FREE WEBINAR

Denial Detour

Stay on track with aligned ICD-10 codes for MDS + UB-04

THU, MAY 29 | 2 PM CT

SKILLED NURSING

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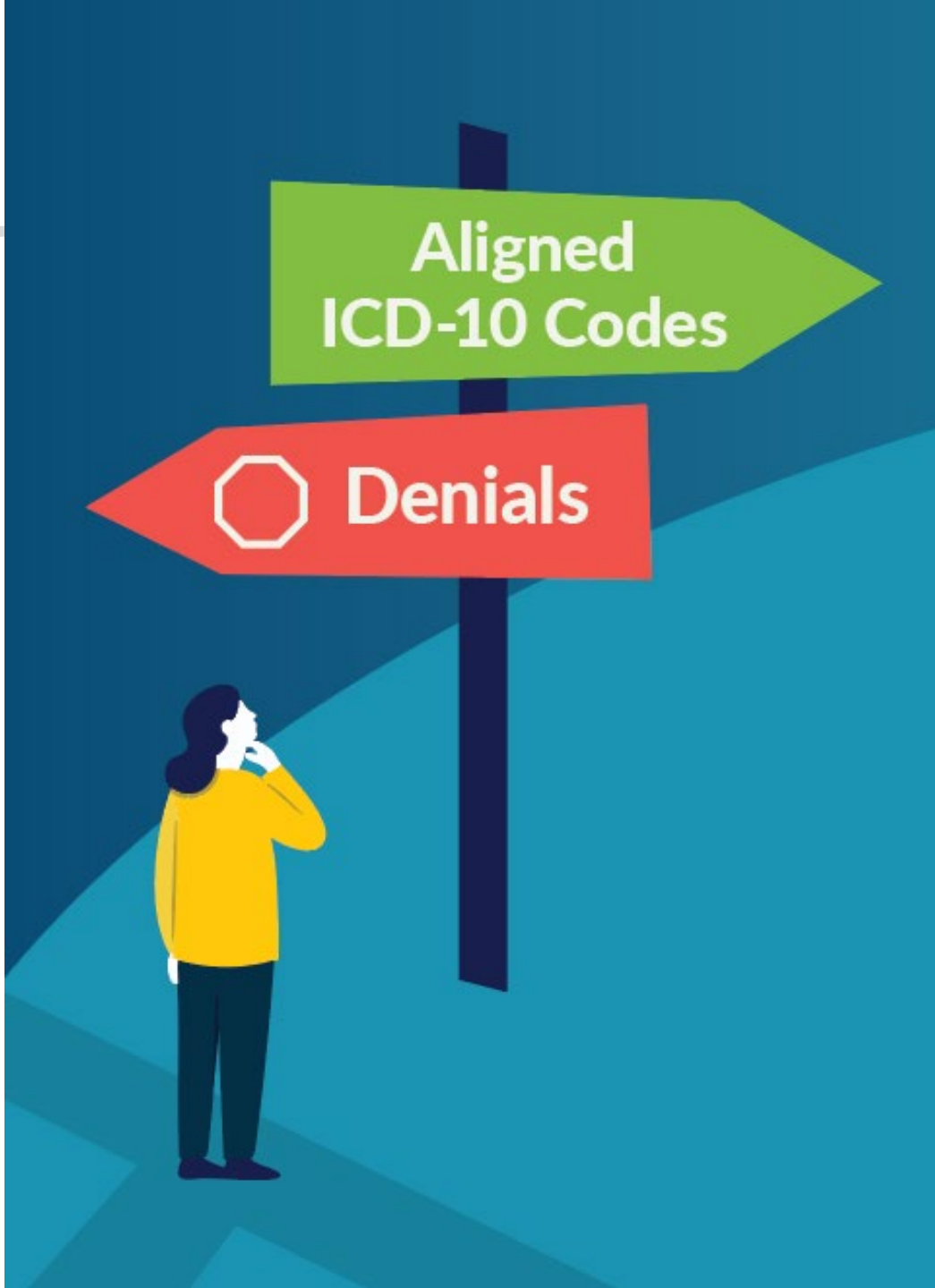

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- *Reference links are provided at the end of the slides.*

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Today's Objectives

Understand how ICD-10-CM conventions and coding guidelines apply to both the MDS and UB-04.

Spot common coding misalignments that cause denials or draw audit attention.

Apply defensible documentation and diagnosis selection practices that support reimbursement and reduce compliance risk.

SNF Post-Acute Care Coding

- Accurate reporting of Diagnosis codes in Section I of the MDS Assessment is significant for care and reimbursement
- Diagnosis codes driving care are reported on the UB-04 in multiple fields
- Principal diagnosis on UB-04 must reflect the reason for SNF admission

Diagnosis Coding is a Team Sport

- All residents need diagnoses coded
- Diagnoses are coded that reflect current function, mood and behavior, cognitive status, treatments & medication, and risk of death
- Accuracy is crucial in billing, supporting medical necessity, and driving the individual plan of care

Who is involved:

- Admissions
- Nursing
- Nurse Assessment Coordinators
- Billing
- Medical Records
- Providers – Physicians, Nurse Practitioners, Physician's Assistants
- Rehab Staff

