DIAGNOSIS CODING ESSENTIALS FOR LONG-TERM CARE: THE BASICS

Preferred Clinical Services for Leading Age Florida
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WHAT IS ICD-10-CM?

- **International Classification of Diseases, 10th Revision, Clinical Modification**
- **Official Coding Guidelines approved by AHA, AHIMA, CMS & NCHS**
- **Code sets are addressed under Administrative Simplifications section of HIPAA (1996)**
- **First approved in 1990**
- **US is the final industrialized nation to adopt**
- **Beginning October 1st, ALL claims must use these codes**
WHAT WE WON’T BE COVERING

• Procedures
• CPT/HCPCS codes
• Pregnancy, Childbirth and Puerperium
• Perinatal Conditions
• Congenital Disorders
• External Causes
WHAT'S NEW?

• 68,000 vs. 16,000 codes
• Codes changed from 3-5 characters to 3-7 characters
  • All codes are alphanumeric: All codes have a “base” of three characters: The letter for that chapter/body system and two numbers
• All letters of the alphabet except U are used
• Greater precision
• Reflective of current technologies
• Addition of laterality
• Time frame changes
WHAT CHANGES?

• No more coding from memory
• Alphabetic and numeric indexes MUST be referenced for code assignments
• Hypertension table is gone
• **Must** have better clinical documentation
• Coder must understand terminology and anatomy/physiology
• Admission for therapy no longer exists

Payers may have their own interpretations
What do you MEAN I can’t code from memory???
“General Equivalence Mappings”
A framework that maps from 9 to 10 and 10 to 9
Used mainly to convert databases
Do NOT rely on the GEMs for correct code selection
May be downloaded from
BOOK LAYOUT

• Official Coding Guidelines
• Alphabetic Index: Two Parts
  • Index of Disease and Injury
    • Table of Neoplasms
    • Table of Drugs and Chemicals
    • Main Terms will be in bold
      Antritis J 32.0
      Maxilla J 32.0
      Acute J 01.00
      Recurrent J 01.01
    • Index of External Causes of Injury (not for LTC use)
• Pay attention to instructional notes. They always supersede any other guidance.
Non-Essential Modifiers

• Appear in parentheses and do not affect code number assigned

• Dashes (--) at the end of an entry indicates additional characters are required

Amblyopia (congenital) (ex anopsia) (partial) (suppression) H53.00-

    deprivation H53.01-
Manifestation codes are included in the alphabetic index by including a second code, shown in brackets [   ] directly after the underlying or etiology code which should always be reported first.

Chorioretinitis – see also inflammation chorioretinal

Egyptian B76.9 [D63.8]
Histoplasmic B39.9 [H32]
Tabular Index:

Chapters are subdivided into subchapters (blocks) that contain three character categories and form the foundation of the code.

Chapter 8 Diseases of the Ear and Mastoid Process (H60 – H95)

This chapter contains the following blocks:

H60 – H62 Disease of external ear
H65 – H75 Disease of middle ear and mastoid
H80 – H83 Disease of inner ear
H90 – H94 Other disorders of ear
BOOK LAYOUT

• Tabular Index: Listing of each disease by code
  • This MUST be referenced!
  • Alphabetical index does not always have full codes
  • Laterality and 7th digits are ONLY in tabular
  • Incomplete codes result in denial of payment
  • Look above and below each code
Tabular List Notes

Notes are located at the beginning of chapters or any subdivisions that follow and apply to all the categories within it.

Always read the beginning of each chapter and directly above and below each entry.
The 7th character is used for injuries, external causes and obstetrics. ONLY injuries apply to LTC.

When required, the 7th character will always be in the 7th position.

If a code that requires a 7th character has less than six characters, placeholder X must be used.

S00.03x D  Contusion of scalp, subsequent episode of care
• True or False: Official Coding Guidelines take precedence over code book instructions.

• True or False: Not all codes have letters.

• True or False: GEMs are a suitable replacement for the alpha and tabular indexes.

