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Maureen is the President of Celtic Consulting, LLC and the CEO and Founder of Care Transitions, LLP. She has been a registered nurse for 30 years with experience as an MDS Coordinator, Director of Nursing, Rehab Director and a Medicare biller. McCarthy is a recognized leader and expert in clinical reimbursement in the skilled nursing facility environment. She is dually certified in both the resident assessment process and QAPI by nationally recognized organizations and holds Master Teacher status in both and is a board member of American Association of Post-Acute Nurses (AAPACN) and is an Expert Advisory Panel member for American Association of Nurse Assessment Coordination (AANAC).

Maureen and her associates at Celtic Consulting regularly provide the following services for SNFs, state affiliates and provider organizations:
- 5 Star Quality Improvement Program
- Quality Auditing
- Clinical Care Management
- RCS/PPS/MDS/CMI Services
- Compliance Solutions
- Medicare Compliance Auditing
- Customized Education / In-Services
Objectives

• Review basic ICD-10 Diagnosis coding concepts
• Discuss 2019 changes
• Explain the importance of accurate diagnosis coding in the PDPM payment system.
• Provide coding examples for practice
• Open discussion regarding coding challenges

ICD-10-CM

• Replaced ICD-9-CM (2015)
• Much higher level of specificity
• Structure has changed to facilitate increase specificity and allow for addition of codes as healthcare grows
• Conventions, general coding guidelines and chapter specific guidelines are included with ICD-10-CM
ICD-10-CM

• 2019 Updates:
  – 279 Codes added
  – 51 Deactivated
  – 143 Codes Revised

• 2016-2019 Changes Overview
  – Quick review of the changes since the transition to ICD-10

ICD-10 Coding: Multipurpose Use

• Collect diagnostic and statistical data about people treated by healthcare providers
• Support clinical decision making
• Support reimbursement for services provided
• Comply with federal standards for reporting diagnostic data
• Provide data to support clinical research and quality improvement activities

• Code assignment and Clinical Criteria
• The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Coding Acute Conditions in SNF/LTC Setting

• An acute condition treated at the hospital that continues to require follow up or ongoing monitoring should be coded with an acute diagnosis code as long as the condition persists & requires continuing treatment or follow-up (i.e. PNA with nebs & antibiotics)
• The status of the acute condition would be assessed whenever the MDS is updated or in clinical review meetings (i.e. 24 hour report, PPS, or weekly Medicare meeting, etc.)
• Codes for the acute medical condition treated and resolved in the hospital are **not** coded or reported in the LTC facility
  – *It is inaccurate to report an acute code for a resolved condition on the health record or claim because it directly contradicts the Official Guidelines for Coding and Reporting and is non-compliant with HIPAA regulations*
• Z code for the aftercare may be used
Billable codes vs. Medical Record codes

• A code may be valid to report a condition, however, that condition may not be billable for the service you are providing.

• Ask yourself, is it reasonable and necessary to bill Medicare Part A for with the condition being reported with this diagnosis code?

• How does MDS, Rehab, & Clinical coding compare?

MDS Coding Assignment

• MDS staff- Although ICD coding and MDS coding are not identical, it will be necessary for the MDS coordinators to have knowledge of the appropriate codes.

• RAI guidelines for coding Section I of the MDS assessment, which contains the medical diagnosis information, have very specific criteria which limits the codes appropriate for the document.

• PPS assessments need to include the correct ICD 10 codes to support skilled services being billed to Medicare.
Auditing & QA

• Monitor appropriateness of diagnosis codes on your claims prior to submission
  – Do all diagnoses agree across various disciplines?
  – All required codes reported?
  – Were any claims denied/returned/suspended
• Update triple check processes to include diagnosis review, if not already included

Auditing & QA

• Quality Assurance & Auditing
  – Review of rejected and denied claims for correction
  – Resubmission of corrected claims
  – Who’s code is it?....
  – Do the codes reported on the claim coincide with the codes reported by MDS, rehab, or the physician?
Drug Regimen Review (DRR)

- A DRR includes:
  - Medication reconciliation
  - A review of all medications a resident is currently using
  - A review of the drug regimen to identify, and, if possible, prevent potential clinically significant medication adverse consequences
  - Additional medications will require diagnoses and conditions to be reported when ordered

What Does the DRR Include?