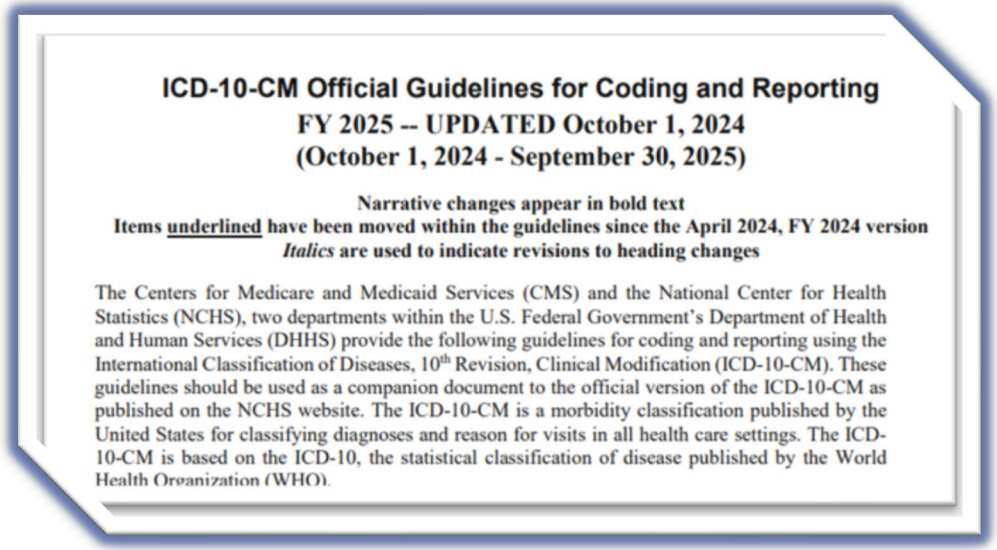
Where Does Supporting Documentation Come From?

- Hospital documentation (must be signed by the provider)
  - Referral forms
  - Hospital transfer form
  - Discharge summary
  - Surgical / Operative reports
- History and physical
- Physician consults
- Provider progress notes
- Radiology reports – hospital or in facility

ICD-10-CM

- Manuals and coding guidelines are released every October for the new fiscal year
- Guidelines and diagnosis codes are updated every year in April
  - No new diagnosis codes added for April 2025
- Published on the CMS website (free):

  https://www.cms.gov/medicare/coding-billing/icd-10-codes
- Available from other publishers



ICD-10-CM Official Guidelines for Coding and Reporting
FY 2025 -- UPDATED October 1, 2024
(October 1, 2024 - September 30, 2025)

Narrative changes appear in bold text
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ICD-10 Coding

- Only a provider can diagnose
  - Physician
  - NP, CNS, APN, or PA
- Coders cannot assign a code to a diagnosis unless it is supported by the provider's documentation in the medical record
- If a diagnosis is unclear, the coder should use the medical record and coding guidelines or query the provider
- If a diagnosis does not have a provider signature or note attached to it, it cannot be included on the master list

Documentation by Clinicians Other Than the Provider

Exceptions include codes for:

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stage
- Coma
- NIH stroke scale (NIHSS)
- Social determinants of health (SDOH) classified to Chapter 21
- Laterality
- Blood alcohol
- Underimmunization status

ICD-10-CM Coding Manual

- Alphabetic Index – divided into 4 Parts
  - Index of Diseases
  - Index of External Causes of Injury
  - Table of Neoplasms
  - Table of Drugs and Chemicals
- Tabular Index – divided into chapters based on body system or condition
  - Full codes, including laterality
  - 7th digits
  - Exclusions, notes

How to Code

- Purpose: Derive clear clinical/medical “picture” just by using codes with high specificity
- Review the clinical record and determine what diagnoses are “driving” the SNF admission as well as the therapy Plan of Care
  - Make sure the physician has documented the diagnoses
- When Body System is known, it’s best to start with the Tabular List of Diseases and Injuries
  - If the body system is not known, then start with the Alphabetical List of Diseases and Injuries.
  - Note: Alphabetical List does not provide the final “code”

Steps for Coding

- Look up the diagnosis in the Alphabetic Index
  - Start with the diagnostic statement

    Congestive Heart Failure (CHF)

    ⟵

    Search: Failure, Heart, Congestive

  - May be directed to another main term: “see,” “see also”

- Once the diagnosis is found in the Alphabetic List, look up the diagnosis in the Tabular List
  - Use the most specific code, including laterality, 7th digit codes

I50.2 Systolic (congestive) heart failure
Heart failure with reduced ejection fraction [HFrEF]
Systolic left ventricular heart failure

Code also end stage heart failure, if applicable (I50.84)

Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)

I50.20 Unspecified systolic (congestive) heart failure

I50.21 Acute systolic (congestive) heart failure

I50.22 Chronic systolic (congestive) heart failure

I50.23 Acute on chronic systolic (congestive) heart failure

Steps for Coding (cont.)

- The Tabular List is broken into Chapters based on body Structures
- Examples
  - Chapter 2: Neoplasms
  - Chapter 9: Disorders of the circulatory system
  - Chapter 13: Diseases of the musculoskeletal system and connective tissues
  - Chapter 19: Injury, poisoning, and certain other consequences of external causes

Steps for Coding (cont.)

- The Tabular List Contains Categories, Subcategories, and Codes.
- All Categories are 3 Characters Long (letters and numbers only). Only if a Category has no further subdivisions can it be used as a code.
  - Fracture of Femur – S72
- Subcategories may have 3, 4, 5, 6, or 7 characters. Must continue to subdivide down to the most specific subcategory known.
  - Fracture of Head and Neck of Femur – S72.0
- The Final level of subdivision is called the Code.
  - Fracture of unspecified part of neck of left femur – S72.002D

Steps for Coding (cont.)

