Billers' Association for Long-Term Care

The role of ICD-10 in PDPM

(see what we did there?)

WHITE PAPER

Once you come to understand how reimbursement will be calculated under the new skilled nursing facility (SNF) prospective payment system (PPS) model, Patient Driven Payment Model (PDPM), you may wonder why it wasn't named the Primary Diagnosis Driven Payment Model, but that's a conversation for another day. What we should be focusing on is the fact that under PDPM, each resident's primary diagnosis code entered into line I0020B of the minimum data set (MDS) (a new MDS field that will be added effective 10/1/2019) will be used to place the patient into one of ten PDPM clinical categories. These clinical categories are then used as part of the patient's classification under the physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) components. A resident's primary diagnosis code is essentially the hinge for that resident's clinical documentation and reimbursement path, so getting it right is essential in order to achieve accurate reimbursement under PDPM.

The following white paper will explain how ICD-10-CM codes are currently used in long-term care, how the evolution of that role under PDPM may look for your clinical, administrative, and business office staff, and what that means for SNF billing and reimbursement. In a nutshell: ICD-10-CM codes don't much matter for reimbursement now, will much matter for reimbursement under PDPM, and this means a lot of training and education for SNF providers. Shall we get started?

ICD-10, reveal yourself

For more than 30 years, the medical community in the United States has used the ICD system in medical claims and to communicate a patient's condition to all providers and payers. Until October 1, 2015, when the United States transitioned from ICD-9 to ICD-10, we were lagging behind most other countries that had already been using the 10th revision. Because ICD-9 was determined to be outdated and limiting for a number of reasons, the transition to ICD-10 was required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA) and all providers, regardless of the healthcare setting. In addition, all payers and vendors, including clearinghouses that process claims on behalf of providers, were also required to transition to ICD-10.

Who deals with ICD-10-CM codes in a SNF?[1]

There are two different and distinct types of coding sets under ICD-10: ICD-10-PCS for the inpatient setting, and ICD-10-CM for the outpatient setting, which includes SNFs. These diagnoses codes have had a unique place in the long-term care setting. Documenting a patient's admitting, primary, and secondary diagnoses is a significant responsibility that requires coding knowledge, on some level, from multiple departments. For example, the following roles in a SNF may deal with ICD-10-CM on a daily basis:

- **Admissions and administrative clinical staff.**
  - These roles may be responsible for verifying referrals and obtaining prior authorizations. They may also review hospital records to determine the facility's ability to care for certain patients. These roles' coding knowledge or lack thereof could negatively impact the facility's ability to care for those patients.
- **Patient records.**
  - The person who places codes into the patient's medical record may be different for each facility, but this role should be aware that acute codes are not acceptable on SNF claims.
- **Clinical staff.**
  - Frequently, nurses must select diagnosis codes when ordering medications for residents as well as identifying resident diagnosis for care plan development.
- **MDS staff.**
  - It's necessary for MDS coordinators to have knowledge of the appropriate ICD-10-CM codes in order to complete section I of the MDS assessment, including the PPS assessments to support skilled services being billed to Medicare. Because quality measures are driven by the coding in the MDS, which in turn determines a facility's five-star rating, MDS coordinators should have a good working knowledge, not only of which diagnoses are coded in Section I, but also which other codes are necessary for complete documentation of the resident's medical status.
- **Physicians/nurse practitioners/physician assistants.**
  - These roles may use ICD-10-CM codes to code their progress notes and history and physical, or to assist with coding when there are questions or discrepancies.
- **Rehab managers and therapists.**
  - Rehab evaluations contain patient diagnoses to support the skilled rehabilitation services being provided.
- **Labs/x-rays/DME.**
  - Laboratory request forms usually include the diagnosis code for the condition requiring the test.

- **Pharmacy.**
  - Some payers require specific diagnoses to be documented by the physician before they will cover the expense of a medication. Facilities that have a consultant pharmacist reviewing the medical record documentation may have ICD-10-CM knowledge for purposes of ensuring that the appropriate diagnosis code for the prescription is being used.