- The DRR includes all medications:
  - Prescribed and over the counter, including nutritional supplements, vitamins, and homeopathic and herbal products
  - Administered by any route
- The DRR also includes total parenteral nutrition (TPN) and oxygen
Therapy Diagnosis Code & Primary Code

- LTC patient with Parkinson’s disease returns after hospitalization for pneumonia with Medicare Part A stay
- Therapy Plan of Care medical diagnosis = Parkinson’s Disease
- If Pneumonia is resolved - Primary diagnosis is Parkinson’s Disease
- If Pneumonia is active - Primary diagnosis is Pneumonia followed by Parkinson’s Disease

- **Granularity** - level of hierarchy and the amount of information the increase hierarchy provides to the diagnostic description.
- **Laterality**
  - right and left designation
  - right usually character 1
  - left usually character 2
  - bilateral usually character 3
  - unspecified is either 0 or 9 depending on 5th or 6th character
PDPM ICD-10 Coding

- Importance of accurate coding will be emphasized
- Reimbursement will be dependent on diagnosis codes chosen
- Effects both PT/OT component and Non-therapy ancillary component
  - 3 areas dependent on diagnoses
  - Nursing RUGs & NTA also use diagnoses

### Diagnosis & Conditions – Applicable to PDPM and SNF QRP

<table>
<thead>
<tr>
<th>Section I</th>
<th>Active Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I020.</td>
<td>Indicate the resident’s primary medical condition category</td>
</tr>
</tbody>
</table>

Enter Code

- 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. Dehility, Cardiorespiratory Conditions
- 13. Medically Complex Conditions

I020B. ICD Code

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<table>
<thead>
<tr>
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</tr>
</thead>
</table>
Surgeries Applicable to PDPM

<table>
<thead>
<tr>
<th>J2100. Recent Surgery Requiring Active SNF Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

Surgeries Applicable to PDPM

<table>
<thead>
<tr>
<th>Surgical Procedures</th>
<th>Complete only if J2100 = 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
<td></td>
</tr>
<tr>
<td>Major Joint Replacement</td>
<td></td>
</tr>
<tr>
<td>J2300</td>
<td>Knee Replacement - partial or total</td>
</tr>
<tr>
<td>J2310</td>
<td>Hip Replacement - partial or total</td>
</tr>
<tr>
<td>J2320</td>
<td>Ankle Replacement - partial or total</td>
</tr>
<tr>
<td>J2330</td>
<td>Shoulder Replacement - partial or total</td>
</tr>
<tr>
<td>Spinal Surgery</td>
<td></td>
</tr>
<tr>
<td>J2400</td>
<td>Involving the spinal cord or major spinal nerves</td>
</tr>
<tr>
<td>J2410</td>
<td>Involving fusion of spinal bones</td>
</tr>
<tr>
<td>J2420</td>
<td>Involving lamina, discs, or facets</td>
</tr>
<tr>
<td>J2499</td>
<td>Other major spinal surgery</td>
</tr>
<tr>
<td>Other Orthopedic Surgery</td>
<td></td>
</tr>
<tr>
<td>J2500</td>
<td>Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)</td>
</tr>
<tr>
<td>J2510</td>
<td>Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)</td>
</tr>
<tr>
<td>J2520</td>
<td>Repair but not replace joints</td>
</tr>
<tr>
<td>J2530</td>
<td>Repair other bones (such as hand, foot, jaw)</td>
</tr>
<tr>
<td>J2599</td>
<td>Other major orthopedic surgery</td>
</tr>
</tbody>
</table>
Surgeries Applicable to PDPM

