

SEE ME!!!

This poem was found among the possessions of an elderly lady who died in the geriatric ward of a hospital. No information is available concerning her -- who she was or when she died.

What do you see, nurses, what do you see?
Are you thinking, when you look at me --
A crabby old woman, not very wise,
Uncertain of habit, with far-away eyes,
Who dribbles her food and makes no reply,
When you say in a loud voice -- "I do wish you'd try."
Who seems not to notice the things that you do, And
forever is losing a stocking or shoe,
Who unresisting or not, lets you do as you will,
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes, nurse, you're looking at ME...
I'll tell you who I am, as I sit here so still;

As I rise at your bidding, as I eat at your will.
I'm a small child of ten with a father and mother,
Brothers and sisters, who love one another,
A young girl of sixteen with wings on her feet.
Dreaming that soon now a lover she'll meet;
A bride soon at twenty -- my heart gives a leap,
Remembering the vows that I promised to keep;
At twenty-five now I have young of my own,
Who need me to build a secure, happy home;
A woman of thirty, my young now grow fast,
Bound to each other with ties that should last;
At forty, my young sons have grown and are gone,
But my man's beside me to see I don't mourn;
At fifty once more babies play 'round my knee,
Again we know children, my loved one and me.

Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread,
For my young are all rearing young of their own,
And I think of the years and the love that I've known;
I'm an old woman now and nature is cruel --
'Tis her jest to make old age look like a fool.
The body is crumbled, grace and vigor depart,
There is now a stone where one I had a heart,
But inside this old carcass a young girl still dwells,
And now and again my battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life over again,
I think of the years, all too few -- gone too fast,
And accept the stark fact that nothing can last --
So I open your eyes, nurses, open and see,
Not a crabby old woman, look closer, nurses -- SEE ME!


KEEP
CALM
AND
CODE
ON
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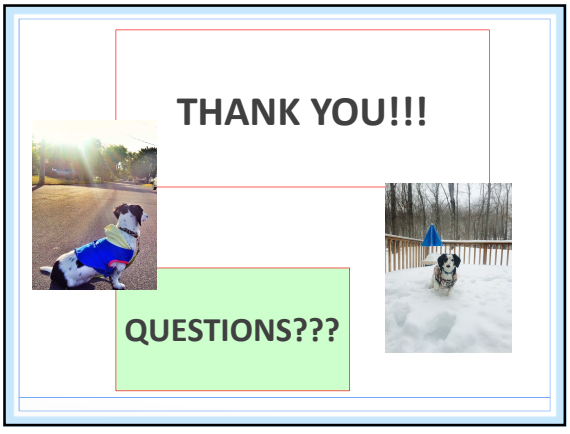
THANK YOU!!!
QUESTIONS???

RESOURCES

- www.cms.gov
- www.ahca.org
- www.hcanj.org
- www.aanac.org
- www.oig.hhs.gov
- www.novitas-solutions.com
- www.ngsmedicare.com
- www.ahima.org
- www.wps.com
- Medicare Benefits Policy Manual Chapter 8
- Medicare Claims Processing Manual Chapter 6
- Medicare Program Integrity Manual Chapter 3
- Medicare Program Integrity manual Chapter 6