Long Term Care
Coding and Documentation

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Coding and Documentation LTC

CHANGING ENVIRONMENT

In 2017, The Medicare Access and CHIP Reauthorization Act of 2015 was implemented. Two tracks were formed: The Merit Based Incentive Program and Advanced Payment Models. Any provider filing claims in the nursing home as a Part B service must comply with MACRA. Many facilities have implemented Mid-Level Programs as a Part B service to offer wellness programs and improve care. These programs are all subject to MACRA.

Patients in a skilled nursing facility or hospital are attributed to the providers who are offering services through their medical practice. Exhibiting quality and reducing costs through accurate coding for primary care providers. MACRA is the quality/costs program for Medicare but all carriers, and Medicare Advantage programs have quality/costs programs.

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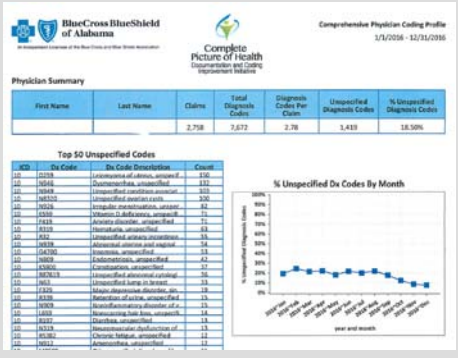
BlueCross BlueShield of Alabama

Complete Picture of Health
Documentation and Coding Improvement Initiative

Comprehensive Physician Coding Profile
1/1/2016 - 12/31/2016

Physician Summary

First Name	Last Name	Claims	Total Diagnosis Codes	Diagnosis Codes Per Claim	Unspecified Diagnosis Codes	% Unspecified Diagnosis Codes
		2,758	7,672	2.78	1,419	18.50%

Top 50 Unspecified Codes

ICD	Dx Code	Dx Code Description	Count
10	D259	Leiomyoma of uterus, unspecif	190
10	N946	Dysmenorrhea, unspecified	132
10	N949	Unspecified condition associat	103
10	N8350	Unspecified ovarian cysts	100
10	N926	Irregular menstruation, unspe	82
10	E559	Vitamin D deficiency, unspecifi	71
10	F419	Anxiety disorder, unspecified	71
10	R319	Hematuria, unspecified	63
10	R32	Unspecified urinary incontinen	59
10	N939	Abnormal uterine and vaginal	54
10	G4700	Insomnia, unspecified	53
10	N809	Endometriosis, unspecified	47
10	K5900	Constipation, unspecified	37
10	R7611	Unspecified abnormal cytologi	36
10	N63	Unspecified lump in breast	33
10	F329	Major depressive disorder, sin	28
10	R339	Retention of urine, unspecified	25
10	N949	Noninflammatory disorder of f	25
10	L409	Psoriasis, unspecified	24
10	R197	Diarrhea, unspecified	24
10	N319	Neuromuscular dysfunction of	23
10	R582	Chronic fatigue, unspecified	22
10	N912	Amenorrhea, unspecified	22

% Unspecified Dx Codes By Month

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Example: 68 year old man with pneumonia, emphysema, diabetes with retinopathy, and respiratory failure.

ICD 10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
J43.9: Other emphysema	0.346
J13.39 Diabetes with ophthalmic manifestations	0.368
J96.00: Acute respiratory failure	0.329
Demographic Component	
68 Year Old Male	0.288
Relative Risk Score	**1.531**

If this member's risk score is 1.531, he is 53 % more complex than the average patient.

