ICD-10-CM Coding Guidance for Long-Term Care Facilities

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Diagnostic coding plays several important roles in every healthcare setting, including long-term care (LTC) nursing facilities. Come October 1, 2015, LTC facilities will assign ICD-10-CM codes to capture a resident's clinical conditions.

ICD-10-CM facilitates the collection and organization of healthcare statistics on the incidence of diseases. Diagnostic coding is used to:

- Collect diagnostic and statistical data about people treated by healthcare providers
- Support clinical decision making
- Support reimbursement for services provided
- Comply with federal standards for reporting diagnostic data
- Provide data to support clinical research and quality improvement activities

HIPAA requires that healthcare providers, including LTC facilities, follow the guidance and direction in the ICD-10-CM code system and the "ICD-10-CM Official Guidelines for Coding and Reporting." LTC facility staff should be knowledgeable of ICD coding guidance to ensure appropriate billing and reimbursement. Knowledge of ICD coding guidance also will help ensure a smooth ICD-10-CM implementation on October 1, 2015.

LTC facilities must educate staff who work with or assign ICD-10-CM codes. Education should include coding rules and regulations related to proper code assignment, especially for principal diagnosis. This Practice Brief provides education on ICD-10-CM as well as guidance for determining the correct principal diagnosis in LTC facilities utilizing ICD-10-CM.

ICD-10-CM Coding and Reporting Guidelines

The "ICD-10-CM Official Guidelines for Coding and Reporting" is the companion document to the official version of ICD-10-CM as published on the National Center for Health Statistics (NCHS) website, publicly available for download. The guidelines are approved by the four organizations that make up the Cooperating Parties for ICD-10-CM: the American Hospital Association (AHA), American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), and NCHS. The guidelines are included in the official version of ICD-10-CM and also appear in *Coding Clinic for ICD-10-CM/PCS*, which is published quarterly by AHA.[1] *Coding Clinic* provides guidance on interpreting and applying the ICD-10-CM guidelines. HIPAA requires adherence to these guidelines when assigning ICD-10-CM diagnosis codes.[2]

The Cooperating Parties developed the LTC coding guidance in conjunction with the editorial advisory board for *Coding Clinic*. The guidance in *Coding Clinic* assists LTC facilities on how the ICD-10-CM Official Guidelines for Coding and Reporting should be interpreted and applied in the long-term care setting, as it was recognized that LTC services are dynamic, depend on many factors, and cover a longer time frame than acute care stays. The guidance was established in order to standardize data collection and assist coding professionals in LTC facilities.[3]

Assigning ICD-10-CM codes in LTC organizations is unique because residents often remain in facilities after their initial episode of illness is resolved. For example, a resident may be admitted to receive rehabilitation services for a healing hip fracture but be unable to return home and continues to reside in the facility for other chronic conditions such as Parkinson's disease, chronic obstructive pulmonary disease (COPD), or chronic kidney disease.

ICD-10-CM codes are assigned on admission and concurrently as diagnoses arise throughout a stay, often when the minimum data set (MDS) is updated. Codes can be assigned at different intervals, such as a resident's discharge, transfer, or expiration.

All diagnoses (i.e., additional diseases or conditions) that affect the resident's care are coded per coding guidelines. Diagnostic listing and sequencing will vary depending on the circumstances of the resident's admission or continued stay in the facility.

Principal Diagnosis Definition and Guidance

Similar to other providers, LTC facilities have varying rules and regulations that require coded data. At times, there may be a conflict in the requirements and terminology. For example, the term "primary diagnosis" is often used to indicate the reason for skilled Medicare services, which may not be the same reason for the resident's continued stay. The term "primary diagnosis," therefore, may conjure different definitions depending on the individual.

In the interest of consistency, the term "principal diagnosis" in this Practice Brief is used to indicate the principal, primary, and first-listed diagnosis. The sidebar on page 47 has additional information on the definitions. Section II of the ICD-10-CM Official Guidelines for Coding and Reporting defines the principal diagnosis and offers guidance on its selection. The Uniform Hospital Discharge Data Set defines principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[4]

This definition has been expanded to include all non-outpatient settings including LTC facilities. *Coding Clinic* further states that for residents who continue to stay in LTC facilities, the condition requiring the resident to stay should be sequenced first.[5] In determining the principal diagnosis, coding conventions in ICD-10-CM, the Tabular List, and the Alphabetic Index take precedence over these official coding guidelines.

Current LTC residents who transfer to the hospital to receive treatment for acute conditions (i.e., pneumonia) and return to the facility for further care of their chronic condition (i.e., COPD) may continue to receive care for the acute condition if unresolved. The principal diagnosis (first-listed) is the reason for the continued stay (i.e., COPD) in the nursing facility.

A newly diagnosed condition will be listed after the principal diagnosis to reflect new conditions that affect the resident. The principal diagnosis may or may not be the reason for Medicare skilled services.

Terms for Principal Diagnosis

LTC facilities have varying rules and regulations that require coded data. At times, there may be a conflict in the requirements and terminology. For example, the term "primary diagnosis" is often used to indicate the reason for skilled Medicare services, which may not be the same reason for the resident's continued stay. Therefore the term primary diagnosis may conjure different definitions, depending on the individual.

Below are the definitions of the different terms for principal diagnosis:

- **First-listed diagnosis:** The diagnosis that is sequenced first. Terms "principal" and "primary" are often used interchangeably to define the diagnosis that is sequenced first.
- **Principal diagnosis:** Condition established after study to be chiefly responsible for the patient's admission to the hospital. It is always the first-listed diagnosis on the health record and the UB-04 claim form. This direction applies to nursing homes as stated in the guidelines.
- **Primary diagnosis:** This term is often used to indicate the reason for the continued stay in the LTC facility. It is also used interchangeably with principal diagnosis.

Note: The Medicare Program Integrity Manual refers to the term "primary diagnosis" as the diagnosis that is the reason for therapy services. This diagnosis is currently referred to as the medical diagnosis for the therapy evaluation and plan of care and may or may not be the principal, primary, or first-listed diagnosis.

Principal Diagnosis in Other Regulations

The Medicare Program Integrity Manual refers to the term "primary diagnosis" as the diagnosis that is the reason for therapy services. This diagnosis is also known as the medical diagnosis.

The Therapy Evaluation and Plan of Care document for new Medicare Part A stays require the medical reason to support the therapy services as documented by the physician or qualified practitioner. The diagnosis code representing the medical reason may be identified as "primary diagnosis" or "medical diagnosis" on the therapy plan. This medical diagnosis may not be the same diagnosis as the reason for the continued stay (principal, primary, or first-listed diagnosis) in the facility.

For example, a patient with Parkinson's disease returns after a hospitalization for pneumonia to start a new Medicare Part A stay. Pneumonia is identified as the medical diagnosis on the therapy evaluation and plan of care to support the skilled therapy services along with the appropriate therapy treatment diagnoses. However, Parkinson's disease is the reason for the continued facility stay and continues to be sequenced first on the record and the UB-04. The reason for the new focus of care and Medicare Part A stay (i.e., pneumonia) is sequenced second.

The Resident Assessment Instrument (RAI) User's Manual provides instructions for reporting diagnoses that had an impact upon the development of individualized care plans for residents. Diagnoses are part of the MDS. Section I of the MDS 3.0, titled "Active Diagnoses," is intended to "code disease related to the resident's functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death."[6]

The term "code" in the MDS 3.0 does not hold the same specificity as an ICD-10-CM code. "Coding" the MDS is the process of assigning values (i.e., numbers, check marks, or dashes) to the MDS items which are more "groups" of ICD codes than directly relatable to the codes in a detailed breakdown. The MDS contains common active diagnoses sets or groups that are to be checked on the form if present in the resident record. However, a resident may have other conditions important to call out in support of care or services provided to the resident.

That said, ICD-10-CM diagnosis codes may be listed on the MDS if the diagnostic groups listed in Section I of the MDS does not allow for identification of a condition/diagnostic group that met the criteria listed above as having an impact upon the resident's functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, risk of death, or if more specificity is provided. It is important to remember the diagnoses on the MDS must meet additional timeframe requirements. Therefore, the documentation supporting the diagnoses must be current.