- Example: Femur Fracture
- Note the structure of the tabular list

S72 Fracture of femur

S72.0 Fracture of head and neck of femur

Excludes2: physeal fracture of upper end of femur (S79.0-)

S72.00 Fracture of unspecified part of neck of femur
Fracture of hip NOS
Fracture of neck of femur NOS

S72.001 Fracture of unspecified part of neck of right femur

S72.002 Fracture of unspecified part of neck of left femur

S72.009 Fracture of unspecified part of neck of unspecified femur

Placeholders and 7th Characters

- ICD-10 utilizes a “placeholder” character for future expansion
  - Utilizes “X” as the “placeholder” character.
  - Example: T60.3X4 Toxic effect of herbicides and fungicides, undetermined
- When the 7th character is required (applicable categories will have notation), it must be used
- When the code is less than 6 characters, and a 7th character is required, an “X” Place holder is required prior to the 7th character.
- If a 7th character is required, it will not be accepted as a CODE without the 7th character.

7th Character Example

S72 Fracture of femur

Note: A fracture not indicated as displaced or nondisplaced should be coded to displaced
A fracture not indicated as open or closed should be coded to closed
The open fracture designations are based on the Gustilo open fracture classification

Excludes1: traumatic amputation of hip and thigh (S78.-)

Excludes2: fracture of lower leg and ankle (S82.-)
fracture of foot (S92.-)
periprosthetic fracture of prosthetic implant of hip (M97.0-)

The appropriate 7th character is to be added to all codes from category S72
A - in[illegible]counter for closed fra[illegible]
B - initial [illegible] type I or II
initial [illegible] NOS
C - in[illegible]counter for open fractu[illegible] IIIA, IIIB, or IIIC
D - subsequent encounter for closed fracture with routine healing
E - subsequent encounter for open fracture type I or II with routine healing
F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
G - subsequent encounter for closed fracture with delayed healing
H - subsequent encounter for open fracture type I or II with delayed healing
J - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
K - subsequent encounter for closed fracture with nonunion
M - subsequent encounter for open fracture type I or II with nonunion
N - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
P - subsequent encounter for closed fracture with malunion
Q - subsequent encounter for open fracture type I or II with malunion
R - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
S - sequela

Definitions

- NEC – Not Elsewhere Classified
  - Refers to a diagnosis about which there is more specific information in the medical record, but there is not a code available in the Tabular List that supports the level of specificity being expressed clinically
  - Also known as “other” or “other specified”

R26.2 Difficulty in walking, not elsewhere classified

Excludes1: falling (R29.6)
unsteadiness on feet (R26.81)

- NOS – Not Otherwise Specified
  - There may be many more specific codes available in the Tabular List, but the medical record does not have enough documentation to support a more specific code
  - Also known as “unspecified”

D05.9 Unspecified type of carcinoma in situ of breast

D05.90 Unspecified type of carcinoma in situ of unspecified breast

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Definitions (cont.)

- “Other” or “other specified” codes
  - For use when the information in the medical record provides detail for which a specific code does not exist
- “Unspecified” codes
  - For use when information in the medical record is insufficient to assign a more specific code
- For the few categories in which an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

Excludes Notes

- Excludes 1
  - Means “NOT CODED HERE”
  - Indicates the code excluded should never be used at the same time as the code above the Excludes1 note
  - Used when two conditions cannot occur together
    - Congenital form vs. an acquired form of the same condition

Z47 Orthopedic aftercare

Excludes1: aftercare for healing fracture-code to fracture with 7th character D

Z47.1 Aftercare following joint replacement surgery

Use additional code to identify the joint (Z96.6-)

Z47.2 Encounter for removal of internal fixation device

Excludes1: encounter for adjustment of internal fixation device for fracture treatment- code to fracture with appropriate 7th character
encounter for removal of external fixation device- code to fracture with 7th character D
infection or inflammatory reaction to internal fixation device (T84.6-)
mechanical complication of internal fixation device (T84.1-)

Excludes Notes

Z89.4 Acquired absence of toe(s), foot, and ankle

Z89.41 Acquired absence of great toe

Z89.411 Acquired absence of right great toe

Z89.412 Acquired absence of left great toe

Z89.419 Acquired absence of unspecified great toe

Z89.42 Acquired absence of other toe(s)

Excludes2: acquired absence of great toe (Z89.41-)

Z89.421 Acquired absence of other right toe(s)

Z89.422 Acquired absence of other left toe(s)

Z89.429 Acquired absence of other toe(s), unspecified side

- Excludes 2
  - Means “not included here”
  - Indications that the condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time
  - Acceptable to use both the code and excluded code together when appropriate

Minimize Denials & Optimize Revenue

Tracking

- Excludes 1 claims denials seem to be more prevalent among Managed Care payers
- Monitor to prevent
- Volume, Type, Payer, Reason

Cause

- Inaccurate PDPM coding leads to denials or missed payment opportunities

17.5%

of total claims had a potential denial with Excludes 1

Based on 42 rules – to be expanded

Source: *SimpleCORE™ – 3 months ending 3/31/2025*

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Top 10 Excludes 1 Denials

Trigger Code	Code Expanded	Total Claims	% of Potential Denials
R26.2	Difficulty in walking, not elsewhere classified	6,828	**35.2%**
R53.1	Weakness	4,888	**25.2%**
Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits	1,224	**6.3%**
R52	Pain, unspecified	1,017	**5.2%**
G31.84	Mild cognitive impairment of uncertain or unknown etiology	893	**4.6%**
N39.0	Urinary tract infection, site not specified	719	**3.7%**
I73.9	Peripheral vascular disease, unspecified	591	**3.0%**
R55	Syncope and collapse	417	**2.2%**
Z73.6	Limitation of activities due to disability	410	**2.1%**
R54	Age-related physical debility	382	**2.0%**

