ICD-10-CM Coding and Documentation for Long Term Care

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Objectives

• Review 2014 Coding Guidelines as they relate to long term care
• Review current documentation practices and how coding is affected
• Review common diagnoses within the long term care arena and identify how we can improve our documentation
• Review process for completing facility-specific gap analysis for coding and related documentation
Assumptions:

• Familiarity with the difference between ICD-9-CM and ICD-10-CM
• Awareness with ICD-10-CM’s laterality
• Awareness of quality measures in long term care
• Awareness of MDS and RUGs Calculations

• Top 20 diagnoses may vary among facility but there are some common ones
• Have physicians and clinical staff who document in the medical record using their own rules and abbreviations
• The MDS and RUGS rules and the Quality Measure Criterion are likely to change with availability of diagnostic specificity
Assumptions, continued:

- Every facility is different
  - Resident demographics
  - Part B Billing
  - Physicians on-staff versus contracted providers
  - In-house therapy versus contracted therapy
  - Diagnostic services in-house versus contracted
Where to begin.......?

• Identify the current coders

• Start identifying common diagnoses for your facility

• Do you have a coding guideline for staff to follow when assigning codes?
Responsibility

• It is still a physician’s responsibility to diagnose conditions and diagnoses

• However, for new admissions, many facilities have staff collect data from multiple sources for verification by the physician

• Beware of the telephone game!
Diabetes Mellitus (E08-E13)

Three types of diabetes: Type 1, Type 2, and secondary

- Coding Guideline C.4.a states: “Assign as many codes as needed to describe all complications of disease”
- Coding Guideline C.4.a.1 states: “Diabetes not mentioned as Type 1 or Type 2, will be coded as E11.- Type 2.
- Coding Guideline C.4.a.3 states: “If documentation does not mention type and insulin is used, code as E11.-, Type 2 Diabetes”
Diabetes - borderline

- Coding guideline B.18 states: “If condition is stated as borderline at time of discharge, code as confirmed.

- For established resident, borderline diabetes should be coded as
  - R73.01, elevated fasting glucose;
  - R73.92, elevated glucose tolerance; or
  - R73.9, hyperglycemia

- Admissions staff need to be careful not to interpret a coded diagnosis as a definitive diagnosis.
Z79.4: Long-term use of insulin

• Need to develop facility-specific guidelines as to when to code long-term use of insulin

• Use of insulin is inherent in coding of E10.-, Type 1 Diabetes; however, coding Z79.4 will help with data queries

• Patients with Type 2 diabetes may routinely require insulin, so code Z79.4, long-term (current) use of insulin, should be considered

• Generally, code long term care drug use if over 1 months and expected to be renewed
Diabetes Mellitus – Documentation concerns:

• Who is documenting diabetes and how?
• Form(s) prompt staff to document Type 1 or Type 2?
• Form(s) prompt staff to list all diabetes-related complications
• Form(s) allow staff to document diabetes as secondary diabetes?
Pressure Ulcers (L89.-)

Coding guideline C.12.a1 states: “L89.- includes combination codes to identify the site and stage of pressure ulcer. ICD-10 classifies stages based on severity: Stage I- IV, unspecified and unstageable. Assign as many codes from L89 to identify all pressure ulcers the resident has.”

• Coding guideline C.12.a.2 states: “Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft)”
Pressure Ulcers, continued

• Coding guidelines C.12.a.5 states: “Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record.”

• Coding guidelines C.12.a.6 states: “If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.”
Pressure Ulcers – Documentation concerns

• Who is documenting pressure ulcers and how?
• Form(s) allow for specific location of ulcer (left versus right)
• Form(s) allow for staging of ulcer?
• Form(s) allow for tracking of ulcer to show worsening?
• Form(s) allow for documentation of multiple pressure ulcers?
Pressure Ulcer considerations:

• It is acceptable to use documentation by nursing staff for staging of pressure ulcers as long as diagnosis is validated by physician.

• If facility does not have skin care team for mapping of pressure ulcers, should identify specific form and/or individuals to use for documentation of staging. Goal is consistency in coding and interpretation of documentation.

• Facility specific guidelines should indicate how frequently codes for pressure ulcers will be reviewed to ensure appropriate site and staging.
Influenza (J09 – J11)

• Coding guidelines C.10.c states: “Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10)”

• “In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus. However, coding should be based on the provider’s diagnostic statement that the patient has influenza”
Influenza Coding Considerations

• The coding guidelines allow use of J11, Influenza due to unidentified influenza virus, for “probable” or “suspected” cases of influenza

• However, this guideline is felt to be more focused on outpatient settings.