The Medicare Claim Processing Manual instructs LTC staff to follow HIPAA's guidance for adhering to instructions in ICD-10-CM and the official guidelines. Appendix A offers regulatory guidance on reporting diagnoses related to reimbursement.

Use of Z Codes in LTC Facilities

Assigning V codes in ICD-9-CM has long been an area of confusion and controversy in LTC facilities. Many facilities were told not to assign V codes as the principal diagnosis—or even at all. Most often this coding directive was handed down from the corporate office to the billing staff as being a directive issued by their Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC). Z codes in ICD-10-CM are synonymous with V codes in ICD-9-CM. The ICD-10-CM code set and the official guidelines provide specific instruction and guidance to both the coder and billing staff for appropriate use of Z codes in LTC facilities.

In long-term care, one of the most common reasons for initial admission is rehabilitation services (i.e., physical, occupational, and speech-language therapy).

In contrast to ICD-9-CM there is no equivalent code in ICD-10-CM for "Admission for, Encounter for, or Care involving rehabilitation procedures." According to *Coding Clinic*, "when a patient is admitted to the long term care facility specifically for rehab following an injury, assign the acute injury code with the appropriate 7th character (i.e., D for subsequent encounter) as the first-listed diagnosis."[7]

When a patient is being treated at the hospital for an acute medical condition (i.e., aspiration pneumonia), and is subsequently admitted to LTC for rehab, code the acute condition (aspiration pneumonia) as the first listed/principal diagnosis followed by any chronic conditions that will be treated at the SNF and/or those conditions that "have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatment, nursing monitoring or risk of death."[8]

Z codes will frequently be assigned for aftercare following surgical procedures performed in the hospital for which the patient is sent to the LTC facility to recover. Aftercare Z codes cover situations "when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease."[9]

Examples of aftercare codes include but are not limited to:

Z48.815 Aftercare following surgery of the digestive system (i.e., for a patient who had a cholecystectomy in an acute care hospital)

Z48.812 Aftercare following surgery on the circulatory system (i.e., repair of abdominal aortic aneurysm with Gortex graft performed in an acute care hospital)

Aftercare Z codes are not used for aftercare following injuries or fractures. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter). The aftercare codes are generally first-listed to explain the specific reason for the encounter. For example, for patients with traumatic fractures, the fractures are coded using the appropriate 7th character for subsequent care encounter after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.

Take for example the code S72.141D, Traumatic intertrochanteric fracture of right closed hip, subsequent episode of care, routine healing. The Official Coding Guidelines Section I.C.19.c states "A fracture not specified as open or closed is coded as closed; a fracture not stated as displaced or non-displaced is to be coded as displaced." In ICD-10-CM, there are no Z code aftercare codes for traumatic fractures, as one is instructed to assign the acute fracture code with the appropriate 7th character.

Coding Non-Traumatic Fractures in LTC with ICD-10-CM

The Official Coding Guidelines Section I.C.3.d.2 provides guidance on non-traumatic fracture coding. A code from category M80, Osteoporosis with current pathological fracture, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if the fall or trauma would not usually break a normal, healthy bone.

For example, consider a patient who has a ground level fall with a diagnosis of osteoporosis, resulting in a compression fracture of the lumbar vertebrae. The patient was sent to the SNF and would be coded as M80.08xD, Age related osteoporosis with current pathological fracture, vertebrae, subsequent encounter with routine healing.

Status Z Codes Used to Add More Information

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example, a patient had a coronary artery bypass graft (CABG) at the hospital immediately preceding the LTC stay and is sent to the SNF for rehab. The codes for this patient would be:

- Z48.812 Aftercare following surgery on the circulatory system
- Z91.1 Presence of CABG

Continued Treatment of Acute Conditions in the LTC Facility

Any acute condition treated at the hospital that continues to require follow up or ongoing monitoring should be coded with an acute diagnosis code as long as the condition persists and requires follow up. In general, the status of the acute condition would be assessed whenever the MDS is updated (i.e., patient status change or at monthly review for billing).

Codes for the acute medical condition treated and resolved in the hospital are assigned and reported by the hospital (i.e., cholecystitis, abdominal aortic aneurysm) but not coded or reported in the LTC facility. The LTC facility reports Z codes to identify the provision of aftercare. It is inaccurate to report an acute code for a resolved condition on the health record or claim because it directly contradicts the Official Guidelines for Coding and Reporting. It is also non-compliant with HIPAA regulations.

Diagnosis List and UB-04 Claim Form

Residents in LTC facilities often have numerous chronic conditions. The diagnosis list is a comprehensive listing of these numerous conditions, which are often sequenced in order of focus and complexity of care for the resident.

The number of diagnoses listed can be extensive and may exceed current reporting capacity with the implementation of the UB-04 (Universal Billing Form, version 5010) on January 1, 2012, which only allows for 25 codes.

Prior to submission of the UB-04 claim, facilities must validate that the ICD-10-CM diagnoses reported on the claim are consistent with the health record documentation and MDS information. This is commonly referred to as a triple-check process. Reporting ICD-10-CM diagnosis codes supported by health record documentation and the MDS will support the claim submitted for therapy services. The facility's reimbursement is determined by the Resource Utilization Group (RUG) category based on the MDS assessment data. The triple-check process ensures that the diagnosis data submitted for each payment mechanism is consistent.

The principal diagnosis is located in fields 67A and 69 on the claim form. There is no strict hierarchy inherent in the ICD-10-CM guidelines regarding the sequencing of secondary diagnosis codes.[10] When diagnoses are sequenced together following instructions such as "use additional code" or "code underlying condition first," the official guidance does not require that the secondary diagnosis code be reported immediately following the code for the related condition. This allows flexibility in selecting the additional diagnoses. However, the sequencing of diagnoses should paint the picture of the need for skilled care.

Facilities are not required to report additional diagnoses on the UB-04 in the order in which they are listed on the diagnosis list. Appendix A of this Practice Brief offers regulatory guidance on reporting diagnoses related to reimbursement.

Medicare Part B Therapy Services

Medicare Part B therapy services also require medical necessity for treatment, identified by a medical diagnosis. The diagnosis must be reasonable and necessary. The medical diagnosis that identifies the reason for the Part B therapy services should be listed on the MDS after the reason for the continued stay. Other ICD-10-CM codes for chronic conditions that affect the resident's progress may also be reported to support therapy services. In addition, ICD-10-CM codes representing the medical condition that required the treatment are used when there is no code representing the treatment.

Section IV in the official guidelines clearly states that the coding guidelines for outpatient diagnoses have been approved for use by hospitals and providers to code and report hospital-based outpatient services and provider-based office visits. They are not used for Part B therapy services for residents in LTC facilities because nursing homes are identified as a non-outpatient setting in section II.[11]

For a current resident receiving Part B therapy services, the principal or first-listed diagnosis reported on the UB-04 is the reason for the continued stay in the LTC facility. Data fields on the UB-04 (such as bill type, specific line items for therapy services, and the appropriate medical and treatment diagnoses) along with accurate and complete documentation in the health record will support appropriate reimbursement for Medicare Part B services.

Medical Reviews

With the increase in third-party audits from entities such as the Office of Inspector General (OIG), recovery auditors, and Medicaid Integrity Contractors, it is imperative that LTC facilities understand the ICD-10-CM guidelines for coding and reporting as required by HIPAA.

In its Compliance Program Guidance for Nursing Facilities, OIG recommends that a nursing facility take all reasonable steps through its policies and procedures to ensure compliance with the federal healthcare programs when submitting information that affects reimbursement decisions. It states:

> A key component of ensuring accurate information is the proper and ongoing training and evaluation of the staff responsible for coding diagnoses and regular internal audits of coding policies and procedures. With the arrival of

consolidated billing and the next edition of the coding manuals, it will be even more critical that knowledgeable individuals are performing these coding tasks. The risk areas associated with billing and cost reporting have been among the most frequent subjects of investigations and audits by the OIG.[12]

In order to ensure compliance, LTC facilities must have sound coding policies and procedures, including the current edition of the ICD-10-CM Official Guidelines for Coding and Reporting and a current subscription to AHA's *Coding Clinic*. Lack of these resources may result in improper coding and reporting, thus resulting in inaccurate data.