- **Business office.**
  - In many facilities, verifying referrals and obtaining prior authorizations falls on the business office staff. Although billers shouldn't ever be determining a patient's diagnoses codes, having knowledge of ICD-10-CM codes can help the biller spot red flags (see examples below) and catch missing codes that could lead to complete or line item claim denials.

What is the primary diagnosis?

In the SNF setting and when Medicare Part A is the primary payer, the primary diagnosis is generally the reason for skilled Medicare coverage. "What's the primary condition that's being studied? Why is the patient being admitted for skilled services?" says **Theresa Lang**, an AHIMA-approved ICD-10 trainer and regional clinical reimbursement specialist for Grace Lutheran Communities in Eau Claire, Wisconsin. "When it comes to the Medicare Part A claim, the admitting and the primary are the two key diagnoses that CMS edits against," she says.

Choosing the correct primary diagnosis according to CMS' rules for Medicare coverage can be tricky, though. For example, a patient may have been admitted to the hospital with a chief complaint of mental status changes. Usually, by the time they are admitted to the SNF, the mental status changes have been resolved and/or the root cause for the symptoms has been identified. The SNF staff is then charged with the task of identifying the reason for utilizing skilled services and accessing available Medicare benefit days. "If a patient incurs a fractured hip but was admitted five years ago due to dementia, you wouldn't want to submit a claim to Medicare saying that his or her admitting diagnosis is dementia. You want to document the medical reason that's causing the patient to need therapy at this time," says Lang.

The clinician assigned to this task should be well versed in Medicare coverage guidelines and coding guidelines and also be familiar with the patient's medical condition. Care should be taken in choosing the primary reason for skilled coverage. Erroneous diagnosis coding may not only result in rejected claims but may also be the cause of a claim going into medical review status. A rejected claim is not accepted into the electronic filing system and is disregarded for payment.

SNFs should have a system of checks and balances in order to verify that all claims have been accepted into the database. Under PDPM, erroneous coding, especially of the primary diagnosis, will likely place the resident in the wrong clinical category from the start, which could lead to under-reimbursement.

How will ICD-10 drive reimbursement?

"I've heard a lot of providers express concern that their SNFs' current diagnosis coding practices would lead to under-reimbursement under PDPM, because the diagnosis codes themselves haven't been significant payment drivers up until now and so accuracy and specificity are not high priorities," says **Jennifer Gross, BSN, RAC-CT, CPHIMS**, senior healthcare specialist for PointRight, Inc.

Gross was an MDS coordinator for four years before joining the team at PointRight, where she has been "up to my neck in MDS" for the past 15. "From my experience, since therapy drives so much of the reimbursement under RUG-IV, MDS coordinators have gotten into the habit of using the therapy treatment diagnosis as the primary. Unfortunately, this has often been non-specific diagnoses such as 'generalized weakness' or 'gait disturbance,' which would be marked as Return to Provider codes when PDPM is implemented October 1," she says.

In addition to determining the primary diagnosis, ICD-10 will also be used to capture additional diagnoses and comorbidities that the patient has under PDPM, which can factor into the SLP comorbidities that are part of classifying patients under the SLP component and the NTA comorbidity score that is used to classify patients under the NTA component. Providers should download the ICD-10 to clinical category mapping tool that will be used under PDPM, available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.[2]

Stefanie Corbett, DHA, post-acute regulatory specialist for HCPro, recommends that "a qualified staff member be available to look at a medical record in prescreening or right upon admission, prior to that initial admission assessment being completed in the MDS, and be able to pick it apart to identify if there is a need for additional codes, questions, or documentation to be pulled from the referral."

While it's not a requirement that your admissions staff be someone with a clinical background, "if that is a move you're comfortable making and investing in, it doesn't have to be someone in MDS; it could be someone familiar with or with a certificate in coding. I would also recommend that if you have a wonderful salesperson or marketer in admissions who has no clue about clinical operations, have that person work very closely with a clinical staff member. They will make an awesome team as we transition to PDPM. If you create this team, ultimately the clinical team member and admissions team member will work together to make admissions decisions related to projections as far as reimbursement," says Corbett.