• For established residents, any probable or suspected case of influenza should be coded using the appropriate symptom code until a definitive diagnosis can be made
Myocardial Infarctions (I21 – I24)

• Myocardial infarction is considered acute if less than 4 weeks from time of onset. (reference: Coding guideline C.6.e.1)
  – Residents admitted within 4 weeks of onset for continual treatment should be coded as acute.
  – Residents admitted after 4 weeks of onset for continual treatment should be coded with appropriate aftercare code

• Subsequent myocardial infarctions are coded as I22.-
• Healed or old MI’s no requiring treatment are coded to I25.2
Hypertension (I10-I15)

• Hypertension is coded to I10 when it is not complicated

• hypertensive heart disease (I11.-): Physician must indicate causal relationship

• hypertensive chronic kidney disease (I12.-): ICD-10 assumes causal relationship automatically

• Transient hypertension is coded to R03.0, Elevated blood pressure without diagnosis of hypertension, when a definitive diagnosis of hypertension has not been made
Circulatory Disorder – Documentation concerns

- Form(s) indicate site of myocardial infarction(s)?
- Form(s) indicate age of myocardial infarction(s)?
- Form(s) differentiate between high blood pressure readings and confirmed diagnosis of hypertension?
- Form(s) indicate hypertension and related complications?
Cerebrovascular Disorders (I60-I68)

• Care must be used to distinguish between a new or current cerebrovascular event (I60-I68) from a previous event (I69.-)

• Terms “stroke” or “CVA” should be further specified to indicate a hemorrhage, infarction, thrombosis, embolism, occlusion or stenosis.

• Current stroke or CVA would be coded to I63.9, Cerebral infarction, unspecified
CVA with residuals (I69.-)

- ICD-10 removes the definitive timeframe for a condition to be considered a late effect of a condition.
- Previous CVA with residuals treated at a different level of care should be coded as CVA with residuals upon admission.
- I69 delineates the cause of the previous event (hemorrhage versus infarction, or unspecified).

- Z86.73 = history of TIA and cerebral infarction without residual deficits.
Neurological deficits: Dominant/Nondominant side

• Coding guidelines C.6.a states:

“Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

– For ambidextrous patients, the default should be dominant.
– If the left side is affected, the default is non-dominant.
– If the right side is affected, the default is dominant.
Cerebrovascular Disorders – Documentation concerns

• Form(s) indicate circumstances involving a current stroke or CVA?
• Form(s) prompt documentation of all residuals from previous stroke?
• Form(s) allow for collection of previous stroke or TIA without residuals?
• Form(s) indicate dominant or nondominant side when neuromuscular deficits are present?
Fractures

• Coding guideline C.19.c.1 states:
  – “A fracture not indicated as open or closed should be coded to closed.”
  – “A fracture not indicated whether displaced or not displaced should be coded to displaced.”
  – “Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture.”

  – Coding guideline C.21.c.7 states: “the aftercare Z code should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with appropriate 7th digit for subsequent encounter.”
Pathological fractures

• Pathological fracture and a traumatic fracture of the same bone/site should not be coded together
• Compression fractures occurring in patients with osteoporosis may be pathological. Query physician to confirm
Osteoporosis

- M80 - Osteoporosis with current pathological fracture
  – Need to code also site of pathological fracture
- M81 - Osteoporosis without current pathological fracture
Fractures – Documentation concerns

- Form(s) prompt for documentation of open or closed fractures?
- Form(s) prompt for documentation of displaced or nondisplaced?
- Form(s) prompt for documentation of nonhealing fractures?
- Form(s) provide information relating to how fracture occurred?
- Form(s) easily identify whether resident has osteoporosis?
External Cause of Injury Codes

• Currently, there is not a requirement for long term care facilities to utilize codes to indicate the cause of injury
• However, these codes provide a great deal of information:
  – Cause of fall resulting in fracture
  – Complication of previous medical or surgical care
  – Victim of abuse or cataclysmic event
  – Status of individual in a transport accident
External Cause of Injury Codes – Documentation concerns

- Facilities may be hesitant to use codes for conditions arising within facility
- External cause of injury codes can be used to “Predict to Prevent”, reducing the need to “Heal and Deal”
- Facility-specific coding guidelines must indicate whether external cause codes will be coded
Glaucomas

• ICD-10 allows for coding of bilateral glaucomas
  – Glaucomas must be of same type and at same stage to use the bilateral code

• If bilateral glaucomas, but different types, code each eye separately

• If bilateral glaucomas, but different stages, code each eye separately
Catheters

• Quality Measures for patients with catheters: Patients with Neurogenic bladders or obstructive uropathy are excluded from this measure.