Ensuring accurate coded data will continue to play an important role in the LTC industry. Credentialed HIM professionals possess valuable knowledge and expertise that will benefit LTC facilities, especially as the industry prepares for ICD-10-CM.

Notes

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. "ICD-10-CM Official Guidelines for Coding and Reporting 2014." www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf.

[2] Centers for Medicare and Medicaid Services. "Standards for Electronic Transactions – New Versions, New Standard and New Code Set – Final Rule." September 26, 2014. www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/TransactionsandCodeSetsRegulations.html.

[3] American Hospital Association. *Coding Clinic for ICD-9-CM* (Fourth Quarter 2012): 90-98.

[4] Centers for Disease Control and Prevention, National Center for Health Statistics. "ICD-10-CM Official Guidelines for Coding and Reporting 2014."

[5] American Hospital Association. *Coding Clinic for ICD-9-CM* (First Quarter 2005): 93-94.

[6] Department of Health and Human Services, Office of Inspector General. "Office of Inspector General's Compliance Program Guidance for Nursing Facilities. Section II.B.2.c." *Federal Register* 65, no. 52 (March 16, 2000). http://oig.hhs.gov/authorities/docs/cpgnf.pdf.

[7] American Hospital Association. *Coding Clinic for ICD-9-CM* (Fourth Quarter 2012): 90-98.

[8] Centers for Medicare and Medicaid Services. "RAI Version 3.0 Manual." www.cms.gov/NursingHomeQualityInits/Downloads/MDS30RAIManual20100127.zip.

[9] Centers for Disease Control and Prevention, National Center for Health Statistics. "ICD-10-CM Official Guidelines for Coding and Reporting 2014."

[10] Ibid.

[11] Ibid.

[12] Department of Health and Human Services, Office of Inspector General. "Office of Inspector General's Compliance Program Guidance for Nursing Facilities. Section II.B.2.c."

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Appendix A: Regulatory Guidance for Reporting Diagnoses Related to Reimbursement

In August 2000, the HIPAA Transaction and Code Sets required the use of the ICD-9-CM code set. Subpart J, section §162.1002 Medical data code sets, states the adoption of the following code sets as standard medical data code sets:

- ICD-9-CM, volumes 1 and 2 (including the "ICD-9-CM Official Guidelines for Coding and Reporting").

ICD-9-CM, volume 3, Procedures, to be used for hospital inpatients reported by hospitals only. ICD-9-CM procedure codes are never assigned in long-term care facilities.

On January 16, 2009, HHS published the final rule for adoption of ICD-10-CM/PCS as the medical data code sets.

The **Medicare Claims Processing Manual** provides direction on how to comply with the HIPAA Transaction and Code Sets in specific chapters. These include:

Chapter 6, "SNF Inpatient Part A Billing and SNF Consolidated Billing" (Rev. 1757, 06-19-09) Section 30, "Billing SNF PPS Services;" (Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08).

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows:

- Principal diagnosis code: SNFs enter the ICD-CM code for the principal diagnosis *in the appropriate form locator*. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-CM diagnosis code, including all five digits for ICD-9-CM or up to seven characters in ICD-10-CM where applicable.
- Other diagnosis codes required: The SNF enters the full ICD-CM codes for additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

Chapter 23, Fee Schedule Administration and Coding Requirements (Rev. 1717, 04-26-09), Section 10, "Reporting ICD Diagnosis and Procedure Codes" (Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08), 10.2, "Relationship of ICD Codes and Date of Service."

- The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD diagnosis codes are a medical code set, effective for dates of service on and after October 1, 2004, CMS does not provide any grace period for providers to use in billing discontinued diagnosis codes on Medicare claims.

Appendix B: Coding Self Assessment

The following 25 scenarios are typical in the long term care setting. Each coding scenario offers a specific coding case with specific conditions being treated.

> **Principal Diagnosis:** is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Additional information regarding the definition and use of principal diagnosis may be found in the Practice Brief: ICD-10 Guidance for Long Term Care.

1. Patient admitted from hospital following an elective total right hip replacement for DJD. During the hospital stay the patient was transfused with 2 units of blood for acute blood loss anemia and continued to be anemic on iron supplements. Following surgery, the patient was placed on Coumadin for DVT prophylaxis until such time the patient was ambulatory. Patient was sent with orders for PT and OT, check PT/INR 2 x week, and CBC in 2 weeks.

   Code(s): _____

2. Patient admitted to the hospital following a fall with diagnosis of pathologic intertrochanteric fracture of the right hip which was treated with ORIF. Patient has additional diagnoses of depression, HTN, chronic compression fractures of T11-12 due to osteoporosis, stage 3 chronic kidney disease, and a history of falls. Sent to SNF for PT & OT rehab.

Code(s): _____

3. Patient admitted from hospital following AAA repair with graft. During hospitalization patient was also noted to have CKD stage 2, hyperlipidemia, PVD, CAD with history of prior MI 2010, history CABG x 3 in 2008. Patient sent to SNF for rehab.

   Code(s): _____

4. Patient admitted to hospital with generalized weakness, history of recent falls and failure to thrive. Patient admitted to SNF for ongoing PT and OT.

   Code(s): _____

5. Patient admitted to SNF for hospice care with diagnoses of history of cancer of lung with brain metastasis. Patient is on Dilantin for seizures thought to be related to brain metastasis. Patient has history of RLL pneumonectomy, history of radiation therapy and chemotherapy. In addition, the patient has chronic diagnoses of chronic systolic CHF and anemia due to neoplastic disease.

   Code(s): _____

6. Resident admitted with diffuse weakness due to underlying dementia, chronic atrial fibrillation on chronic Coumadin therapy, COPD with acute exacerbation and a history of breast cancer with Tamoxifen prescribed. Resident has orders for PT and OT and PT/INR checks, Oxygen at 2 liters and Prednisone for COPD.

   Code(s): _____

7. Patient was admitted to the hospital with slurred speech, facial droop, and change in mental status. Testing revealed an acute embolic cerebral infarction. While hospitalized, the patient received treatment for hypertension and hyperlipidemia. Due to the patient's inability to swallow, a PEG tube was placed. Discharge diagnosis was documented as follows: Embolic CVA with cognitive deficit, facial droop and oropharyngeal dysphagia; Hypertension; Hyperlipidemia. Patient is now being admitted to the SNF with orders for PT, OT, and ST, tube feedings. Med orders include Plavix, Hytrin, and Lipitor. What are the appropriate codes for the SNF admission?

   Code(s): _____

8. Resident being admitted to the SNF following a hospital stay for acute stroke. Documentation shows right non-dominant hemiplegia, as well as stroke related vertigo and seizure disorder. Additional diagnoses include GERD, Rheumatoid Arthritis, Allergic Rhinitis and multi-infarct dementia. Resident has orders for PT and OT, as well as med orders for all these diagnoses. What are the appropriate codes?

   Code(s): _____

9. Resident admitted to the nursing home following hospitalization for acute osteomyelitis and gangrene due to a chronic non-healing decubitus ulcer stage IV of the left heel. Long-term antibiotic therapy is continued for the osteomyelitis in the heel and for a stage II left buttock pressure ulcer. The resident has Type I diabetes with PVD, stage IV CKD, HTN and status post right above the knee amputation. Past medical history also includes gout with tophi on Colchicine, ASCVD, hypercholesterolemia and chronic alcoholism in remission.

   Code(s): _____

10. Long term resident with MS admitted for a UTI due to E. Coli, history of recurrent UTI's with long-term antibiotic therapy prophylaxis

Code(s): _____

11. Resident is admitted for OT and PT following a left knee replacement surgery due to osteoarthritis of the left knee. Resident also has osteoarthritis of the bilateral hips and shoulders.

    Code(s): _____

12. Resident has vancomycin-resistant acute respiratory infection. A PICC line has been placed to administer IV antibiotics which the physician has noted will be used indefinitely. Orders include IV antibiotics and flushing of the PICC line. What diagnosis code(s) are assigned?