<table>
<thead>
<tr>
<th>Section J</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Procedures - Continued</td>
<td>Other Major Surgery</td>
</tr>
<tr>
<td></td>
<td>J2900. Involving tendons, ligaments, or muscles</td>
</tr>
<tr>
<td></td>
<td>J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hema repair)</td>
</tr>
<tr>
<td></td>
<td>J2920. Involving the endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus - open</td>
</tr>
<tr>
<td></td>
<td>J2930. Involving the breast</td>
</tr>
<tr>
<td></td>
<td>J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant</td>
</tr>
<tr>
<td></td>
<td>JS000. Other major surgery not listed above</td>
</tr>
</tbody>
</table>
Alphabetical Index

List of terms and their corresponding codes are divided into 4 parts:

Index of Diseases and Injury
Index of External Causes of Injury
Table of Neoplasms
Table of Drugs and Chemicals

Tabular List

A structured list of codes divided into chapters based on body system or condition
ICD-10 CM Format & Structure

- Alphabetic Index
  - Lists main terms & corresponding codes
  - Also contains Table of Neoplasms & Table of Drugs/Chemicals

- Tabular List
  - Numerical list of codes divided by chapter, according to condition or body system
  - Defines terms, provides directions/coding instructions

❖ Never code strictly from the Alphabetical index – always confirm code choice in the Tabular List to insure the most appropriate/specific code.

Format and Structure General

- Tabular List contains categories, subcategories and codes
- Characters can be letters or numbers
- Category = 3 characters (first is always letter)
- Subcategory= 4 or 5 characters
- Codes= 3,4,5,6 or 7 characters
- Each level after category is subcategory and the final level is a code
ICD-10 CHAPTERS

- A&B- INFECTIOUS DISEASE
- C- NEOPLASM
- D- NEOPLASM & BLOOD
- E- ENDOCRINE, NUTRITION, METABOLIC
- F- MENTAL, BEHAVIOR, & Neurodevelopmental Disorders
- G- NERVOUS SYSTEM
- H- EYE & EAR
- I- CIRCULATORY
- J- RESPIRATORY
- K- DIGESTIVE
- L- SKIN
- M- MUSCULOSKELETAL
- N- GENITOURINARY SYSTEM
- O- PREGNANCY
- P- PERINATAL
- Q- CONGENITAL
- R- SIGNS / SYMPTOMS, ABNORMAL CLINICAL & LAB FINDINGS
- S&T- INJURY & POISONING
- U- NOT USED, RESERVED FOR WHO EMERGENCE CODES
- V, W, X, Y- EXTERNAL CAUSE OF MORBITY (Falls, Accidents, Complications of Care)
- Z- FACTORS INFLUENCING HEALTH STATUS (PAST V CODES)

Three Character Categories

Each chapter begins with a list of blocks or subchapters of three character categories

Chapter 2 Neoplasms (C00-D49)
C00-C75 Malignant neoplasms, stated.....
C00-C14 Lip, oral cavity and pharynx
C15-C26 Digestive organs
Four Character Categories (subcategory)  

- Further defines site, etiology and manifestations
- Includes 3 character category, a decimal and an additional character

Ex:  **D69** Purpura and other hemorrhagic conditions
   - **D69.0** Allergic purpura
   - **D69.1** Qualitative platelet defects

Five and Six Character Subcategory

The most precise level of specificity

Ex:  **J10.8** Influenza due to other identified virus with other manifestations
   - **J10.81** Influenza due to other identified influenza virus with encephalopathy
   - **J10.82** Influenza due to other identified virus with myocarditis
7th Character Extension and The Dummy Placeholder

- Some categories require 7th character
- If code is not 6 characters a dummy placeholder “X” must be used
- Mostly found in Injury and Fracture codes
- Tabular List instructions should guide assignment

Example - FRACTURE OF FEMUR

- **S72.00** - Unspecified FRACTURE NECK OF FEMUR
- **S72.051** - Unspecified FRACTURE OF HEAD OF RIGHT FEMUR
- **S72.111** DISPLACED FRACTURE OF GREATER TROCHANTER RIGHT FEMUR
- **S72.112** DISPLACED FRACTURE OF GREATER TROCHANTER LEFT FEMUR
- **S72.109** Unspecified FRACTURE OF Unspecified FEMUR
7th Character Example

S83.0 Subluxation and dislocation of patella
S83.00 Unspecified subluxation and dislocation of patella
S83.001__ Unspecified subluxation of right patella