One missing diagnosis code and one unspecified code reduces the relative risk score by 61%

ICD 10 Code	Relative Risk Score
J13: Pneumococcal pneumonia	0.200
~~J43.9: Other emphysema~~	~~0.346~~
E11.9 Diabetes without mention of complication	0.118
J96.00: Acute respiratory failure	0.329
Demographic Component	
68 Year Old Male	0.288
Relative Risk Score	**0.935**

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MIPS PERFORMANCE CATEGORY WEIGHTS

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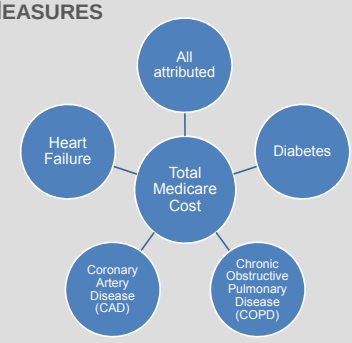
COST MEASURES



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CHALLENGES

- Great software for the nursing home or home health agency is not designed around the documentation needs of the physician or extender. The entire concept is different. Facility software is built around the incredibly detailed CMS Survey & Certification process in which exactitude in detail is paramount.
- The facility, pharmacy, and physician must share a patient's care at each change in condition and orders. Daily evaluation and assessment by the nursing team is essential in identifying patient changes. Communication between the nurses, mid-level providers and physicians is key to avoiding poor outcomes.

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OPPORTUNITIES

Many long-term care facilities are adding mid-level providers to assist in the care of the patients. Consistent care, wellness care and timely attention to acute illness allows the patient to reside in the facility as opposed to being sent to the hospital for emergent care.

Several workflows are available to document physician/mid-level services:

1. Paper forms- handwriting can be a problem
2. Electronic Medical Record- the physician may not be fluent with the facility EMR
3. Physician Office EMR through mobile app

GOAL: One concise and complete medical record

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PREVENTIVE SERVICES

There are a number of preventive services covered by Medicare that can be provided by physicians and mid-level providers in a nursing facility. These services will assure wellness is maintained along with preparation for end of life care.

- Medicare Annual Wellness Visit
- Glaucoma Screening
- Diabetes Screening
- Advanced Care Planning

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The NP's Role in Nursing Facilities

- NPs may perform the initial history and physical for new long-term care (non-skilled) admissions. NPs may also make additional visits, which must be substantiated based on the patient's need (ie, acute illness). Medicare provisions permit 1.5 visits per month; more than this frequency may invite increased scrutiny in the form of an audit. Medical necessity must be documented!

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The NP's Role in Nursing Facilities

- Assuming state law permits, Medicare allows NPs to help with monitoring and managing patient conditions, counseling patients and families, performing certain procedures, annual physical examinations, communication with hospital and community physicians, and discharge visits.

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Covered Services

- Medicare covers services an NP is "legally authorized to perform in accordance with State law." In addition, all of the following conditions must be met. Services must be:
- Considered as physician's services
- Furnished by a person who meets the NP qualifications
- Furnished in collaboration with an MD/DO as required by state law
- Within the NP's scope of practice as defined in state law
- Not otherwise precluded from coverage by Medicare law (eg, routine foot care)

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DOCUMENTATION CONCEPTS

- Type
- Temporal Parameters
- Caused by/ Contributing Factors
- Symptoms/Findings/ Manifestations
- Localization/Laterally
- Anatomy
- Associated with
- Severity
- Multiple Concept Examples

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OTHER CONCEPTS

- Episode
- Remission status
- History of
- Morphology
- External cause
- Activity
- Place of occurrence
- Substance
- Number/weeks of gestation
- Outcome of delivery
- BMI

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LOCALIZATION/LATERALITY

- Right
- Left
- Bilateral
- Distal
- Proximal
- Oblique

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Cerebrovascular Disorders (I60-I68)

- Care must be used to distinguish between a new or current cerebrovascular event (I60-I68) from a previous event (I69.-)
- Terms "stroke" or "CVA" should be further specified to indicate a hemorrhage, infarction, thrombosis, embolism, occlusion or stenosis.
- Current stroke or CVA would be coded to I63.9, Cerebral infarction, unspecified

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CVA with residuals (I69.-)