    Code(s): _____

13. Resident with ESRD on dialysis with hypertension.

    Code(s): _____

14. Resident with PVD secondary to Type I diabetes mellitus with diabetic ulcers of right ankle and calf. Focus of care is on the ulcers.

    Code(s): _____

15. Resident has dementia with delusions and depression, and is incontinent of both bowel and bladder due to the cognitive impairment.

    Code(s): _____

16. Resident has chronic diastolic congestive heart failure with left ventricular failure and pulmonary edema. Resident did have recent exposure to tuberculosis. Resident also has diagnoses of ischemic cardiomyopathy, mitral valve regurgitation and aortic valve stenosis.

    Code(s): _____

17. Resident admitted to SNF from acute inpatient rehab facility following hospitalization for evacuation of acute subdural hematoma due to head trauma from fall at home to continue PT, SP and OT for residuals of mild memory disturbance and gait ataxia.

    Code(s): _____

18. Resident admitted to SNF for therapy services post hospitalization for acute coronary syndrome which was diagnosed as an acute non-ST elevation myocardial infarction (NSTEMI MI). Resident had a cardiac catheterization with placement of stents in blocked vessels due to coronary artery disease. Resident also has HTN, dyslipidemia, glaucoma and wears a hearing aide in both ears.

    Code(s): _____

19. Resident admitted to SNF following right lobectomy and excision of sentinel lymph node with metastasis to lymph node. Resident will return in 2 weeks to oncologist to start chemo and radiation therapy.

    Code(s): _____

20. Resident admitted to SNF following ER visit and overnight stay at the hospital in observation for fracture distal right radius and ulna related to fall at home. A cast was placed in the ER before the resident transferred to the SNF. Resident had lived alone and has mild cognitive impairment. Resident admitted with order for occupational therapy.

Code(s): _____

21. Patient admitted following laminectomy and spinal fusion for lumbar spinal stenosis and spondylosis. Patient to have dressing changed and sutures removed in 2 weeks.

    Code(s): _____

22. Patient was hospitalized for a below-the-knee amputation of the left leg. Following surgery, he developed an infection of the amputation stump which was treated during the hospitalization and the antibiotics were complete at the time of discharge. The patient is now admitted to the nursing facility for dressing changes.

    Code(s): _____

23. **EPISODE A:** Resident is admitted to NH following hospitalization for dehydration due to UTI with staphylococcus aureus. Resident is admitted for therapies due to weakness following the UTI and to complete the course of the antibiotics in the NH. Resident has progressing Parkinsonism dementia and will remain in facility. Medical history includes mitral valve regurgitation with aortic valve stenosis, kyphosis, mild asthma, insulin resistance and overweight.

    Code(s): _____

24. **EPISODE B:** Six months later the resident continues to remain in the facility because of the progressing Parkinsonism dementia.

    Code(s): _____

25. **EPISODE C:** Nine months following admission, the resident develops pneumonia requiring a hospital stay. The resident returns to the facility following a 3-day stay to receive PT and OT for weakness and to complete the course of antibiotics.

    Code(s): _____

Appendix C: Coding Self Assessment Answers

The following 40 scenarios are typical in the long term care setting. Each coding scenario offers a specific coding case with specific conditions being treated and corresponding codes with primary diagnosis.

> **Principal Diagnosis:** is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Additional information regarding the definition and use of principal diagnosis may be found in the Practice Brief: ICD-10 Guidance for Long Term Care.

	Scenario	Principal Diagnosis Description (Index Entry)	Principal Diagnosis Rationale	Secondary Diagnosis Description	Secondary Diagnosis Rationale
1	Patient admitted from hospital following an elective total right hip replacement for DJD. During the hospital stay the patient was transfused with 2 units	**Z47.1 Aftercare following joint replacement** *Aftercare; following*	The ICD-10-CM Official Guidelines for Coding and Reporting section II. K states that when the purpose for the	**D62 Acute posthemorrhagic anemia** *Anemia; blood loss; acute.* **D50.9 Iron deficiency anemia, unspecified**	D62: RATIONALE: The patient is still receiving iron supplements hence the anemia is still being treated and needs to be

	of blood for acute blood loss anemia and continued to be anemic on iron supplements. Following surgery, the patient was placed on Coumadin for DVT prophylaxis until such time the patient was ambulatory. Patient was sent with orders for PT and OT, check PT/INR 2 x week, and CBC in 2 weeks.	*surgery; joint replacement*	admission is for rehabilitation, to sequence first the code for the condition for which the service is being delivered. There is a "use additional code" note to identify the joint replaced.	*Anemia; iron deficiency.* **Z96.641 Presence of right artificial hip Joint** *Presence; implanted device (artificial); joint; hip* **Z79.01 Long term (current) use of anticoagulants** *Long Term; anticoagulants.* **Z51.81 Encounter for therapeutic drug level monitoring** *Monitoring (encounter for); therapeutic drug level*	coded. D50.9 RATIONALE: Patient is being treated with iron for iron deficiency anemia. Excludes notes do not allow the coder to select Iron Deficiency Anemia secondary to blood loss since D62 is selected to describe the acute posthemorrhagic anemia. Z96.641 RATIONALE: Under Z47.1 there is a "use additional code" note to identify the joint replaced. Laterality can be found in the Tabular List. Z79.01 RATIONALE: Patient is admitted on Coumadin for DVT prophylaxis Z51.81 RATIONALE: Code also note under Z79.01 instructs the coder to code the monitoring code if applicable. The patient is having PT/INR checked twice a week.
2	Patient admitted to the hospital following a fall with diagnosis of pathologic intertrochanteric fracture of the right hip which was treated with ORIF. Patient has additional diagnoses of depression, HTN, chronic compression fractures of T11-12 due to osteoporosis, stage 3 chronic kidney disease, and a history of falls. Sent to SNF for PT & OT rehab.	**M80.051D Age-related osteoporosis with current pathological fracture, right femur, subsequent encounter for fracture with routine healing.** *Osteoporosis; age-related; with current pathologic fracture; pelvis*	Osteoporosis is a systemic disease. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone. Osteoporosis NOS codes to age-related osteoporosis. There is no entry in the alphabetic index for hip or femur, so the closest body part would be the pelvis or ischium. The	**I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease** *Hypertension, hypertensive; kidney; with; stage 1 through stage 4 chronic kidney disease* **N18.3 Chronic kidney disease, stage 3 (moderate)** *Disease; kidney; chronic; stage 3 (moderate)* **F32.9 Major depressive disorder, single episode, unspecified** *Depression (acute)(mental)* **Z91.81 History of falling** *History; personal (of); fall, falling* **Z87.310 Personal history of (healed) osteoporosis fracture**	I12.9/N18.3 RATIONALE: The ICD-10-CM Official Guidelines for Coding and Reporting section I.C.9.a.2 states there is a presumed cause and effect relationship between hypertension and chronic kidney disease. It also states that a code from N18 should be assigned to identify the stage of chronic kidney disease. F32.9 RATIONALE: Patient has depression with no other clarification. Z91.81 RATIONALE: Patient has documented history of falls. Z87.310 RATIONALE: Patient has chronic compression fractures of