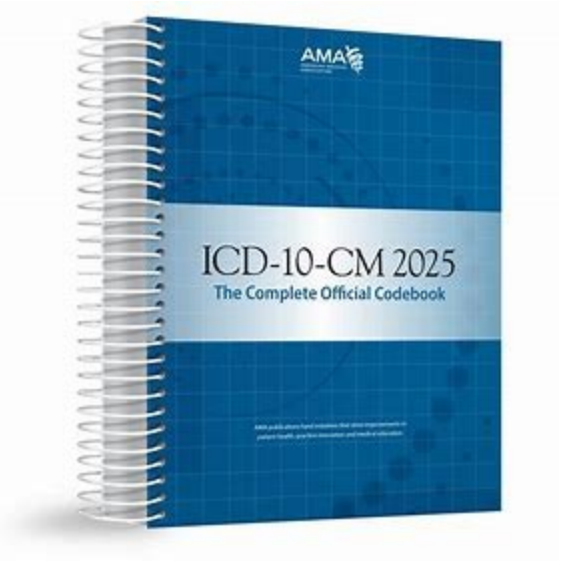
Source: *SimpleCORE™ – 3 months ending 3/31/2025*

Top 10 Excludes 1 Denials – Details

Trigger Code	Code Expanded	Excludes 1
R26.2	Difficulty in walking, not elsewhere classified	(R29.6) Falling; (R26.81) Unsteadiness on feet
R53.1	Weakness	(R54) Age-related weakness; (M62.8-) Muscle weakness; (R54) Senile asthenia
Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits	(Z87.820) Personal history of traumatic brain injury; (I69.-) Sequelae of cerebrovascular disease
R52	Pain, unspecified	(G89.-) Acute and chronic pain, not elsewhere classified; localized pain, unspecified type - code to pain by site; (F45.41) Pain disorders exclusively related to psychological factors
G31.84	Mild cognitive impairment of uncertain or unknown etiology	(R41.81) Age related cognitive decline; (R41.82) Altered mental status; (G31.9) Cerebral degeneration; (R41.82) Change in mental status; (I69.01, I69.11, I69.21, I69.31, I69.81, I69.91) Cognitive deficits following (sequelae of) cerebral hemorrhage or infarction; (S06.-) Cognitive impairment due to intracranial or head injury; (F01.-, F02.-, F03) Dementia; (F06.8) Mild memory disturbance; (R41.4) Neurologic neglect syndrome; (F68.8) Personality change, nonpsychotic
N39.0	Urinary tract infection, site not specified	(B37.4-) Candidiasis of urinary tract; (P39.3) Neonatal urinary tract infection; (N30.-) Urinary tract infection of specified site, such as: cystitis; (N34.-) Urethritis
I73.9	Peripheral vascular disease, unspecified	(I70.2--I70.7-) Atherosclerosis of the extremities
R55	Syncope and collapse	(R57.0) Cardiogenic shock; (G90.01) Carotid sinus syncope; (T67.1) Heat syncope; (F45.3) Neurocirculatory asthenia; (G90.3) Neurogenic orthostatic hypotension; (I95.1) Orthostatic hypotension; (T81.1) Postprocedural shock; (F48.8) Psychogenic syncope; (R57.9) Shock NOS; (O00-O07, O08.3) Shock complicating or following abortion or ectopic or molar pregnancy; (O75.1) Shock complicating or following labor and delivery; (I45.9) Stokes-Adams attack; (R40.2-) Unconsciousness NOS
Z73.6	Limitation of activities due to disability	(Z74.-) Care-provider dependency
R54	Age-related physical debility	(R41.81) Age-related cognitive decline; (F03) Senile psychosis; (R41.81) Senility NOS

Excludes 1 & 2 Denial Prevention

- Accurate documentation
- Understanding of/familiarity with ICD-10 CM
- Awareness of top Excludes 1 Codes
- Billing tools



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Approach for Excludes 1 & 2 Denials

- Excludes 1
  - Claim will need to be corrected and resubmitted
  - Documentation
    - Review Medical Record
    - Query Physician
- Excludes 2
  - Compare the medical record with the claim
  - Correct or Appeal

Other Coding Examples

- Fractures or Injuries
  - Primary diagnosis is the fracture
  - Surgical procedure is coded in MDS item J
- Elective Joint Replacements
  - Z47.1 Aftercare following joint replacement surgery
- Aftercare Codes
  - Z48.812 Encounter for surgical aftercare following surgery on the circulatory system
  - Z48.815 Encounter for surgical aftercare following surgery on the digestive system
- BMI Codes
  - Z68.41 – Z68.45 BMI 40-70 or greater, adult
  - Can be coded without a diagnosis of E66.01; however, MUST be supported by clinicians in the record
  - For MDS purposes, height within 365 days, and weight within 30 days, to calculate

Code Pairings – Orthopedic Aftercare – ICD-10 Manual

- Surgical Amputation Example (R AKA)
  - Code the orthopedic aftercare Z47.81 (orthopedic aftercare following surgical amputation)
  - This code refers you to specify the limb amputated in the Z89 series)
    - In this case, Z89.611 (acquired absence of right leg above knee)
- Joint Replacement Example (Left TKR)
  - Code the orthopedic aftercare Z47.1 (aftercare following joint replacement surgery)
  - This code refers to you specify the joint replaced in the Z96.6 series
    - In this case, Z96.652 (presence of artificial joint left knee)

Surgical Aftercare – Z48.xxx

Z48.81 Encounter for surgical aftercare following surgery on specified body systems

- These codes identify the body system requiring aftercare. They are for use in conjunction with other aftercare codes to fully explain the aftercare encounter. The condition treated should also be coded if still present.