The 7th character is required
A= initial encounter
D= subsequent encounter
S= sequela

Code Structure

[M1A.3120]

Etiology (Renal Impairment)
Laterality (Left Shoulder)

Category (Chronic Gout)
Location (Shoulder)
Extension (Without tophus)
Dummy Placeholder Example – 7 Characters

**S33.0XXD –**

Traumatic rupture of lumbar intervertebral disc, subsequent encounter

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Fractures and The 7th Character

- 7th character in fractures includes more specificity than laterality alone

- Open or Closed as well as routine or delayed healing and mal vs non union

**Review chapter specific guidelines before assigning codes in this chapter**
TRAUMATIC FRACTURE RULES

• IF Documentation in the record does not indicate DISPLACED or NON-DISPLACED, code as DISPLACED.
• IF Documentation in the record does not indicate OPEN or CLOSED FRACTURE, code as CLOSED.
• 7th Character will usually be “D” for Subsequent Care in a SNF or another letter to note Care of Complications of Fractures such as nonunion or malunion, if documented
• Aftercare codes (Z codes) are not used, the 7th character is used instead
• Sequencing of Multiple Fractures – code in order of fracture severity

7TH Character & Traumatic Fractures

• Last Space should be “D” in SNF/LTC as a follow up or SUBSEQUENT visit
• “A” is used for INITIAL ENCOUNTER as in Acute Care
• “S” is used for Late Effects/Residual/Sequelae
• Many other letters may be used. SEE DIRECTIONS FOR EACH SECTION.
• If a code has only 5 characters & requires 7, then an “X” placeholder must be used
Coding Specificity

- Will Need to Dig Deeper For a More Accurate/Specific Code
- May need to discuss with MD/APRN
- USE of “UNSPECIFIED” Codes Discouraged
- LATERALITY (Code Left/Right/Bilateral)
  - If Bilateral is Noted in Record & No Bilateral Code is Given, Use Separate Codes For Right & Left Sides.
- Combo Codes (Do Not UNBUNDLE Them)

Conventions
ICD-10-CM Conventions

- The conventions are general rules for use of the classification independent of the guidelines
- Conventions are used both in the Alphabetical Index and the Tabular List

Abbreviations

- **NEC** - “not elsewhere classifiable” same as “other specified” - a specific code is not available for a condition
  - used when the information in the medical record provides detail but a specific code does not exist.
- **NOS** - “not otherwise specified” - same as unspecified.
  - used when the information in the medical record is insufficient to assign a more specific code
- Some categories do not have an unspecified code so “other specified” may be used
“other” and “unspecified”

- “other” and “other specified” are used when the information in the medical record provides detail but a specific code does not exist.
- “unspecified” codes are used when the information in the medical record is insufficient to assign a more specific code.
- Some categories do not have an unspecified code so “other specified” may be used.

Includes Notes

- Found in the Tabular List
- Immediately under a three character code title to further define or give examples of the content of the category

G30 Alzheimer’s Disease

INCLUDES Alzheimer’s dementia senile and pre-senile forms
Inclusion Terms

• List of terms included under some codes that are conditions that the code should be used for
• May be synonyms
• Not an exhaustive list

General Coding Instructions

• EXCLUDES 1 NOTE: Cannot be coded there. Used when two conditions cannot occur together
  EX: (Chronic Bronchitis J42 & COPD J44.9; R53.1 & M62.81)

• EXCLUDES 2 NOTE: Condition excluded is not part of condition represented by the code but the patient may have both conditions at the same time. It’s acceptable to then code both.
  EX: (Acute Bronchitis J20.9 & Chronic Bronchitis J42)
• “Use Additional Code”
• “Code First”
• S/S Codes and Diagnosis Codes
**Excludes Notes 1 & 2**

G25.0 **Essential tremor**

Familial tremor

**Excludes 1** tremor NOS (R25.1)

G24 **Dystonia**

Includes dyskinesia

**Excludes 2** athenoid cerebral palsy (G80.3)

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**Code First/Use Additional Codes**

- These are conventions seen in codes that have both an underlying etiology and multiple body system manifestations.
- Etiology codes use “use additional code” notes
- Manifestation codes use “code first” notes
- Manifestation code titles will include “in diseases classified elsewhere”
ICD-10-CM Official Coding Guidelines FY 2017 I.A. 13 (page 11-12)

- Etiology/manifestation (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
- Certain conditions have both an underlying etiology and multiple body system manifestation due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing (in the medical record) order of the codes, etiology followed by manifestation.