			tabular has the option for right femur.	*History; personal (of); fracture (healed); osteoporosis*	the thoracic spine due to the osteoporosis.
3	Patient admitted from hospital following AAA repair with graft. During hospitalization patient was also noted to have CKD stage 2, hyperlipidemia, PVD, CAD with history of prior MI 2010, history CABG x 3 in 2008. Patient sent to SNF for rehab.	**Z48.812 Encounter for surgical aftercare following surgery on the circulatory system** *Aftercare (see also Care), following surgery (for) (on), circulatory system*	The ICD-10-CM Official Guidelines for Coding and Reporting state that aftercare codes are used when "the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease."	**N18.2 Chronic kidney disease, stage 2 (mild)** *Disease, diseased; kidney; chronic; stage 2 (mild)* **I73.9 Peripheral vascular disease, unspecified** *Disease, diseased; peripheral; vascular NOS* **I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris** *Atherosclerosis (see also Arteriosclerosis); coronary; artery* **E78.5 Hyperlipidemia, unspecified** *Hyperlipemia, hyperlipidemia* **I25.2 Old myocardial infarction** *History; personal (of); myocardial infarction (old)* **Z95.1 Presence of aortocoronary bypass graft** *Presence (of); aortocoronary (bypass) graft* **Z95.9 Presence of cardiac and vascular implant and graft, unspecified** *Presence (of); intravascular implant (functional) (prosthetic) NEC*	N18.2 RATIONALE: Patient has CKD stage 2. I73.9 RATIONALE: Patient has documented PVD. I25.10 RATIONALE: Patient has documented CAD. It is not noted if it affects a native vessel of graft from the CABG. Therefore the native artery is coded. E78.5 RATIONALE: Patient has documented hyperlipidemia. I25.2 RATIONALE: Patient had a MI in 2010. Z95.1 RATIONALE: Patient had a CABG in 2008. Z95.9 RATIONALE: Patient had the AAA repair with graft. This code captures the presence of the graft material.
4	Patient admitted to hospital with generalized weakness, history of recent falls and failure to thrive. Patient admitted to SNF for ongoing PT and OT.	**R53.1 Weakness** *Weak, weakening, weakness (generalized)*	In ICD-10-CM, there is not a separate code to identify admission to a long-term care facility for physical, occupational, or speech therapy. Coding Clinic 4th Quarter 2012, pages 90-98 state that when a patient is admitted	**R62.7 Adult failure to thrive** *Failure, failed; to thrive; adult* **Z91.81 History of falling** *History; personal (of); fall, falling*	R62.7 RATIONALE: Patient has documented failure to thrive. Z91.81 RATIONALE: Patient has a documented history of falling.

			to a long-term care facility for nonspecific reasons rather than a specific diagnosis, it is appropriate to assign codes for the symptoms.		
5	Patient admitted to SNF for hospice care with diagnoses of history of cancer of lung with brain metastasis. Patient is on Dilantin for seizures thought to be related to brain metastasis. Patient has history of RLL pneumonectomy, history of radiation therapy and chemotherapy. In addition, the patient has chronic diagnoses of chronic systolic CHF and anemia due to neoplastic disease.	**C79.31 Metastatic Cancer of Brain** *Neoplasm Table; brain; malignant secondary column*	The patient no longer has lung cancer; only the metastasis to the brain. The brain malignancy is the reason for the hospice care and therefore is sequenced first.	**D63.0 Anemia in neoplastic disease** *Anemia; in (due to) (with); neoplastic disease* **Z51.5 Encounter for palliative care** *Care; Palliative* **I50.22 Chronic systolic (congestive) heart failure** *Failure; heart; systolic; chronic (congestive)* **G40.909 Epilepsy, unspecified, not intractable, without status epilepticus** *Seizure(s); disorder* **Z85.118 Personal history of other malignant neoplasm of bronchus and lung** *History; personal (of); malignant neoplasm; lung NEC* **Z79.899 Other long term (current) drug therapy** *Long term (current) (prophylactic); drug specified, NEC* **Z51.81 Encounter for therapeutic drug level monitoring** *Monitoring (encounter for); therapeutic drug level* **Z90.2 Acquired absence lung [part of]** *Absence; lung; acquired (any part)* **Z92.3 Personal history of irradiation**	D63.0 RATIONALE: Patient has documented anemia that is specified as due to neoplastic disease. Z51.5 RATIONALE: The patient is admitted for Hospice care, which is palliative care. I50.22 RATIONALE: Patient has chronic CHF which is specified as systolic. G40.909 RATIONALE: Patient has seizures caused by the brain metastasis. Z85.118 RATIONALE: Patient has a history of lung cancer that had been removed and is no longer present. Z79.899 RATIONALE: Patient is receiving Dilantin for the seizures. Z51.81 RATIONALE: The Dilantin levels have to be monitored so that patient is not getting too much or too little. Coding note under Z51.81 states to code also long-term (current) drug therapy (Z79.-) Z90.2 RATIONALE: This is for the RLL pneumonectomy done prior to patient admission to SNF Z92.3 RATIONALE: This is for the documented radiation therapy done prior to patient admission to SNF

				History; personal (of); radiation therapy **Z92.21 Personal history of antineoplastic chemotherapy** *History; personal (of); drug therapy; antineoplastic chemotherapy*	Z92.21 RATIONALE: This is for the documented chemo therapy done prior to patient admission to SNF
6	Resident admitted with diffuse weakness due to underlying dementia, chronic atrial fibrillation on chronic Coumadin therapy, COPD with acute exacerbation and a history of breast cancer with Tamoxifen prescribed. Resident has orders for PT and OT and PT/INR checks, Oxygen at 2 liters and Prednisone for COPD.	**F03.90 Unspecified dementia without behavioral disturbance** *Dementia (degenerative (primary)) (old age) (persisting)*	The patient's dementia is the underlying etiology for the weakness and the primary reason for the SNF stay.	**J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation** *Disease, diseased; pulmonary; chronic obstructive; with; exacerbation (acute)* **R53.1 Weakness** *Weak, weakening, weakness (generalized)* **I48.2 Chronic atrial fibrillation** *Fibrillation; atrial or auricular (established); chronic* **Z79.01 Long-term (current) use of anticoagulants** *Therapy; drug, long-term (current) (prophylactic); anticoagulants* **Z51.81 Encounter for therapeutic drug level monitoring** *Monitoring (encounter for); therapeutic drug level* **Z85.3 Personal history of malignant neoplasm of breast** *History; personal (of); malignant neoplasm; breast* **Z79.810 Long-term (current) use of selective estrogen receptor modulators (SERMs)** *Therapy; drug, long-term (current) (prophylactic); tamoxifen (Nolvadex)*	J44.1 RATIONALE: The patient is admitted with an exacerbation of COPD. R53.1 RATIONALE: The patient has diffuse weakness from the dementia. I48.2 RATIONALE: The patient has documented chronic atrial fibrillation. Z79.01 RATIONALE: Patient is admitted on chronic Coumadin therapy. Z51.81 RATIONALE: Code also note under Z79.01 instructs the coder to code the monitoring code if applicable. The patient is having PT/INR checks. Z85.3 RATIONALE: Patient has a history of breast cancer. Z79.810 RATIONALE: Patient is on chronic Tamoxifen.
7	Patient was admitted to the hospital with slurred speech, facial droop, and change in mental status. Testing	**I69.31 Cognitive deficits following**	The SNF is not treating the acute embolic infarction (CVA), but will be	**I69.392 Facial weakness following cerebral infarction** *Sequelae, infarction, cerebral, facial droop*	I69.392 RATIONALE: Coded for the facial droop following the infarction.