Lang points out, for example, that a patient with a hip replacement as the first code will be valued higher than someone with congestive heart failure, so that will affect the amount of revenue that's generated for PT and OT. Another example is

someone who has experienced a cerebrovascular accident with swallowing issues. "That's going to be considered a neurological and when it comes to the speech therapy, because of the swallowing issues, that resident is going to generate more revenue than someone with cognitive impairment alone," she says.

Trading old habits for specificity

To prevent being overwhelmed after the new payment model is implemented, Gross recommends that the MDS coordinator and interdisciplinary team develop a few new habits now and get them embedded in the facility's processes between now and October 1. Opportunities for change include the following:

- Have the interdisciplinary team meet as close to a resident's admission as possible. You need to develop the baseline care plan anyway, so during this meeting, hash out exactly what the primary reason for the resident being admitted to the SNF is. This will do two things:
  - Identify the primary diagnosis
  - Identify any conditions that need documentation from the physician in order to assign a diagnosis if there isn't one
- Get comfortable asking for clarification from the physician and nurse practitioner. Gross explains that the standard of specificity in the documentation in order to be able to truly code out as far as you can requires source documentation. "It might require your medical staff to have some training to work on their documentation, and that may involve bringing in your medical director."

Identifying return-to-provider codes

Gross says this is an area where "rules of thumb" that have been developed through experience can only take you so far. "MDS coordinators generally work closely with their business office to make sure that the appropriate ICD-10 codes are sequenced for the UB-04 claim. I'd be willing to bet that most of them have heard back from the business office manager when a diagnosis is kicked out with a RTP code, and have learned to avoid those codes. For example, a basic rule of thumb would be any code that is unspecified would be rejected. However, that assumption doesn't cover every circumstance, especially under PDPM. My go-to recommendation is to download CMS' Clinical Category Mapping spreadsheet and use this to double check your codes. In addition to listing the Clinical Category for each code, the Return to Provider codes are also listed. If your code falls into that bucket, then you can review the physician's documentation and ask for clarification to get an acceptable code."

She warns providers, however, that the mapping tool should be considered as an additional resource, and providers should avoid going to the mapping tool first. "ICD-10 coding is a discipline so to truly do it properly you have to go through the steps of making sure you have selected the appropriate code and coded to the highest level of specificity you can get. The mapping tool is a last line of defense to check that code and make sure it's not going to get rejected," she says.

Should your MDS coordinator be your coding specialist?

"I believe that the role of the MDS coordinator requires a certain level of ICD-10 coding competency, just as with any other aspect of the MDS assessment. However, if providers are concerned that this means the time and expense of a full ICD-10 certification course, I don't think that is necessary," says Gross. She recommends using low-cost resources that are available to learn the rules for ICD-10 coding, and how to apply them in the SNF. "That should be enough to enable the MDS coordinator to develop the basic competency. I should point out, though, that the MDS coordinator's role is to coordinate the MDS assessment process. She isn't responsible for completing all the documentation or chasing down missing documentation, but she can hand any issues with diagnoses off to the nurse manager on the floor or the therapy director, whichever department is responsible for the source documentation," says Gross.

While choosing the right primary diagnosis determines a resident's PDPM classification, Gross adds one additional suggestion: don't panic! "In many cases, the decision for what ICD-10 code goes in I0020B is straightforward. For example, if the resident's prior qualifying hospital stay was for a hip replacement, coding the surgery in item J2310 would automatically place the resident in the Major Joint Replacement or Spinal Surgery clinical category for PT and OT, and Non-Neurologic for SLP. Similarly, other common reasons for hospitalization such as a CVA or septicemia would most likely be your first choice. Just make sure that the ICD-10 code you select is one that will map to the appropriate clinical category, and you're good to go."