Etiology/Manifestation Example

**H42** Glaucoma in diseases classified elsewhere

Code first underlying condition, such as:

- amyloidosis (E85.-)
- aniridia (Q13.1)
- Lowe’s syndrome (E72.03)
- Reiger’s anomaly (Q13.81)
- specified metabolic disorder (E70-E90)
“with”
Means “associated with” or “due to” when it appears in the code title

- The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a casual 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. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the condition in order to code them as related.

“see” and “see also”
- “see” following a main term in the Alphabetic Index indicates that another term should be referenced.

- “see also” following a main term in the Alphabetic Index indicates there is another main term that may also be referenced that may provide useful additional entries.
“*code also*”

- Two codes may be required to fully describe a condition.

- This does not direct the sequencing of codes on the claim.

**Default Codes**

- A code listed next to the main term that is most commonly associated with the main term, or is the unspecified code.

- If a condition is reported yet not identified as acute or chronic and no additional information is available, a default code should be used.

***Never code directly from the default code listed, always confirm choice in the tabular list***
General Coding Guidelines

Locating a code

- First locate code in the Alphabetic Index
- Verify the code in the Tabular List
- Use the instructional notes to choose the most appropriate code
- Selection including laterality and character extensions can only be accomplished in the Tabular List
Level of Detail

* Diagnosis codes are to be used and reported at their highest number of characters available
* Three character codes should only be used if it is not further subdivided.
* A code is **invalid** if is has not been coded to the full number of characters.

Signs and Symptoms

- Signs and symptoms should not be used if definitive diagnosis is available
- Signs and symptoms integral to a diagnosis should not be reported with the diagnosis
- Signs and symptoms associated routinely with a disease process should not be assigned as additional diagnosis
- SNF specific details
Conditions not an Integral Part of Disease Process

• Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present

Multiple coding for single condition

• “Use additional code” are found in Tabular List when a secondary code is useful to describe condition. (ex: bacterial infections)
• “code first” under codes not specifically manifestation codes due to an underlying cause. Code underlying cause first
• “code .causal condition first” instructs to use this code as first listed if causal agent not known
Acute and Chronic

• May code both acute and chronic conditions if instructions allow

• Acute should be sequenced first

Combination Codes

• Single code used to classify two diagnoses, with a diagnosis with an associated sign or symptom or a diagnosis with an associated complication.

• Multiple codes should not be used

• Allows for fewer codes
Sequela (Late Effects)

• The residual effect after the acute phase of illness or injury has terminated.
• There is no time limit when using sequela.
• The condition or nature of the sequela is sequence first and the sequela code is sequenced second.
• Acute phase of the illness or injury is never used with a code for late effects.

Limited in SNF Environment

• Impending or Threatened Condition
• Complications of Surgery and Other Medical Care
• Documentation from provider will determine code assignment. Cause and Effect must be documented.
Syndromes

- Follow Alphabetic Index guidance when coding
- When no guidance is available code manifestations
- How is the syndrome being represented?

Documentation to support BMI, non-pressure and pressure ulcers

- Documentation from clinicians not the patient’s provider may be used to assign codes. (dietician, RN)
- Associated diagnosis must be documented by the provider
- Provider should clarify any conflicting documentation
Principal or First-listed Diagnosis

Selection of principal diagnosis/first listed code is based on the conventions in the classification that provide sequencing instructions. If no specific instructions then the condition that brought the patient to the healthcare setting and was/is the primary focus of treatment.

Two Diagnoses as First Listed

• When two or more interrelated conditions potentially meeting the definition of principle 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.
Secondary Diagnosis

- Also referred to as additional or ‘Other’ diagnoses
- Affects patient care in terms of requiring clinical evaluation or therapeutic treatment or diagnostic procedures or extended length of stay or increased nursing care and/or monitoring.