• Seventh characters and characters used for laterality are found only in the _________ index.

• True or False: “Unspecified” codes may result in an automatic denial of payment.
Whoa! TMI, Dude.

T-M-I-!!!
CODING CONVENTIONS

• (NEC) – “not elsewhere classified”: We have a better code than the book

• (NOS) – “not otherwise specified”: The book has a better code than we do.
  
  F03.90 Unspecified Dementia without behavioral disturbance – Dementia NOS

• Codes must be used to the highest number of characters available or to the highest level of specificity.
CODING CONVENTIONS

Code First/Use Additional Code:

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. The underlying condition is sequenced first followed by the manifestation. The “use additional code” note appears at the etiology and a “code first” note at the manifestation code.
CODING CONVENTIONS

Code First/Use Additional Code:

**G30 Alzheimer’s disease**

Use additional code to identify:
- dementia with behavioral disturbance (F02.81)
- dementia without behavioral disturbance (F02.80)

G30.0 Alzheimer’s with early onset
G30.1 Alzheimer’s with late onset

**F02 Dementia in other diseases classified elsewhere**

Code first the underlying physiological condition, such as Alzheimer’s (G30.-)

F02.80 Dementia in other diseases classified elsewhere, without behavioral disturbance
F02.81 Dementia in other diseases classified elsewhere, with behavioral disturbance
CODING CONVENTIONS

Cross Reference Notes: Used in the Alphabetic Index to advise the coding professional to look elsewhere before assigning a code. There are three terms used: see, see also, see condition.

- **Hemorrhage, cranial** - see Hemorrhage, intracranial
- **Labyrinthitis** (circumscribed) (destructive) (diffuse) (inner ear) (latent) (purulent) (suppurative)
  - see also subcategory H83.0
- **Lumbar** - see condition
Relational Terms

And – Means “and/or” when it appears in the code title within the Tabular List.

180 Phlebitis and thrombophlebitis

With – Means “associated with” or “due to” when it appears in the code title, the Alphabetical Index, or an instructional note in the Tabular List.

Asthma, asthmatic
with
chronic obstructive pulmonary disease J44.9
CODING CONVENTIONS

Excludes Notes

**Excludes 1:** Mutually exclusive codes that cannot exist together. It means “NOT CODED HERE”.

*Example:* Type 2 Diabetes  
Excludes 1: Type 1 Diabetes

**Excludes 2:** Means “Not Included Here”

Patient may have both conditions, but it is not represented by the code

*Example:* Hypertension  
Excludes 2: Hypertension involving vessels of the eye
CODING GUIDELINES

Code Selection

1. Locate the term in the Alphabetical Index
2. Verify the code in the Tabular Index
3. Read and be guided by the instructional notes in both indexes

The Alphabetical Index does not always provide the full code. Laterality and 7th character selection can only be done using the Tabular Index. The Alphabetical Index does not always indicate a dash.
Signs & Symptoms

Codes that describe signs and symptom, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Formally known as “700 Codes”, now located in Chapter Chapter R00 – R99 Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified.
Integral Part of Disease

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

- Altered Mental Status due to UTIN39.0
- COPD with Shortness of Breath J44.9

What is the exception?
Multiple Coding for Single Condition

In addition to the etiology/manifestation convention that requires two codes, there are other single conditions that also require more than one code. See “Use additional code” notes in the Tabular List at the code level. These are sequenced secondary to the condition code.

“Code first” notes are under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition is sequenced first.
Multiple Codes for Single Condition

“Code if applicable, any causal condition” notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable.

If the causal condition is known, then the code for that condition should be sequenced as the principal diagnosis or first-listed diagnosis.