  - ***Excludes1:*** *aftercare for injury- code the injury with 7th character D aftercare following surgery for neoplasm (Z48.3)*
  - ***Excludes2:*** *aftercare following organ transplant (Z48.2-) orthopedic aftercare (Z47.-)*

    - ***Z48.810*** *Encounter for surgical aftercare -* ***sense organs***
    - ***Z48.811*** *Encounter for surgical aftercare -* ***nervous system***
    - ***Z48.812*** *Encounter for surgical aftercare -* ***circulatory system***
    - ***Z48.813*** *Encounter for surgical aftercare -* ***respiratory system***
    - ***Z48.814*** *Encounter for surgical aftercare -* ***teeth or oral cavity***
    - ***Z48.815*** *Encounter for surgical aftercare -* ***digestive system***
    - ***Z48.816*** *Encounter for surgical aftercare -* ***genitourinary system***
    - ***Z48.817*** *Encounter for surgical aftercare -* ***skin and subcutaneous tissue***

ICD-10 Coding & PDPM

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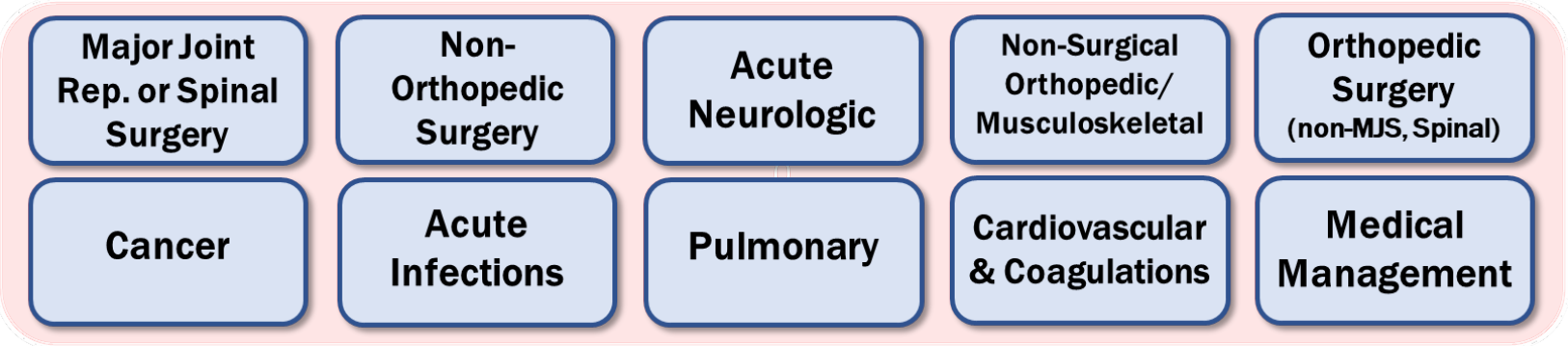
Mapping the Clinical Categories



- 10 clinical categories "mapped" from ICD-10-CM codes to capture the patient's primary diagnosis
- MDS item I0020B reports the patient's primary SNF diagnosis code
  - PDPM: primary reason for the skilled stay for *this* claim period
  - OBRA (in states that require): primary reason the resident is admitted/living in the SNF
  - MDS item I0020 is a "gateway" question – no direct impact on reimbursement

PT/OT: 10 Categories Collapsed into 4

Major Joint Replacement or Spinal Surgery

- Major Joint Replacement or Spinal Surgery

Non-Orthopedic Surgery & Acute Neurologic

- Non-Orthopedic Surgery
- Acute Neurologic

Other Orthopedic

- Non-Surgical Orthopedic / Musculoskeletal
- Orthopedic Surgery (Except MJR or Spinal)

Medical Management

- Cancer
- Pulmonary
- Acute Infections
- Cardiovascular and Coagulations
- Medical Management

PT/OT 1 of 16

SLP: 10 Categories Collapsed into 2

Acute Neurologic

Acute Neurologic

SLP 1 of 12

Non-Neurologic

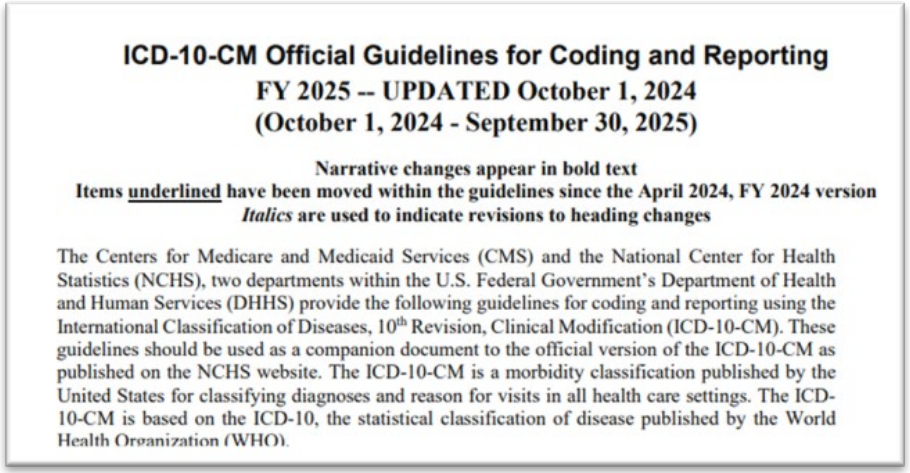
Major Joint Replacement or Spinal Surgery	Non-Orthopedic Surgery	Non-Surgical Orthopedic / Musculoskeletal
Orthopedic Surgery (Except MJR or Spinal)	Cancer	Pulmonary
Acute Infections	Cardiovascular and Coagulations	Medical Management