Previous Conditions

- Some physicians include in the diagnostic statement resolved conditions or diagnoses and status post procedures from previous visits that have no bearing on the current treatment. Such conditions are not to be reported and are coded only if required by the hospital or physician office policy.
Infectious Agents Causing Disease

- Infections coded in other chapters may require codes from this chapter to identify the organism causing the infection.
- Instructional notations should guide code assignment.
- Antibiotic resistant infections may also include Z code if infection code does not specify resistance.

What’s the Difference?

- **Bacteremia**: Bacteria are present in the bloodstream. Bacteremia can result from a serious infection or from something as harmless as vigorous toothbrushing.
- **Sepsis**: Bacteremia or another infection triggers a serious bodywide response (sepsis), which typically includes fever, weakness, a rapid heart rate, a rapid breathing rate, and an increased number of white blood cells.
- **Severe sepsis**: Sepsis plus either the failure of an essential system in the body or inadequate blood flow to parts of the body due to an infection is known as severe sepsis.
- **Septic shock**: Sepsis that causes dangerously low blood pressure (shock) is called septic shock. As a result, internal organs typically receive too little blood, causing them to malfunction. Septic shock is life threatening.
Sepsis and Septic Shock

• Review sequencing and coding guidelines when coding sepsis, severe sepsis and septic shock

• Bacteremia and Septicemia are not coded as sepsis
  
  R78.81 Bacteremia
  excludes 1: sepsis- code to specific infection (A00-B99)

• Urosepsis is not synonymous with sepsis

Neoplasm Code Assignment

• Documentation as to malignant, benign, in situ or uncertain is needed to assign a code

• The Alphabetic Index should be used to locate the appropriate term for the neoplasm

• The term is then found on the Neoplasm Table

• The Tabular List should then be referenced to assure accurate assignment of codes
Diabetes

- Codes for Diabetes are combination codes that include:
  - Type of diabetes mellitus
  - Body system affected
  - Any complications of that body system
- May need to use multiple combination codes within a diabetes category to describe all complications
- Use additional code to identify any insulin use (Z79.4)

Chapter 4: Endocrine, Nutritional & Metabolic Diseases (E00-E89)

- New Excludes 1 note E16.0-E16.2
- New Use Additional Code (UAC) note at E08, E09, E11, E13
  - Use additional code to identify control using:
    - Insulin (Z79.4)
    - Oral antidiabetic drugs (Z79.84)
    - Oral hypoglycemic drugs (Z79.84)
Diabetes Coding Guidelines

- If the type of DM is not documented, the default code category is E11- *(Type II DM)*
- Secondary DM, in categories E08, E09, & E13, is always caused by another condition or event
- Watch for additional coding instructions in the Tabular List, such as Code first..., Use additional code...
- Coding for Gestational Diabetes or Diabetes during pregnancy is found in Chapter 15.

CATEGORIES for DM in ICD-10

- **E08** Diabetes Mellitus due to an underlying condition
- **E09** Drug or chemical induced DM
- **E10** Type 1 DM
- **E11** Type 2 DM
- **E13** Other specified DM
Specifics Continued

• Z79.84 LT use of oral hypoglycemic agents
• Long term use of insulin should be coded Z79.4
• Temporary use of insulin in emergency should not be coded in this setting
• Insulin pump complications can be found under : Pump malfunction

Hypertension with Heart Disease (I11)

• Heart conditions for I50 and I51 are combined into codes from category I11 Hypertensive heart disease when there is a stated (due to) or implied (hypertensive) causal relationship.
• If the patient also has heart failure another code from I50 will be needed to identify the type of failure
• If no causal relationship stated no combination can be assigned, or if provider identifies a different cause, then both codes are reported separately
Hypertensive CKD (I12)

- Combination codes from I12 are used when both hypertension and CKD (N18) are present
- A cause-and-effect is presumed, unless provider state otherwise
- CKD with hypertension = hypertensive CKD
- 2019 Revisions:
  - CKD should not be coded as hypertensive if the provider indicates it is not related
  - Also code from N18 to identify Stage of CKD