Coding red flags: Billers beware[3]

Billers should look out for the following red flags that could indicate a coding error during claim review:

- "A" as the seventh character. An "A" as the seventh character signifies that the accident, injury, or drug overdose occurred in the facility, was diagnosed in the facility, and is being treated in the facility, and that the person never left the skilled building. In short, the "A" indicates that the facility is the first provider of care for that particular problem, and this is rarely true. In most cases, nursing homes/SNFs should be using a "D" as the seventh character, which signifies subsequent episode of care. Hospitals and ERs should be using the "A" code, as they are the first provider of care for a given issue.
- F codes as the primary or admitting diagnosis. These indicate dementia and mental health diagnoses, which Medicare doesn't pay for. If the biller comes across this scenario, he or she should consult with the coder and question whether another primary medical diagnosis could be listed.
- I60 (nontraumatic subarachnoid hemorrhage), I61 (nontraumatic intracerebral hemorrhage), I62 (other and unspecified nontraumatic intracranial hemorrhage), and I63 (cerebral infarction) codes. These codes should seldom be used in postacute care unless the situation occurred in the SNF, was diagnosed in the SNF, and was treated in the SNF without a trip to the ER or physician's office.
- SNFs should use an I69 code instead (which signifies residual effects or conditions produced after the acute phase of an illness or injury), followed by a decimal point and then up to four digits. This indicates that the postacute care facility is treating the late effects of the stroke, not the stroke at the time of its occurrence.
- Unspecified code, followed by a list of specific codes. For example, I69.30 (unspecified sequelae of cerebral infarction) may be coded, indicating that the doctor has documented that the person had a stroke but that the aftereffects are not known. Then the coder will code additional I69 codes that indicate the resident's specific problems as a result of the stroke. This documentation is clearly contradictory to the I69.30 unspecified code. Instead, says Lang, the coder should document what the resident's other problems are.
- Speech-language therapy without a supporting diagnosis code. The billing claim shows that therapy has been seeing the resident five or six days a week and there isn't a diagnosis code on the claim to support speech therapy. Lang notes that this error is a huge red flag for medical review. Review your Medicare administrative contractor's local coverage determinations for acceptable codes.s
- R codes as the admitting or primary diagnosis. R codes are symptom codes, and the only time symptom codes should be used in LTC is to support therapy or to indicate that the cause of the symptom is unknown.

Coding and Medicare Part B

While PDPM only affects Medicare Part A, Lang recommends that billers also pay particular attention to diagnoses codes related to Medicare Part B claims as a best practice. "Every facility with a Medicare Administrative Contractor has medical review policies that specifically allow certain diagnoses to be used to bill Part B and a lot of the time, when a patient is receiving Part B services, their claim might not get adjusted to explain the reason for submitting that claim, so they wind up with denied charges."

For example, says Lang, a patient may come into the nursing home due to dementia, cognitive issues, and weakness. The admitting diagnoses include dementia, weakness, hypertension, congestive heart failure, etc. During the patient's stay, it's identified that he or she is experiencing swallowing issues, so the code that explains why the therapist is seeing the patient is a dysphagia code. The doctor verifies that treatment for dysphagia is needed, but the dysphagia code is never added to the list. In medical review, it's found that there is no code to back-up the speech therapy services that were billed, so the claim is rejected.

"Billers should be looking out for codes that might be missing because facilities are notoriously not good at keeping their diagnoses lists up to date and every time they submit a claim to Medicare Part B, the claim is supposed to be submitted with the reason why the claim is being submitted to Medicare. If they don't make adjustments, some diagnoses get missed and you start having complete claim denials or line item denials," says Lang. She also recommends that billers become familiar with codes for accidents and injuries (found in Chapters F and P) and codes found in the cardiac respiratory sections, as these are common services provided in the long-term care setting.

References

1. Breese, K., McCarthy, M. (2015). *ICD-10 Compliance: Process Improvement and Maintenance for Long-Term Care*. Middleton, MA: HCPro.

2. Centers for Medicare & Medicaid Services. *Patient-Driven Payment Model: Frequently Asked Questions (FAQs)*. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final.pdf

3. The Billers' Association for Long-Term Care. (Oct. 19, 2018). 473 changes to ICD-10 codes. *Billing Alert for Long-Term Care, volume 20, issue 10*. Retrieved from http://www.longtermcarebillers.com/content/473-changes-icd-10-codes