• Now is the time to review consult reports to determine specific type of neurogenic bladder:
  – reflex (N31.1) or flaccid (N31.2)
  – to eliminate need to use Unspecified (N31.9)

• Obstructive Uropathy (N13.-) has 15 codes to indicate hydronephrosis, hydroureter, versus pyonephrosis
Drug Resistant Infections

• ICD-10 distinguishes between Methicillin susceptible (MSSA) and Methicillin resistant *Staphylococcus aureus* (MRSA) infections
• It is important to distinguish between colonization or an active infection as colonization means infectious organism is present without causing a disease
  – Z22.322 – Carrier or suspected carrier of MRSA
  – Z22.321 – Carrier or suspected carrier of Methicillin susceptible *Staphylococcus aureus*
• ICD-10 also has designation for history of MRSA (Z86.14)
Drug Resistant Infections, continued

• ICD-10 provides several combination codes for MRSA or MSSA infections.
• If a combination code is not available, code the infection followed by the resistant (or susceptible) organism.
• If an infection is listed as drug resistant, code infection followed by code from Z16.-, resistant to antimicrobial drugs.
  – May be referred to as “multi-drug resistant”
Miscellaneous Z-codes:

• Facility-specific coding guidelines must indicate when and if the following codes will be used:
  – Do Not Resuscitate status (Z66)
  – Carrier of infection diseases (Z22.-)
  – Personal history of neoplasm (Z85.-)
  – Long-term (current) drug use (Z79.-)
  – Acquired absence of limb (Z89.-)
  – Acquired absence of organ (Z90.-)
  – History of falling (Z79.81)
  – Artificial opening status (Z93.-)
• Facility-specific coding guidelines must indicate when and if the following codes will be used:
  – Transplanted organ and tissue status (Z94.-)
  – Presence of cardiac and vascular implants (Z95.-)
  – Presence of other functional implants (Z96.-)
  – Presence of other devices (Z97.-)
  – Dependence of enabling machines and devices (Z99.-)
Sample Case 1:

Resident admitted for facility following ORIF treatment of right hip fracture sustained during a fall. Resident has diabetes and previous MI. Resident has history of breast cancer treated with chemotherapy. Patient has been on insulin for several months

- S72.001D – Fracture of right hip, subsequent care;
  - coded as closed as not indicated;
  - coded as unspecified part of neck as not indicated
- Unable to code cause of fracture as not indicated
Sample Case 1:

- E11.9 – Type 2 diabetes without complications
  - Since type of diabetes is not specified, need to code as type 2 even with insulin
- Unable to code MI as does not indicate timeframe for MI
- Z79.4 – Long-term (current) use of insulin
- Z85.3 – History of breast carcinoma
- Z51.11 – History of chemotherapy
Sample Case 2:

65-year-old male was admitted for occupational therapy following hospitalization for type I open traumatic fractures of the left radius and ulna.

- S52.92XE - Fracture, traumatic, radius
- S52.202E - Fracture, traumatic, ulna
- Unable to code external cause of injury
Sample case 3:

48-year-old male patient admitted for PT and OT to maintain strength for Parkinson’s disease. He requires continued monitoring and is not able to live alone. He also has type 1 diabetes mellitus and COPD.

- **G20** Disease, Parkinson’s
- **E10.9** Diabetes, Type 1
- **J44.9** COPD
- **Z60.2** Living alone (problems with) (optional, facility-specific)
Sample case 4:

Nursing home resident admitted following a hospital stay for an acute cerebral infarction. Resident will receive multiple therapies for the resulting left hemiplegia of the nondominant side, and dysphagia. Other admitting diagnoses include GERD, rheumatoid arthritis, and early onset Alzheimer’s disease with dementia and aggressive behavior

- I69.354 – Hemiplegia following cerebrovascular disease
- I69.321 – Dysphasia following cerebrovascular disease
- K21.9 – GERD
- M06.9 – Arthritis, rheumatoid
- G30.0 – Disease, Alzheimer’s, early onset, with behavioral disturbances
Where to begin…… ?

• Identify the current coders
  – their current skill level
  – knowledge of A&P

• Start identifying common diagnoses for your facility
  – Where is the documentation obtained from now?
  – How and where is the diagnosis used?

• Do you have a coding guideline for staff to follow when assigning codes?
Next Steps:

• Review the 2014 ICD-10-CM coding guidelines by chapter;
• Determine if your facility is affected by coding guideline and how?
• Identify top 10-15 most common diagnoses at facility;
• Are common diagnoses affected by coding guideline and how?
• Review ICD-9-CM codes for common diagnoses?
• Is facility coding common diagnoses to “unspecified category” in ICD-9?
• Review ICD-10-CM code for common diagnoses?
• Do ICD-10 codes allow for greater specificity than currently coded?
QUESTIONS?