Hypertensive Heart and CKD (I13)

- Must have stated hypertensive heart disease and hypertensive CKD (heart & kidneys involved)
- Assume a relationship between hypertension and CKD unless stated it is not related
- A code from category N18 should be secondary to identify stage of CKD
- I10-I15- Hypertensive diseases
- I16-Reserved for Hypertensive crisis/emergency
- *Residents with both acute & CKD need the additional code to represent the acute condition
CVA Sequela (I69)

- Conditions classifiable to categories I60-I67 (cerebrovascular diseases) as the causes of late effects (neuro deficits).
- Deficits persist after initial onset of cerebrovascular disease/event
- Use history of codes when no neurological deficits are present

Chapter 9: Diseases of the Circulatory System (I00-I99)

- Code I69.- Expanded codes with 6th character to include specific cognitive deficits following cerebral hemorrhage or infarction to identify:
  - 0 Attention and concentration deficit
  - 1 Memory deficit
  - 2 Visuospatial deficit and spatial neglect
  - 3 Psychomotor deficits
  - 4 Frontal lobe and executive function deficit
  - 5 Cognitive social or emotional deficit
  - 8 Other symptoms and signs involving cognitive function
  - 9 Unspecified symptoms and signs involving cognitive function
ICD-10-CM Official Coding Guidelines FY 2017 I.C. 12.a.6 (page 51)

• Patients admitted with pressure ulcers documented as healing
  – Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code on the documentation in the medical record. If the documentation does not provide information about the stage of healing pressure ulcer, assign the appropriate code for unspecified stage.
  – If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient treated for a healing pressure ulcer, query the provider.
  – For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer, query the provider.

ICD-10-CM Official Coding Guidelines FY 2017 I.C. 12.a.6 (page 51)

• Patient admitted with pressure ulcer evolving into another stage during the admission
  – If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admissions and a second code for the same ulcer site and the highest stage reported during the stay.
TRAUMATIC FRACTURE RULES

• IF Documentation in the record does not indicate DISPLACED or NON-DISPLACED, code as DISPLACED.
• IF Documentation in the record does not indicate OPEN or CLOSED FRACTURE, code as CLOSED.
• 7th Character will usually be “D” for Subsequent Care in a SNF or another letter to note Care of Complications of Fractures such as nonunion or malunion, if documented.
• Aftercare codes (Z codes) are not used, the 7th character is used instead.
• Sequencing of Multiple Fractures – code in order of fracture severity.

7TH Character & Traumatic Fractures

• Last Space should be “D” in SNF/LTC as a follow up or SUBSEQUENT visit.
• “A” is used for INITIAL ENCOUNTER as in Acute Care.
• “S” is used for Late Effects/Residual/Sequelae.
• Many other letters may be used. SEE DIRECTIONS FOR EACH SECTION.
• If a code has only 5 characters & requires 7, then an “X” placeholder must be used.
Pathological Fractures and Osteoporosis

• 7\textsuperscript{th} character is to be used to identify initial or subsequent encounters

• \textit{Review definitions of initial and subsequent carefully}

• M81 osteoporosis w/o current pathological fx

• Z87.310 Personal history of healed osteoporosis fx

• M80 osteoporosis w/ current pathological fx

ICD-10 Codes Rehab

• Encounter codes 7\textsuperscript{th} character fractures
  – A- initial encounter closed fracture
  – B- initial encounter open fracture
  – D- subsequent encounter routine healing
  – G- subsequent encounter delayed healing
  – K- subsequent encounter fx nonunion
  – P- subsequent encounter fx malunion
  – S- sequela
ICD-10-CM Official Coding Guidelines FY 2017
I.C.13.c. (page 52)

• Coding of Pathologic Fractures
• 7th character A is for use as long as the patient is receiving active treatment for the fracture. While the patient may be seen by a or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