Primary Diagnosis Coding

- The ICD-10 Clinical Category Crosswalk will convert the ICD-10 code captured in I0020B into one of the 10 PDPM primary clinical categories
- Not all diagnoses are considered valid primary diagnoses for the SNF stay. Invalid primary diagnoses are listed as “return to provider” in the ICD-10 Clinical Category Crosswalk
- Clinical category may change depending on the presence of a surgical procedure from MDS section J during the immediately preceding hospital stay
- May or may not be the same as the primary diagnosis from the hospital stay
- May or may not be the highest-paying category

Primary Diagnosis Coding

- May not necessarily be the highest-paying diagnosis
- Orthopedic surgery, fractures, and Section J
- ICD-10-CM coding rules apply
  - Use ICD-10-CM Official Guidelines for Coding and Reporting for the correct fiscal year – always begins Oct. 1
  - Do not use online/internet searches
  - Smartphone apps
  - Google
  - Cheat sheets



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Primary Diagnosis Coding

I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

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. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

Diagnosis Coding for PDPM

- MDS Section I – diagnoses and conditions impact the following areas:
  - PT/OT clinical category classification
  - SLP clinical category classification
  - SLP-related comorbidities
  - Nursing categories
  - Non-therapy Ancillaries

SLP Comorbidities

SLP Comorbidities			
Aphasia	I4300	Laryngeal Cancer	I8000
CVA, TIA, or Stroke	I4500	Apraxia	I8000
Hemiplegia / Hemiparesis	I4900	Dysphagia	I8000
Traumatic Brain Injury	15500	ALS	I8000
Tracheostomy Care*	O0110E1b	Oral Cancers	I8000
Vent or Respirator Care*	O0110F1b	Speech & Lang Deficits	I8000

** while a resident*

Diagnoses and conditions under I8000 can be found in the SLP Comorbidity tab on the CMS ICD-10-CM Mapping tool

Nursing Case-Mix Classification

PDPM CATEGORY *with corresponding MDS Section*						Function Score: GG	Secondary End Split	RUG	CMI
EXTENSIVE SERVICES								*Urban Set*	
Tracheostomy care	O0110E1b	----- *AND* -----		Ventilator / Respirator	O0110F1b	0 - 14	Not Used	ES3	3.84
Tracheostomy care	O0110E1b	----- *OR* -----		Ventilator / Respirator	O0110F1b	0 - 14	Not Used	ES2	2.90
Isolation for active infectious disease	O0110M1b					0 - 14	Not Used	ES1	2.77
SPECIAL CARE HIGH (any one of these is a qualifier)									
Comatose (fully dep)	B0100	Fever with one of:	J1550A	Parenteral/IV feedings	K0520A2, 3	0 - 5	Depression	HDE2	2.27
Septicemia	I2100	Pneumonia	I2000	Respiratory Tx, 7 days	O0400D	0 - 5		HDE1	1.88
Diabetes with:	I2900	Vomiting	J1550B	COPD with:	I6200	6 - 14	Depression	HBC2	2.12
Daily insulin inj. &	N0350A	Feeding Tube*	K0520B3	Shortness of breath when lying flat	J1100C	6 - 14		HBC1	1.76
Insulin order changes > 1 day	N0350B	Weight loss	K0300	Quad as prim. (GG <12)	I5100	***Depression = MDS Section D PHQ***			

Nursing Case-Mix Classification (cont.)

PDPM CATEGORY *with corresponding MDS Section*						Function Score: GG	Secondary End Split	RUG	CMI
SPECIAL CARE LOW (any one of these is a qualifier)									
Cerebral Palsy (GG < 12)	I4400	Pressure Ulcers w/ Tx***:		Radiation therapy^	O0110B1b	0 - 5	Depression	LDE2	1.97
Multiple Scler (GG < 12)	I5200	> 1 Stage II	M0300B	Resp failure & Oxy Tx^	I6300, O0110C1b	0 - 5		LDE1	1.64
Parkinson's (GG < 12)	I5300	Any Stage III/IV/US d/t slough or eschar	M0300C,D,F	Dialysis^	O0110J1b	6 - 14	Depression	LBC2	1.63
Foot infection w/tx	M1040A; M1200I	2 or more skin tx*** w/:		Diabetic Foot Ulcer w/tx	M1040B; M1200I	6 - 14		LBC1	1.35
Feeding tube *	K0520B3	>1 ven/art ulcers; or	M1030	Foot lesions w/ Tx	M1040C; M1200I				
** = calories ≥ 51% or 26-50% & & fluid ≥ 501cc per day fluid enteral intake in the last 7 days*		1 Stage 2 pres ulcer &	M0300B	*^ = while a resident*					
		1 venous/arterial ulcer	M1030	**** = w/tx M1200A, B, C, D, E, G, H A&B = 1 tx even if both provided*		***Depression = MDS Section D PHQ***			
CLINICALLY COMPLEX (any one of these is a qualifier)									
Extensive Services, Special Care High or Special Care Low qualifier with GG Function Score = 15 - 16						0 - 5	Depression	CDE2	1.77
Pneumonia	I2000	Chemotherapy^	O0110A1b	Burns	M1040F	0 - 5		CDE1	1.53
Hemi-plegia/paresis*	I4900	IV medications^	O0110H1b	** = GG score < 12*		6 - 14	Depression	CBC2	1.47
Surgical wounds**	M1040E	Transfusions^	O0110I1B	*** = with treatment M1200F, G, or H*		15 - 16	Depression	CA2	1.03
Open lesions**	M1040D	Oxygen therapy^	O0110C1b	*^ = while a resident*		6 - 14		CBC1	1.27
				Depression = MDS Section D PHQ		15 - 16		CA1	0.89