- ICD-10 removes the definitive timeframe for a condition to be considered a late effect of a condition
- Previous CVA with residuals treated at a different level of care should be coded as CVA with residuals upon admission
- I69 delineates the cause of the previous event (hemorrhage versus infarction, or unspecified
- Z86.73 = history of TIA and cerebral infarction without residual deficits

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Myocardial Infarctions (I21 – I24)

- Myocardial infarction is considered acute if less than 4 weeks from time of onset. (reference: Coding guideline C.6.e.1)
  - Residents admitted within 4 weeks of onset for continual treatment should be coded as acute.
  - Residents admitted after 4 weeks of onset for continual treatment should be coded with appropriate aftercare code
- Subsequent myocardial infarctions are coded as I22.-
- Healed or old MI's no requiring treatment are coded to I25.2

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Hypertension (I10-I15)

- Hypertension is coded to I10 when it is not complicated
- hypertensive heart disease (I11.-): Physician must indicate causal relationship
- hypertensive chronic kidney disease (I12.-): ICD-10 assumes causal relationship automatically
- Transient hypertension is coded to R03.0, Elevated blood pressure without diagnosis of hypertension, when a definitive diagnosis of hypertension has not been made

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Diabetes Mellitus (E08-E13)

Three types of diabetes: Type 1, Type 2, and secondary

- Coding Guideline C.4.a states: "Assign as many codes as needed to describe all complications of disease"
- Coding Guideline C.4.a.1 states: "Diabetes not mentioned as Type 1 or Type 2, will be coded as E11.- Type 2.
- Coding Guideline C.4.a.3 states: "If documentation does not mention type and insulin is used, code as E11.-, Type 2 Diabetes"

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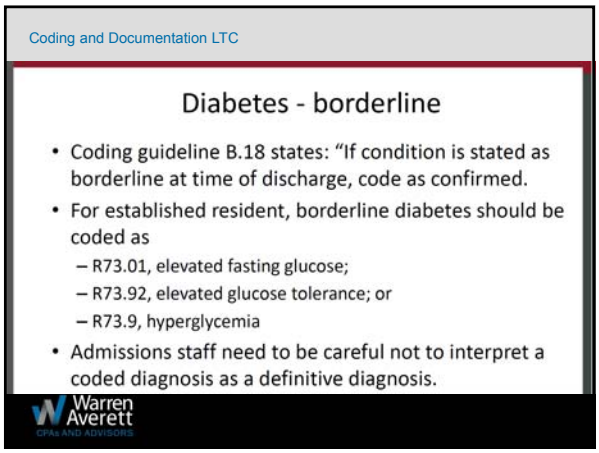
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Diabetes - borderline
• Coding guideline B.18 states: "If condition is stated as borderline at time of discharge, code as confirmed.
• For established resident, borderline diabetes should be coded as
– R73.01, elevated fasting glucose;
– R73.92, elevated glucose tolerance; or
– R73.9, hyperglycemia
• Admissions staff need to be careful not to interpret a coded diagnosis as a definitive diagnosis.
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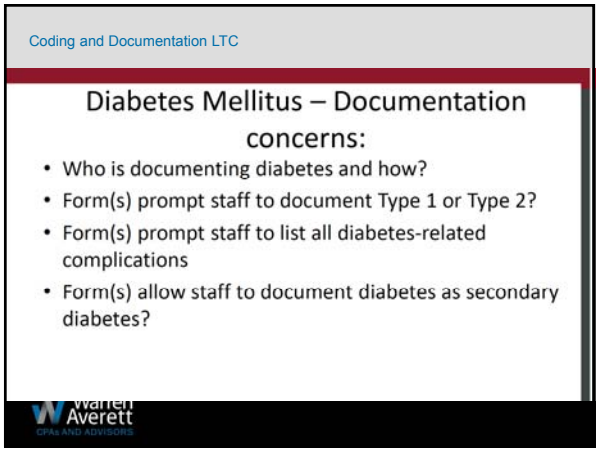
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Diabetes Mellitus – Documentation concerns:
• Who is documenting diabetes and how?
• Form(s) prompt staff to document Type 1 or Type 2?
• Form(s) prompt staff to list all diabetes-related complications
• Form(s) allow staff to document diabetes as secondary diabetes?
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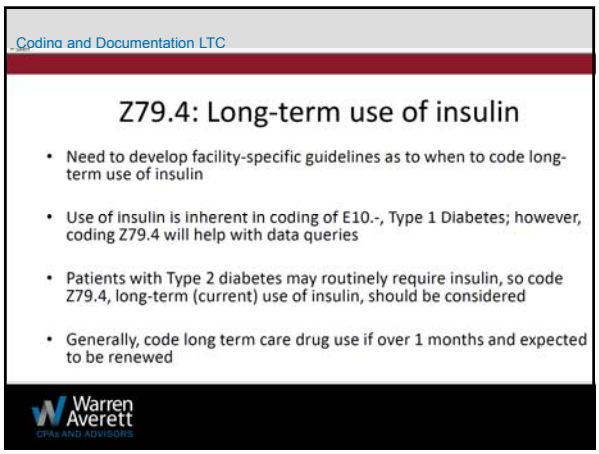
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Z79.4: Long-term use of insulin
• Need to develop facility-specific guidelines as to when to code long-term use of insulin
• Use of insulin is inherent in coding of E10.-, Type 1 Diabetes; however, coding Z79.4 will help with data queries
• Patients with Type 2 diabetes may routinely require insulin, so code Z79.4, long-term (current) use of insulin, should be considered
• Generally, code long term care drug use if over 1 months and expected to be renewed
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EXPANSION OF COMBINATION CODES