	revealed an acute embolic cerebral infarction. While hospitalized, the patient received treatment for hypertension and hyperlipidemia. Due to the patient's inability to swallow, a PEG tube was placed. Discharge diagnosis was documented as follows: Embolic CVA with cognitive deficit, facial droop and oropharyngeal dysphagia; Hypertension; Hyperlipidemia. Patient is now being admitted to the SNF with orders for PT, OT, and ST, tube feedings. Med orders include Plavix, Hytrin, and Lipitor. What are the appropriate codes for the SNF admission?	**cerebral infarction** *Sequelae, infarction, cerebral, cognitive deficits*	treating the sequelae (late effects) of the infarct. The Official Guidelines for Coding and Reporting state that when the purpose for the admission is for rehabilitation, to sequence first the code for the condition for which the therapy is being delivered.	**I69.391 Dysphagia following cerebral infarction** *Sequelae, infarction, cerebral, dysphagia* **R13.12 Dysphagia, oropharyngeal phase** *Dysphagia, oropharyngeal phase* **I10 Essential (primary) hypertension** *Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)* **E78.5 Hyperlipidemia, unspecified** *Hyperlipemia, hyperlipidemia* **Z43.1 Encounter for attention to gastrostomy** *Attention (to); artificial, opening (of), digestive tract, stomach* **Z79.02 Long term (current) use of antithrombotics/antiplatelets** *Long term (current) (prophylactic) drug therapy (use of), antiplatelet*	I69.391 RATIONALE: Coded for the dysphagia following the infarction. R13.12 RATIONALE: Per the coding instructions at I69.391, the dysphagia is specified as oropharyngeal and is coded. I10 RATIONALE: The patient has documented hypertension. E78.5 RATIONALE: The patient has documented hyperlipidemia. Z43.1 RATIONALE: Gastrostomy care is provided on an ongoing basis. Z79.02 RATIONALE: The patient is on chronic Plavix.
8	Resident being admitted to the SNF following a hospital stay for acute stroke. Documentation shows right non-dominant hemiplegia, as well as stroke related vertigo and seizure disorder. Additional diagnoses include GERD, Rheumatoid Arthritis, Allergic Rhinitis and multi-infarct dementia. Resident has orders for PT and OT, as well as med orders for all these diagnoses. What are the appropriate codes?	**I69.353 Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side** *Sequelae, stroke NOS, hemiplegia*	The SNF is not treating the acute stroke, but the sequelae of the stroke. The Official Guidelines for Coding and Reporting state that when the purpose for the admission is for rehabilitation, to sequence first the code for the condition for which the therapy is being delivered.	**I69.398 Other sequelae of cerebral infarction** *Sequelae, stroke NOS, specified effect NEC* **R42 Dizziness and giddiness** *Vertigo* **G40.909 Epilepsy, unspecified, not intractable, without status epilepticus** *Seizure(s); disorder* **K21.9 Gastro-esophageal reflux disease without esophagitis** *Disease, gastroesophageal reflux (GERD)*	I69.398 RATIONALE: The patient has stroke related vertigo and seizure disorder. Coding notes instruct the use of additional codes to identify the conditions caused by the stroke. R42 RATIONALE: This is the code for the stroke related vertigo. G40.909 RATIONALE: This is the code for the stroke related seizure disorder. K21.9 RATIONALE: The patient has documented GERD.

				M06.9 Rheumatoid arthritis, unspecified *Arthritis, arthritic (acute) (chronic) (nonpyogenic) (subacute), rheumatoid* **F01.50 Vascular dementia without behavioral disturbance** *Dementia, multi-infarct – See Dementia, vascular (acute onset) (mixed) (multi infarct) (subcortical)* **J30.9 Allergic rhinitis, unspecified** *Rhinitis (atrophic) (catarrhal) (chronic) (croupous) (fibrinous) (granulomatous) (hyperplastic) (hypertrophic) (membranous) (obstructive) (purulent) (suppurative) (ulcerative), allergic*	M06.9 RATIONALE: The patient has documented rheumatoid arthritis. F01.50 RATIONALE: The patient has multi-infarct dementia, which codes to a vascular dementia. No behaviors are documented. J30.9 RATIONALE: The patient has documented allergic rhinitis.
9	Resident admitted to the nursing home following hospitalization for acute osteomyelitis and gangrene due to a chronic non-healing decubitus ulcer stage IV of the left heel. Long-term antibiotic therapy is continued for the osteomyelitis in the heel and for a stage II left buttock pressure ulcer. The resident has Type I diabetes with PVD, stage IV CKD, HTN and status post right above the knee amputation. Past medical history also includes gout with tophi on Colchicine, ASCVD, hypercholesterolemia and chronic alcoholism in remission.	**M86.172 Acute osteomyelitis, left heel** *Osteomyelitis; acute; metatarsus*	Osteomyelitis is the principal because it is still being treated with antibiotics. The gangrene was resolved in the hospital and is not coded in the nursing home setting.	**L89.624 Pressure ulcer of left heel, stage 4** *Ulcer; pressure; stage 4; heel* **L89.322 Pressure ulcer of left buttock, stage 2** *Ulcer; pressure; stage 2; buttock* **E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene.** *Diabetes, diabetic; type 1; with; peripheral angiopathy* **E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease.** *Diabetes, diabetic; type 1; with; chronic kidney disease* **I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.** *Hypertension, hypertensive; kidney; with; stage 1 through stage 4 chronic kidney disease*	L89.624 RATIONALE: Stage 4 pressure ulcer on the left heel is still present. L89.322 RATIONALE: Stage 2 pressure ulcer on the left buttock is still present. E10.51 RATIONALE: The patient has type 1 diabetes with peripheral vascular disease, but the gangrene is no longer present as it was treated in the hospital. E10.22 RATIONALE: The patient has chronic kidney disease associated with the type 1 diabetes. A coding note indicates the stage of CKD is to be coded. I12.9/N18.4 RATIONALE: The ICD-10-CM Official Guidelines for Coding and Reporting section I.C.9.a.2 states there is a presumed cause and effect relationship between hypertension and chronic kidney disease. It also states that a code from N18 should be assigned to

				N18.4 Chronic kidney disease, stage 4 (severe). *Disease, diseased; kidney; chronic; stage 4 (severe)* **M1A.9XX1 Chronic gout, unspecified.** *Gout, chronic* **E78.0 Pure hypercholesterolemia** *Hype cholesterolemia* **I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris.** *Disease; heart; ischemic; atherosclerotic* **F10.21 Alcohol dependence, in remission** *Alcoholism; with; remission* **Z89.611 Acquired absence of right leg above knee.** *Absence; leg (acquired) (above knee)*	identify the stage of chronic kidney disease. M1A.9XX1 RATIONALE: The patient has a diagnosis of gout with tophi and is on Colchicine. E78.0 RATIONALE: Patient has documented diagnosis of hypercholesterolemia. I25.10 RATIONALE: Patient has documented diagnosis of ASCVD. It is coded to the native vessel as there is no indication of a previous CABG. F10.21 RATIONALE: Since the physician documented chronic alcoholism in remission, alcohol dependence is the only option with in remission. Z89.611 RATIONALE: The patient has an above knee amputation.
10	Long term resident with MS admitted for a UTI due to E. Coli, history of recurrent UTI's with long-term antibiotic therapy prophylaxis	**G35 Multiple sclerosis** *Sclerosis, sclerotic; multiple*	MS is the reason for continued facility stay, and the reason for the new focus of care (UTI) is sequenced second	**N39.0 Urinary tract infection, site not specified.** *Infection; urinary (tract)* **B96.20 Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere.** *Escherichia coli (E. coli), as cause of disease classified elsewhere* **Z87.440 Personal history of urinary (tract) infections.** *History; personal (of); urinary (recurrent) (tract) infection(s)* **Z79.2 Long-term (current) use of antibiotics** *Long-term (current) (prophylactic) drug therapy (use of); antibiotics*	N39.0 RATIONALE: Patient has a UTI. A coding note instructs that a code for the infectious agent is to be assigned. B96.20 RATIONALE: E. coli is identified in the documentation as the infectious agent causing the UTI. Z87.440 RATIONALE: Documentation indicates the patient has recurring UTI's requiring continuous monitoring. Z79.2 RATIONALE: Long term antibiotic therapy for prophylaxis is documented.
11	Resident is admitted for OT and PT following a left knee	**Z47.1 Aftercare following joint**	The Official Guidelines for	**Z96.652 Presence of left artificial knee joint**	Z96.652 RATIONALE: Coding instruction under

