ICD-10 Diagnosis Coding for Patient-Driven Payment Model 4/16/19 Webinar Q&A's

Webinar Objectives:

Upon completion of the WebEx, participants will be able to:

1. Review intermediate ICD-10 principles
2. Prepare for the transition by learning PDPM components relevant to diagnosis coding
3. Explore 'real world' coding examples

Presenter:

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Handouts and Recording Link: https://greatplainsqin.org/blog/event/great-8-webex-icd-10-diagnosis-coding-for-patient-driven-payment-model/?instance_id=1604

Questions and Answers: (Revised as of 5/6/19).

Q&A's highlighted in yellow are the revised/ clarifications since original mailing of Q&A.

1. Deb Goble to all participants:
   Do you know if Priority Health and UHC advantage plans will require pps or pdpm?
   It's up to them; you will have to ask each insurer what they are planning.

2. Crystal Glynn to all participants:
   Do we start now with the switching of diagnosis for long term residents or when PDPM starts? For example long term resident with Parkinson's which is principal diagnosis comes in with Pneumonia and is now skilled we would normally put Pneumonia as admission 69 on the diagnosis sheet. Parkinson's would remain as Principal.
   You are only going to change for skilled care billing. If they remain long term with no hospitalizations there is no need to change the primary diagnosis.

3. Pamela C Bartolone, RHIT to all panelists:
   Normally, I place status codes such as, insulin use Z79.4, dialysis Z99.2, oxygen Z99.81, etc., at the bottom of my Dx list. Should I be placing these NTA components within my Top Ten Dxs along with the "real" Dx; DM, ESRD, COPD? This will take up a lot of my Top Ten spots.
   I wouldn't even add status codes on a claim, they aren't necessary. Also, I would add the status coded if I had extra room but would certainly not prioritize these before NTA items.

4. Ellen Pearson to all participants:
   Can you clarify what you said about sec I0020 A and B? We thought you said that DX will not be used by PDPM, but will be used in QM's. Pretty sure we heard that wrong...
   I0020A will be replaced wit I0020B. I002oB will be used for PDPM clinical category assignments. The boxes above (I0020) will be used to risk adjust for SNFQRP.

5. Brigid Glennen to all participants:
   What do you do in the example when physician states probable cancer but due to them being 90 years no further testing was done? Family chose not further testing as they did not want to treat.
   If that is a diagnosis by a physician then no further testing/confirmation is required in a SNF. I would query the physician to get a more definitive answer to see if this is an actual diagnosis.

6. Colleen Chase to all participants:
   Do you have to get a doctors order to resolve diagnosis?
   Not necessarily an order, but you will want a physician or extender to make that statement. They can write it in their progress notes or in another place in the record and that will count too.

7. Ellen Pearson to all participants:
   We heard in another PDPM webinar that Med A will only look at the first 9 diagnoses. Is this your understanding?
   Yes, the FISS system only reads the first 9 diagnosis on the claim. (top line)

8. Marguerite Kono to all participants:
   In regards to the resolving diagnoses question-if the treatment for UTI ends, that is sufficient enough to resolve the diagnosis? A provider progress note is not needed?
   For MDS purposes, yes. Once the condition is no longer being treated, monitored, medicated, etc. it is considered resolved by MDS standards.

9. Colleen Chase to all participants:
   So if we have duplicate codes in our record now....and they need to be cleaned up is that something we can just do? **Yes, it's a good time to get those old ones cleaned up.** Or do we need an order to get that out of there?
   Depends on the condition, if its s self-limiting condition like skin tear, UTI, etc. you can resolve, other types of diagnoses would need a MD or extender to make that call.

10. April Koehler to all participants:
    What's a good way to sequence diagnoses in the medical record? We use Point Click Care and right now we just have Primary, Secondary, and Other. They are not in a specific order.

    a. Marguerite Kono to all participants:
       We have PCC too. We have Admitting, Principal and Other. The only way to sequence them is to make sure they are entered that way.

       In PCC, when you set the diagnoses up they stay in the order you set them up. So, after Primary, everything else is considered a secondary diagnosis. They should flow over to the claim in the order you have them set up on the diagnosis code screen.

11. Rich McManman to all panelists:
    Do you recommend no longer using R26.2 - difficulty walking?
    As a primary, yes. It does not cross over to PDPM in I0020B.

12. Sherry Finnesand to all participants:
    Can you give an example of a sequela code with part B for the condition and then the sequela code. What to ensure I'm going this correctly as I have a lot of part B.
    S83.011S (sequela of an dislocated R patella)

13. Deb Goble to all participants:
    Are the 1CD10-CM code books updated and available for sale? Is there a downloadable version?
    Yes. AAPC, Optum, and AHCA all have good ICD-10 manuals.

    1. Pamela C Bartolone, RHIT to all panelists:
       ICD 10 books are usually available in September. Don't buy it too early, you may not have the up to date final version of the ICD 10 codes. New codes go into effect October 1st every year.

2. ICD-10-CM code books are updated every year. Should always purchase a new code book every year as codes are added, removed, changed, etc.