Other Section I Diagnoses

- Require physician support in the 60 days prior to the ARD *and* support for the diagnosis as a current problem in 7-day ARD look-back period
- The RAI Manual states that diagnoses in parentheses in Section I are examples and not all-inclusive

Potential ICD-10 Coding Risks

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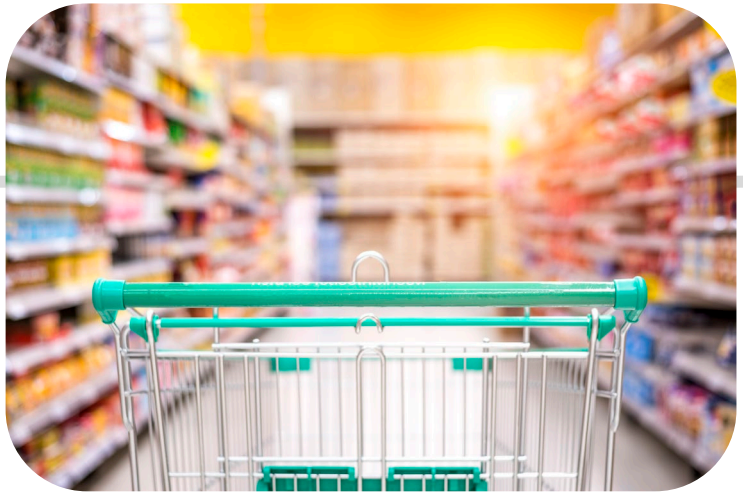
Diagnosis Shopping



Hemiplegia – via Google Search

Hemiplegia, unspecified affecting left dominant side

G81. 92 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. The 2022 edition of ICD-10-CM G81. 92 became effective on October 1, 2021.

G81 Hemiplegia and hemiparesis – ICD-10 Coding Manual - Tabular

G81 Hemiplegia and hemiparesis

Note: This category is to be used only when hemiplegia (complete)(incomplete) is reported without further specification, or is stated to be old or longstanding but of unspecified cause. The category is also for use in multiple coding to identify these types of hemiplegia resulting from any cause.

Excludes1: congenital cerebral palsy (G80.-)
hemiplegia and hemiparesis due to sequela of cerebrovascular disease (I69.05-, I69.15-, I69.25-, I69.35-, I69.85-, I69.95-)

Diagnosis Shopping (cont.)

- CVA (Cerebral Infarction) - Google Search or Hospital Record

> Cerebral infarction, unspecified
>
> **I63. 9** is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. The 2022 edition of ICD-10-CM I63. 9 became effective on October 1, 2021.

- CVA coding – Sequela – ICD-10 Official Guidelines for Coding and Reporting
  - Category I69, Sequelae of Cerebrovascular disease (Nontraumatic)
  - Category I69.xxx is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela. These "late effects" include neurological deficits that persist after the initial onset of conditions in I60-167 and may be present from the onset or may arise at any time after the onset.
  - *Examples may include hemiplegia, aphasia, dysphagia, and cognitive deficits, each of which has its own ICD-10 code relative to the type of cerebrovascular event that occurred.*

Using the PDPM Mapping Tool as a Code Book

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Physician Query

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When Should Physician Query Be Used?

- To support documentation of diagnoses or conditions that are evident in the medical record but do not have corresponding diagnoses documented
- For clarification when a diagnosis is not clinically supported
- To resolve conflicting documentation between providers
- To clarify the diagnosis to avoid default or unspecified ICD-10 codes
- To establish a condition as “active” or “history of,” or to determine ruled-in or ruled-out status
- To clarify a diagnosis noted by a non-physician clinical team member that the provider has not addressed
- When more specificity is needed to assign the most accurate and complete ICD-10 code

When Is a Physician Query Not Needed?