Initial vs Subsequent

• Initial= surgical treatment, ER encounter and evaluation and continuing (ongoing) treatment by same or different physician. **patient delay in treatment should still be initial
• Subsequent= healing or recovery phase. Cast change or removal, an xray to check healing status of fracture, removal of external or internal fixation device, medication adjustment and follow up visits
Chapter 20 (V00-Y99)

- Data collection items
- **There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state based external cause code reporting mandate or these codes are required by a particular payer.**
- Not used in LTC

Categories of Z Codes

- **Z16** Resistance to antimicrobial drugs
- **Z20-Z29** Persons with potential health hazards r/t communicable diseases (Carrier, Asymptomatic HIV, immunizations)
- **Z43** Encounter for attention to artificial openings
- **Z45** Encounter for adjustment and management of implanted device
- **Z47** Orthopedic aftercare
- **Z48** Encounter for other postprocedural aftercare
- **Z79** Long term (current) drug therapy
Categories Z40-Z53
Encounters for other specific health care

**Z47** Orthopedic aftercare
  Z47.1 Aftercare following joint replacement surgery
*use additional code to identify joint

- **Z85** Personal history of malignant neoplasm
- **Z86-Z87** Personal history of certain other diseases / conditions
- **Z89-Z90** Acquired absence of limb / organs
- **Z91** Personal risk factors, not elsewhere classified
- **Z92** Personal history of medical treatment
- **Z93** Artificial opening status – (management= Z43-)
- **Z94** Transplanted organ and tissue status
- **Z95** Presence of cardiac and vascular implants and grafts
- **Z96** Presence of other functional implants
- **Z97** Presence of other devices
- **Z98** Other postprocedural states
- **Z99** Dependence on enabling machines and devices, NEC
### Example ICD-10 Coding PDPM

<table>
<thead>
<tr>
<th>EMR ICD-10 Code (Claim codes in italics)</th>
<th>Suggested ICD10 Code (Claim suggestions in italics)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adm I47.2</strong> VTach</td>
<td><strong>Adm S72.142D</strong> Displaced Left intertrochanteric femur fracture</td>
</tr>
<tr>
<td><strong>Primary I47.2</strong></td>
<td><strong>Primary S72.142D</strong></td>
</tr>
<tr>
<td>N17.9 Acute kidney failure, unsp</td>
<td>Z96.642 Presence L THR</td>
</tr>
<tr>
<td>Z96.642 Presence L THR</td>
<td>A41.9 Sepsis</td>
</tr>
<tr>
<td>A41.9 Sepsis</td>
<td>M62.81 Muscle weakness</td>
</tr>
<tr>
<td>M62.81 Muscle weakness</td>
<td>R27.8 Other lack of coordination</td>
</tr>
<tr>
<td>R27.8 Other lack of coordination</td>
<td>R26.2 Difficulty walking</td>
</tr>
<tr>
<td>S72.143S Displaced intertrochanteric fracture, unspecified side</td>
<td>R26.81 Unsteadiness on feet</td>
</tr>
<tr>
<td>R26.2 Difficulty walking</td>
<td>R48.9 Symbolic dysfunction, unsp</td>
</tr>
<tr>
<td>R26.81 Unsteadiness on feet</td>
<td>I11.0 Hypertensive heart dis w/HF</td>
</tr>
<tr>
<td>R48.9 Symbolic dysfunction, unsp</td>
<td>150.9 CHF</td>
</tr>
<tr>
<td>I50.9 CHF</td>
<td>Z95.810 Presence AICD</td>
</tr>
<tr>
<td>J48.91 Afib</td>
<td>J44.9 COPD</td>
</tr>
<tr>
<td>L89.90 Pressure ulcer, unsp site/stg</td>
<td>G47.33 Obstructive sleep apnea</td>
</tr>
<tr>
<td>R53.81 Other malaise</td>
<td>N40.1 BPH with LUTS</td>
</tr>
<tr>
<td>R33.9 Urinary retention</td>
<td>R33.9 Urinary retention</td>
</tr>
<tr>
<td></td>
<td>M48.00 Spinal stenosis, unsp site</td>
</tr>
<tr>
<td></td>
<td>Z86.73 Hx CVA w/o residual</td>
</tr>
</tbody>
</table>

### Questions?

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