	replacement surgery due to osteoarthritis of the left knee. Resident also has osteoarthritis of the bilateral hips and shoulders.	**replacement surgery** *Aftercare (see also Care), following surgery, Joint replacement*	Coding and Reporting state that when the purpose for the admission is for rehabilitation, to sequence first the code for the condition for which the therapy is being delivered.	*Presence (of), Implanted device (artificial) (functional) (prosthetic), Joint, Knee* **M16.0 Bilateral primary osteoarthritis of hip.** *Osteoarthritis; hip; bilateral* **M19.011 Primary osteoarthritis, right shoulder.** *Osteoarthritis; shoulder* **M19.012 Primary osteoarthritis, left shoulder.** *Osteoarthritis; shoulder*	Z47.1 indicates the need to code the joint that was replaced. M16.0 RATIONALE: The patient has documented OA of both hips. There is a single code for bilateral hips. M19.011 and M19.012 RATIONALE: The patient has documented OA of both shoulders. Because there is no code for bilateral, two codes should be assigned; one indicating left shoulder and one indicating right shoulder.
12	Resident has vancomycin-resistant acute respiratory infection. A PICC line has been placed to administer IV antibiotics which the physician has noted will be used indefinitely. Orders include IV antibiotics and flushing of the PICC line. What diagnosis code(s) are assigned?	**J22 Unspecified acute lower respiratory infection** *Infection, infected, infective; respiratory; acute*	The note at Z16 says to "code first the infection". Therefore, the acute respiratory infection is coded as the primary diagnosis with the drug resistance being a secondary diagnosis.	**Z16.21 Resistance to vancomycin** *Resistance, resistant (to); organism(s); to; drug; vancomycin* **Z45.2 Encounter for adjustment and management of vascular access device.** *Admission (for) (see also Encounter (for)); adjustment (of); device NEC; vascular access* **Z79.2 Long-term (current) use of antibiotics** *Long-term (current) (prophylactic) drug therapy (use of); antibiotics*	Z16.21 RATIONALE: Resistance to the vancomycin is coded as a secondary code due to the "code first" note indicating the infection should be sequenced first. Z45.2 RATIONALE: The PICC line is coded because of the orders for managing the line. Z79.2 RATIONALE: Since there is no end date to the antibiotics and the physician has documented intended long term use, the long term use of antibiotics is coded.
13	Resident with ESRD on dialysis with hypertension.	**I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease.** *Hypertension, hypertensive; kidney; with; stage 5 CKD or ESRD*	The ICD-10-CM Official Guidelines for Coding and Reporting section I.C.9.a.2 states there is a presumed cause and effect relationship between hypertension and chronic kidney disease. The hypertensive CKD code is sequenced first with a "code also" note for the	**N18.6 End stage renal disease** *Disease; renal; end-stage (failure)* **Z99.2 Dependence on renal dialysis** *Dialysis; renal (hemodialysis) (peritoneal), status*	N18.6 RATIONALE: ESRD is coded as a secondary code per the "code also" note at I12.0. Z99.2 RATIONALE: Coding Clinic 4th Quarter of 2013 supports the use of additional code Z99.2 for dependence on renal dialysis as a secondary diagnosis if it has been started.

			stage of kidney disease.		
14	Resident with PVD secondary to Type I diabetes mellitus with diabetic ulcers of right ankle and calf. Focus of care is on the ulcers.	**E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene.** *Diabetes; Type 1; with; peripheral angiopathy*	In this case the focus of treatment is the Diabetic Ulcers of the right ankle and calf, but code E10.51 would be assigned first as the PVD is the cause (etiology) of the ulcers (manifestation).	**E10.622 Type 1 diabetes mellitus with other skin ulcer.** *Diabetes; Type 1; with; Skin Ulcer NEC* **L97.319 non-pressure chronic ulcer of right ankle with unspecified severity.** *Ulcer; lower limb; ankle; right* **L97.219 Non-pressure chronic ulcer of right calf with unspecified severity.** *Ulcer; lower limb; calf; right*	E10.622 RATIONALE: The ulcers are a complication of the Diabetic PVD and the cause of the ulcers. L97.319 and L97.219 RATIONALE: In the Tabular List under E10.622, there is an instructional note to use additional code to identify the ulcer. In the code assignment for the ulcers, you would select a 5th digit for laterality (right) but there is no documentation of the level of breakdown; therefore you assign the codes for unspecified severity. You would not assign a separate code for the PVD, as it is included in the diabetic combination code.
15	Resident has dementia with delusions and depression, and is incontinent of both bowel and bladder due to the cognitive impairment.	**F03.90 Unspecified dementia without behavioral disturbance.** *Dementia (degenerative) (primary) (old age) (persisting)*	The dementia is the reason for the patient's admission to the nursing home, and is coded as without behaviors. Delusions are not considered a behavioral disturbance.	**F22 Delusional disorders** *Delusional (paranoid) – see Disorder, delusional* *Disorder, delusional (persistent) (systematized)* **F32.9 Major depressive disorder, single episode, unspecified** *Depression (acute) (mental)* **R39.81 Functional urinary incontinence** *Incontinence; urine; due to cognitive impairment or severe physical disability or immobility* **R15.9 Full incontinence of feces** *Incontinence; feces*	F22 RATIONALE: The patient has documented delusions that are coded. F32.9 RATIONALE: The patient has documented depression with no additional clarification. R39.81 RATIONALE: The documentation for the incontinence states it is due to cognitive impairment, which is an option when coding the bladder incontinence. R15.9 RATIONALE: The bowel incontinence is coded, but does not have the specificity the bladder incontinence has to indicate the cause as cognitive impairment.
16	Resident has chronic diastolic congestive heart failure with left ventricular failure and pulmonary edema. Resident did have	**I50.32 Chronic diastolic (congestive) heart failure**	The patient is admitted with the principle diagnosis of chronic diastolic CHF, which is	**I50.1 Left ventricular failure** *Failure, failed; ventricular; left*	I50.1 RATIONALE: The patient has a diagnosis of left ventricular failure related to the diastolic CHF. Pulmonary edema

	recent exposure to tuberculosis. Resident also has diagnoses of ischemic cardiomyopathy, mitral valve regurgitation and aortic valve stenosis.	*Failure, failed; heart; diastolic (congestive); chronic (congestive)*	sequenced first.	**I25.5 Ischemic cardiomyopathy** *Cardiomyopathy (familial) (idiopathic); ischemic* **I08.0 Rheumatic disorders of both mitral and aortic valves** *Regurgitation; mitral (valve) – See Insufficiency, mitral* *Insufficiency; mitral (valve); with; aortic valve disease* **Z20.1 Contact with and (suspected) exposure to tuberculosis** *Exposure; tuberculosis*	leads the coder to the same code. I25.5 RATIONALE: The patient has a documented diagnosis of ischemic cardiomyopathy. I08.0 RATIONALE: The mitral regurgitation and aortic valve stenosis are coded to I08.0 rheumatic disorders of both mitral and aortic valves due to the includes note at category I08 "includes multiple valve diseases specified as rheumatic or unspecified". Z20.1 RATIONALE: Patient has a documented exposure to TB.
17	Resident admitted to SNF from acute inpatient rehab facility following hospitalization for evacuation of acute subdural hematoma due to head trauma from fall at home to continue PT, SP and OT for residuals of mild memory disturbance and gait ataxia.	**S06.5X9D Traumatic subdural hemorrhage with loss of consciousness of unspecified duration; subsequent encounter** *Hematoma (traumatic); subdural (traumatic) – see Injury; intracranial; subdural hemorrhage, traumatic*	Subsequent encounter is defined as an encounter after the patent has received active treatment for the condition and is receiving routine care for the condition, during the healing or recovery phase. The acute phase of the subdural hematoma was treated in the hospital.	**R26.0 Ataxic gait** *Gait abnormality; ataxic* **R41.3 Other amnesia** *Memory disturbance, lack or loss – see also Amnesia* *Amnesia* **Z91.81 History of falling** *History; personal (of); fall, falling*	R26.0 RATIONALE: The patient continues to have an ataxic gait that is being treated with therapies. R41.3 RATIONALE: The patient is receiving therapy for the mild memory disturbance. Z91.81 RATIONALE: Patient has a documented history of falling.
18	Resident admitted to SNF for therapy services post hospitalization for acute coronary syndrome which was diagnosed as an acute non-ST elevation myocardial infarction (NSTEMI MI). Resident had a cardiac catheterization with placement of stents in blocked vessels due to coronary artery disease. Resident also has HTN,	**I21.4 Non-ST elevation (NSTEMI) myocardial infarction** *Infarct, infarction; myocardium, myocardial (acute) (with state duration of 4 weeks or less); non-ST*	Per the Official Coding Guidelines, "if an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as subendocardial AMI."	**I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris** *Atherosclerosis (see also Arteriosclerosis); coronary; artery* **I10 Essential (primary) hypertension** *Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)*	I25.10 RATIONALE: The patient has documented CAD for which the patient had stents placed. I10 RATIONALE: Patient has documented hypertension. E78.5 RATIONALE: The patient has documented dyslipidemia, which codes to Hyperlipidemia, unspecified.