For example:

- Diabetes with ophthalmic manifestations, type 1, not stated as uncontrolled expands to 12 types of combination codes—
  - E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
  - E10.339 Type 1 diabetes mellitus with moderate non-proliferative diabetic retinopathy without macular edema

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Pressure Ulcers (L89.-)

Coding guideline C.12.a1 states: "L89.- includes combination codes to identify the site and stage of pressure ulcer. ICD-10 classifies stages based on severity: Stage I- IV, unspecified and unstageable. Assign as many codes from L89 to identify all pressure ulcers the resident has."

- Coding guideline C.12.a.2 states: "Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft)"

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Pressure Ulcers, continued

- Coding guidelines C.12.a.5 states: "Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record."
- Coding guidelines C.12.a.6 states: "If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site."

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Pressure Ulcers – Documentation concerns

- Who is documenting pressure ulcers and how?
- Form(s) allow for specific location of ulcer (left versus right)
- Form(s) allow for staging of ulcer?
- Form(s) allow for tracking of ulcer to show worsening?
- Form(s) allow for documentation of multiple pressure ulcers?

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Pressure Ulcer considerations:

- It is acceptable to use documentation by nursing staff for staging of pressure ulcers as long as diagnosis is validated by physician.
- If facility does not have skin care team for mapping of pressure ulcers, should identify specific form and/or individuals to use for documentation of staging. Goal is consistency in coding and interpretation of documentation
- Facility specific guidelines should indicate how frequently codes for pressure ulcers will be reviewed to ensure appropriate site and staging.

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Neurological deficits: Dominant/Nondominant side

- Coding guidelines C.6.a states:

"Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

  - For ambidextrous patients, the default should be dominant.
  - If the left side is affected, the default is non-dominant.
  - If the right side is affected, the default is dominant.

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Fractures

- Coding guideline C.19.c.1 states:
  - "A fracture not indicated as open or closed should be coded to closed."
  - "A fracture not indicated whether displaced or not displaced should be coded to displaced."
  - "Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture."
- Coding guideline C.21.c.7 states: "the aftercare Z code should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with appropriate 7th digit for subsequent encounter."