3. Laura Rusbult to all participants:
   ICD-10-CM code books are updated yearly and are available for purchase through American Medical Association, Optum Coding, and several other sites. You can Google it to find where to purchase. ICD-10-CM is also available on CDC website and CMS website. But the books are a much better resource to lookup the codes.
   Agreed

14. Pamela C Bartolone, RHIT to all panelists:
    Where should I sequence these Z codes?
    Sequencing happens on the claim. It will depend on the nature of the condition. Z-codes for joint replacements will likely be the primary position on the claim.
    Additional comment: It says z-codes for joint replacements are likely a primary position on the claim…..in our software, PointClickCare, it comes up as not a valid diagnosis.
    They might be using the wrong code. There are many Z-codes. Also may be a configuration issue with a specific software. Z47.1-Aftercare for joint replacement, and the code for the specific joint that was replaced, would be expected on a claim and is one of the highest PT/OT PDPM reimbursed conditions.

15. April Koehler to all participants:
    What provider documentation can we get diagnoses from? Can we use PT, OT, ST notes or does it have to be documented by a MD, NP, or PA?
    It has to be someone who can diagnose within their scope of practice so No a therapist cannot do this, neither can a nurse, only a physician or extender.

16. Kristin England to all participants:
    Does the physician query have to be completed within the lookback period or can it be done after the ARD?
    Within the lookback period. Or within a 60-day period prior to the MDS.

17. Sharilyn Althoff to all participants:
    If resident has a diagnosis of osteoporosis and presents to SNF with a fracture due to fall is the fracture coded as osteoporosis with current pathological fracture or coded as traumatic fracture and then also osteoporosis without pathological fracture.
    It will be an M80 code for the osteoporotic fractures.

18. April Koehler to all participants:
    I've been seeing physical deconditioning documented as the reason for being admitted for therapy often lately. There is no specific code for this. What is the best code to use?
    A medical diagnosis that shows a functional decline. Physical deconditioning is a symptom not a diagnosis.

19. Terrel Mielitz to all participants:
    When a patient admits to LTC after having a hypertensive crisis, how would you code that?
    By using an I10-I15 code, not the I16 crisis code.

20. Michele Ball to all participants:
    How to you advise providers to code E11.8 DM with unspecified complication. What would be unspecified conditions?
    Complication that has not been fully defined.

21. Emily Haakinson to all participants:
    R53.81 is what we've used for physical deconditioning

Might want to explore other options. Deconditioning due to what? What was the functional decline caused by?

22. cindy sardinha to all participants:
    Would you code both pressure ulcers on present on admission if admitted with a stage 2 but assessed at a stage 3 pressure ulcer by nurse?
    No, only the stage 2 was present on admit, the stage 3 you grew yourself.
    Additional comment: I read this scenario as the admit orders indicate Stage 2 but on admit the wound care nurse assesses as a stage 3. Wouldn't we then need to notify MD and get a new diagnosis. Sometimes the wound changes at the hospital but the diagnosis is not changed or it was not accurately staged at the hospital.
    I didn't read it that way or answer it that way. That would be a different answer. There was no indication that the wound nurse did this on admission.

23. CINDY THOMPSON to all participants:
    Is there any conversion available from ICD10 to billable coding
    Verification in the ICD-10 manual that you've got the correct code and it represents the conditions the resident is presenting with. Other than that, it should make sense for their treatment and length of stay.

24. Holly Freund to all participants:
    I was always told not to code probable and/or possible for the medical record. Now I am being told I should. Thoughts?? (This usually comes up when a doctor put possible or probable Alzheimer's)
    I agree with you. Press the MD for a definitive diagnosis.

25. Michelle Mangan to all participants:
    Where is the survey? https://www.surveymonkey.com/r/PDPM0416.

26. cindy sardinha to all participants:
    Where would you include aftercare for any wounds involving dressing changes or suture care/monitoring?
    Yes

27. Could you include information on the following scenarios in your Q and A?

    1. Resident is at home UTI develops, resident ends up in hospital debilitated now sent to SNF for rehab due to debility, muscle weakness etc. Recommendations for coding? **O038.8**
       Additional comment: In going over the Q&A's, look at #27 where they say we should use O038.8 for the proper code. The O section for ICD 10 is for pregnancy, childbirth and the puerperium. You have to move the decimal point to even find a diagnosis and it comes up UTI following an abortion.
       Yes, she is correct. What I did was try to find a code that crosses over to PDPM for her. So I went to the CMS Clinical Category list and looked for a code that would have worked for that scenario. I didn't cross reference that code to the ICD-10 manual. So we can delete that answer from the Q&A and say that more additional info would be needed to assign a primary diagnosis code. Otherwise the answer would be that they can assign the codes mentioned in her original Email and they do not have a valid PDPM clinical category to bill from.

    2. Resident has hx of Dementia ends up in hospital for altered mental status – is debilitated and sent to SNF for rehab due to difficulty walking, weakness etc.
       Again, O038.8. Anything else will RTP (return to provider) or not cross over.
       See above yellow highlighted (red font) answer from speaker

28. Brenda Mohs to all attendees:
    AHIMA says the doctor has to indicate a dx has resolved in order to remove it unless they are self-limiting such

as UTI or pneumonia and such.
Yes, this is consistent with what was said. Get the old resolved conditions off the MDS and claim.