Escherichia Coli Urinary Tract Infection

N39.0 Urinary Tract Infection
B96.20 Unspecified Escherichia Coli
WHAT YOU TALKIN BOUT WILLIS?
Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Acute and Chronic Renal Failure

N17.9   Acute Renal Failure
N18.9   Chronic Renal Failure
Combination Codes

A combination code is a single code used to classify:
  Two diagnoses, or:
  * A diagnosis with an associated secondary process (manifestation)
  * A diagnosis with an associated complication
    J 44.0 Acute Bronchitis with COPD

See Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)
**Combination Codes**

- Assign only the combination code that fully identifies the diagnostic conditions involved or when directed by the Alphabetical Index.
- Multiple coding should not be used when the classification provides a combination code that clearly identifies all the elements documented in the diagnosis.
- When a combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.
Sequelae

“A residual effect (condition produced) after the acute phase of an illness or injury has terminated.”

- There is no time limit to use the sequelae code
- The residual may be apparent early or years later
- Generally requires two codes
  - The condition or nature of the sequelae – first
  - The sequelae code - second
Sequelae

Exception to above guideline:
In instances where the code for the sequelae is followed by a manifestation code identified in the Tabular List and title, or the sequelae code has been expanded at the 4th, 5th, or 6th character level to include the manifestation. (I69 Sequelae of cerebrovascular Disease)

The code for the acute phase of an illness or injury that led to the sequelae is never used with a code for the late effect.
CODING GUIDELINES

Impending or Threatened Condition
• Code any condition described at the time of discharge as “impending” or “threatened” as follows:
  • If it did occur, code as confirmed diagnosis.
  • If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
  • If the sub-terms are listed, assign the given code.
  • If the sub-terms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

Impeoding myocardial infarction   I20.0
Coding Guidelines

Reporting Same Diagnosis 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 no distinct codes for laterality or two different conditions classified to the same ICD-10-CM diagnosis code.
CODING GUIDELINES

Laterality

- For bilateral sites, the final character of the codes indicates laterality.
- An unspecified site code is also provided should the side not be identified in the medical record.
- If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.
**CODING GUIDELINES**

**Documentation of BMI and Pressure Ulcer Stages**

Body Mass Index and Pressure Ulcer stage codes may be based on the medical record documentation from clinicians who are not the patient’s provider, such as a dietician for BMI or nurse for pressure ulcer staging.
BMI & Pressure Ulcers, Cont’d

Associated conditions (overweight, obesity, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.
CODING GUIDELINES

Syndromes

• Follow the Alphabetical Index for guidance when coding syndromes.

• If there is no guidance in the Alphabetical Index assign codes for the documented manifestations of the syndrome.

Look for the syndrome by name in the alphabetical index first and if not there, under Syndrome.
Complications

“Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure.”

The guideline extends to any complications of care, regardless of the chapter the code is located in.

**Note:** not all conditions that occur during or following medical care or surgery are classified as complications.
Complications

There must be a *cause-and-effect* relationship between the care provided and the condition and an indication in the documentation that it is a complication. If the complication is not clearly documented, query the provider for clarification.

Example: Joint prosthesis
• True or False: Underlying conditions must be sequenced before manifestations

• What two types of characters may be found ONLY in the tabular index?

• Name two instances where diagnoses are not required to be physician documented.
• When to code?
• Section I of the MDS (must meet both)
  • Documented by the physician within the last 60 days
  • Active within the last 7 days
PRINCIPLE & PRIMARY DIAGNOSES

Principle vs. Primary

- **Primary** is the reason that caused the admission and/or the reason for therapy services (medical diagnosis); box 67 A
  - 67 A-W support principle diagnosis (therapy treatment)
  - CMS ignores all but top eight
  - Sequencing is of the essence
  - May change during stay
- **Principal** (admitting dx) is first-listed dx, reason resident is admitted to the center; box 69. This will not change during stay.
IF YOU DON'T HAVE TIME TO DO IT RIGHT, WHEN WILL YOU HAVE TIME TO DO IT OVER?
WHY DOES IT HAVE TO BE RIGHT?

- Billing
- Data for care
- To support clinical decision making (ADRs, RACs)
- To comply with federal standards
- Statistical purposes
"If I had eight hours to chop down a tree, I'd spend six sharpening my axe"