- To clarify the laterality of a diagnosis already documented by the provider
- When there is enough information in the medical record to assign a valid and accurate ICD-10 code

Compliant Queries

- Include multiple options that are supported by the medical record
- Must include non-leading statements
- Cannot include the impact on quality measures, reimbursement, Five-Star, or any other reportable data
- Multiple choice options should only include those supported in the medical record
- Multiple choice options should allow the provider to enter their diagnosis choice
- Should not lead the provider to a specific diagnosis
- The query is part of the resident's medical record and must be dated and signed by the provider

Query Templates Should:

- Include resident identification
- Be in an editable and customizable format
- Be worded clearly for the provider to review
- Include relevant information that supports the clinical indicators and their location in the medical record
- Offer multiple-choice answers that are clinically relevant to the resident's condition
- Choices offered that allow for accurate diagnosis and ICD-10 code assignment
- Offer the option for the provider to include their diagnosis option

Key Takeaways

- Use Official ICD-10-CM Coding Manuals for the correct fiscal year
- Check the April updates
- Follow the Coding Guidelines
- Don’t diagnosis shop online or use the PDPM Mapping Tool
- Watch those Excludes1 and Excludes2 rules
- Compliant physician query
- Supporting documentation
- Educate the IDC and medical team

References

- IDC-10:
  - https://www.cms.gov/medicare/coding-billing/icd-10-codes#
- FY 2025 ICD-10-CM Coding Guidelines:
  - https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf
- Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual:
  - https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual
- MDS 3.0 RAI Manual v1.19.1:
  - https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf
- Revised Long-Term Care (LTC) Surveyor Guidance memo QSO-25-14-NH:
  - https://www.cms.gov/files/document/qso-25-14-nh.pdf
- State Operations Manual Appendix PP:
  - https://www.cms.gov/files/document/qso-25-14-nh.pdf
- AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice (2022 Update):
  - https://ahima.org/media/51ufzhgl/20221212_acdis_practice-brief.pdf
- FY 2025 PDPM ICD-10 Mapping:
  - https://www.cms.gov/files/zip/fy-2025-pdpm-icd-10-code-mapping.zip
- ZHSG PDPM Support File 8/1/2024

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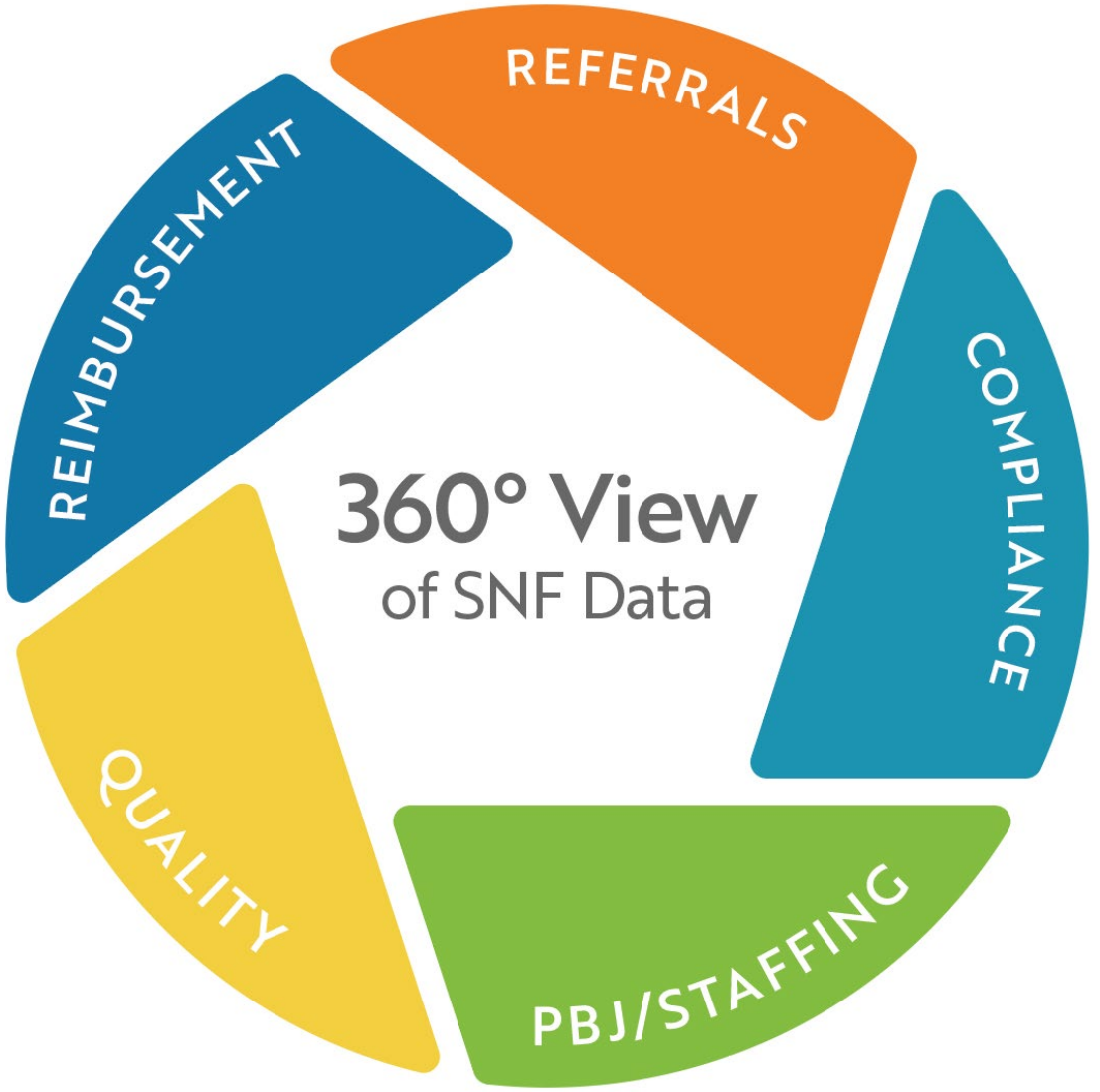

MDS predictive analytics.

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Thanks for joining us!

Recording/slides will be available soon at:

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