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Pathological fractures

- Pathological fracture and a traumatic fracture of the same bone/site should not be coded together
- Compression fractures occurring in patients with osteoporosis may be pathological. Query physician to confirm

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External Cause of Injury Codes

- Currently, there is not a requirement for long term care facilities to utilize codes to indicate the cause of injury
- However, these codes provide a great deal of information:
  - Cause of fall resulting in fracture
  - Complication of previous medical or surgical care
  - Victim of abuse or cataclysmic event
  - Status of individual in a transport accident

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Drug Resistant Infections

- ICD-10 distinguishs between Methicillin susceptible (MSSA) and Methicillin resistant *Staphylococcus aureus* (MRSA) infections
- It is important to distinguish between colonization or an active infection as colonization means infectious organism is present without causing a disease
  - Z22.322 – Carrier or suspected carrier of MRSA
  - Z22.321 – Carrier or suspected carrier of Methicillin susceptible staphylococcus aureus
- ICD-10 also has designation for history of MRSA (Z86.14)

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Drug Resistant Infections, continued

- ICD-10 provides several combination codes for MRSA or MSSA infections.
- If a combination code is not available, code the infection followed by the resistant (or susceptible) organism
- If an infection is listed as drug resistant, code infection followed by code from Z16.-, resistant to antimicrobial drugs
  - May be referred to as "multi-drug resistant"

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Miscellaneous Z-codes:

- Facility-specific coding guidelines must indicate when and if the following codes will be used:
  - Do Not Resuscitate status (Z66)
  - Carrier of infection diseases (Z22.-)
  - Personal history of neoplasm (Z85.-)
  - Long-term (current) drug use (Z79.-)
  - Acquired absence of limb (Z89.-)
  - Acquired absence of organ (Z90.-)
  - History of falling (Z79.81)
  - Artificial opening status (Z93.-)

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CONCLUSION

Clear, specific documentation supports accurate coding. Nursing Home residents may have constant updates to their health status which leads to changes in the problem lists.

"If it is not documented, it did not happen"

Supplying forms and systems to document accurately. Accountability for timeliness and accuracy will provide a good medical record for the

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Profile

Jim Stroud has been with Warren Averett since 1988 and is a member of the Firm's Healthcare Consulting Group. With over 30 years of accounting and consulting experience, Jim represents a diverse client base spanning various industries. Jim specializes in comprehensively serving medical practices, striving to make each practice operate as efficiently and effectively as possible. Jim facilitates monthly Practice Management Roundtables designed to identify and discuss feasible solutions to daily practice management issues. He also serves as facilitator for employee and physician retreats and is a frequent speaker to various medical groups.

Areas of special emphasis include:

- Strategic planning for medical practices
- Employee and physician retreats
- Business succession planning
- Profitability enhancement
- Retirement plan design
- Contractual arrangements
- Physician and staff compensation formula models and incentive plans

Professional affiliations include:

- American Institute of Certified public Accountants
- Alabama Society of Certified Public Accountants
- Birmingham Area Chamber of Commerce, Lifetime Member
- Local, State and National Medical Group Management Association Member

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Tammie Lunceford serves Warren Averett as a dental and healthcare consultant. She obtained her Bachelor of Science in Health Administration from UAB in 1995. Tammie is a Certified Professional Coder, CPC and registered with the American Society of Pathology as a medical laboratory technician, collectively bringing her clinical and administrative experience to more than 25 years. She has served in an Administrator or Director role in multiple specialties, with health systems, private practice, and medical management organizations. Tammie serves medical and dental practices by evaluating scheduling, patient flow, operational efficiencies, revenue cycle management, and EMR selection process and planning. In addition, she is knowledgeable with evaluating staff structure and compensation.

Professional Affiliations

- State and Local Medical Group Management Association
- American Society of Clinical Pathology
- American Association of Professional Coders

Designations and Certifications

Certified Procedural Coder

Education
Bachelor of Science in Health Administration
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