	dyslipidemia, glaucoma and wears a hearing aide in both ears.	*elevation (NSTEMI)*		**E78.5 Hyperlipidemia, unspecified** *Dyslipidemia* **H40.9 Unspecified glaucoma** *Glaucoma* **H91.93 Unspecified hearing loss, bilateral** *Deafness (acquired) (complete) (hereditary) (partial)* **Z95.5 Presence of coronary angioplasty implant and graft** *Status (post); angioplasty; coronary artery; with implant*	H40.9 RATIONALE: The patient has documented glaucoma. H91.93 RATIONALE: The physician documented the use of hearing aides in both ears. Z95.5 RATIONALE: The physician documented that the patient had stents placed prior to admission to the nursing home.
19	Resident admitted to SNF following right lobectomy and excision of sentinel lymph node with metastasis to lymph node. Resident will return in 2 weeks to oncologist to start chemo and radiation therapy.	**Z48.3 Aftercare following surgery for neoplasm** *Aftercare; following surgery (for); neoplasm*	The ICD-10-CM Official Guidelines for Coding and Reporting state that aftercare codes are used when "the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease."	**C34.91 Malignant neoplasm lung right lobe** *Neoplasm table; lung; lobe NEC; malignant primary column* **C77.1 Malignant neoplasm, intrathoracic lymph node secondary** *Neoplasm table; lymph, lymphatic channel NEC; gland (secondary); intrathoracic; Malignant Secondary column* **Z90.2 Acquired absence of lung [part of]** *Absence; lung; acquired (any part)*	C34.91 and C77.1 RATIONALE: Official Guidelines for Coding and Reporting state that malignancies still be treated are coded, even if the site of the malignancy has been removed. Therefore, both the neoplasm of the lung and the metastasis to the lymph node are both coded as active conditions. Z90.2. RATIONALE: The patient had the lobectomy performed prior to admission to the nursing home.
20	Resident admitted to SNF following ER visit and overnight stay at the hospital in observation for fracture distal right radius and ulna related to fall at home. A cast was placed in the ER before the resident transferred to the SNF. Resident had lived alone and has mild cognitive impairment. Resident admitted with order for occupational therapy.	**S52.501D Unspecified fracture of the lower end of right radius; subsequent encounter** *Fracture, traumatic; radius; lower end*	Subsequent encounter is defined as an encounter after the patent has received active treatment for the condition and is receiving routine care for the condition, during the healing or recovery phase. The acute phase of the subdural radial fracture was treated in the hospital.	**S52.601D Unspecified fracture of lower end of right ulna; subsequent encounter** *Fracture, traumatic; ulna; lower end* **G31.84 Mild cognitive impairment, so stated** *Impaired, impairment (function); cognitive, mild, so stated* **Z91.81 History of falling**	S52.601D RATIONALE: The same explanation applies regarding the subsequent encounter. As with the radial fracture, the acute phase of the ulnar fracture was treated in the hospital. G31.84 RATIONALE: The physician documented mild cognitive impairment. Z91.81 RATIONALE: Patient has documented fall as cause of fractures.

				History; personal (of); fall, falling	Because there is no documentation that the patient has had recurrent falls, only the history of falling can be coded.
21	Patient admitted following laminectomy and spinal fusion for lumbar spinal stenosis and spondylosis. Patient to have dressing changed and sutures removed in 2 weeks	**Z47.89 Encounter for other orthopedic aftercare** *Aftercare; following surgery (for) (on); spinal*	The ICD-10-CM Official Guidelines for Coding and Reporting state that aftercare codes are used when "the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease." Therefore the patient is admitted for care following the spinal surgery	**M48. 06 Spinal stenosis, lumbar region** *Stenosis, stenotic; spinal; lumbar region* **M47.896 Other spondylosis, lumbar region** *Spondylosis; specified NEC; lumbar region* **Z48.01 Encounter for change or removal of surgical wound dressing** *Aftercare; following surgery (for) (on); attention to; dressings; surgical* **Z48.02 Encounter for removal of sutures** *Aftercare; following surgery (for) (on); attention to; sutures*	M48.06 RATIONALE: The patient had surgery to help with the spinal stenosis, which is a narrowing of the open spaces in the spine, but it is a chronic condition. M47.896 RATIONALE: Spondylosis is a type of arthritis in the vertebral joints and is a chronic condition that can be helped with surgery. Z48.01 RATIONALE: The patient entered the nursing home with orders for dressing changes to be done at the nursing home. Z48.02 RATIONALE: The patient entered the nursing home with orders to have the sutures removed in 2 weeks, which will be done by the nursing home staff.
22	Patient was hospitalized for a below-the-knee amputation of the left leg. Following surgery, he developed an infection of the amputation stump which was treated during the hospitalization and the antibiotics were complete at the time of discharge. The patient is now admitted to the nursing facility for dressing changes.	**Z47.81 Encounter for orthopedic aftercare following surgical amputation** *Aftercare; following surgery (for) (on); amputation*	The ICD-10-CM Official Guidelines for Coding and Reporting state that aftercare codes are used when "the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease." Therefore the patient is admitted for care following the amputation.	**Z89.512 Acquired absence of left leg below knee** *Absence (of) (organ or part) (complete or partial); leg; below knee (acquired)* **Z48.01 Encounter for change or removal of surgical wound dressing** *Aftercare; following surgery (for) (on); attention to; dressings; surgical*	Z89.512 RATIONALE: A code also note at Z47.81 states the need for a code that indicates what was amputated. Z48.01 RATIONALE: The patient admitted to the nursing home with orders for dressing changes to be done at the facility.

23	**EPISODE A:** Resident is admitted to NH following hospitalization for dehydration due to UTI with staphylococcus aureus. Resident is admitted for therapies due to weakness following the UTI and to complete the course of the antibiotics in the NH. Resident has progressing Parkinsonism dementia and will remain in facility. Medical history includes mitral valve regurgitation with aortic valve stenosis, kyphosis, mild asthma, insulin resistance and overweight.	**N39.0 Urinary tract infection, site not specified** *Infection; urinary (tract)*	Coding Clinic 4th Quarter 2012, pages 90-98 state that when a patient is admitted to a long-term care facility for nonspecific reasons rather than a specific diagnosis, it is appropriate to assign codes for the symptoms. In this case, the patient was admitted for weakness caused by the UTI, and the UTI was still being treated with antibiotics. For this reason, the UTI is listed as the principle diagnosis.	**B95.61 Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere** *Staphylococcus, staphylococcal; as cause of disease classified elsewhere; aureus (methicillin susceptible) (MSSA)* **G31.83 Dementia with Lewy bodies** *Parkinsonism; dementia* **I08.0 Rheumatic disorders of both mitral and aortic valves** *Regurgitation; mitral (valve) – See Insufficiency, mitral* *Insufficiency; mitral (valve); with; aortic valve disease* **M40.209 Unspecified kyphosis, site unspecified** *Kyphosis, kyphotic (acquired)* **J45.909 Unspecified asthma, uncomplicated** *Asthma, asthmatic* **E88.81 Metabolic syndrome** *Resistance, resistant (to); insulin* **E66.3 Overweight** *Overweight*	B95.61 RATIONALE: A “code also” note appears at code N39.0 indicating a need to assign the code for the infectious agent causing the UTI. Staphylococcus aureus is identified in the documentation as the infectious agent causing the UTI. G31.83 RATIONALE: The patient has documented Parkinsonism dementia, which codes to Dementia with Lewy bodies. I08.0 RATIONALE: The mitral regurgitation and aortic valve stenosis are coded to I08.0 rheumatic disorders of both mitral and aortic valves due to the includes note at category I08, which states that it “includes multiple valve diseases specified as rheumatic or unspecified”. M40.209 RATIONALE: The patient has documented kyphosis. J45.909 RATIONALE: The patient has documented mild asthma. E88.81 RATIONALE: The patient has documented insulin resistance, which codes to metabolic syndrome. E66.3 RATIONALE: The physician documents that the patient is overweight.
24	**EPISODE B:** Six months later the resident continues to remain in the facility because of the progressing Parkinsonism dementia.	**G31.83 Dementia with Lewy bodies** *Parkinsonism; dementia*	At this point in the patient’s nursing home stay, the UTI has resolved, but the patient continues to stay because of the progressing Parkinsonism dementia.	**I08.0 Rheumatic disorders of both mitral and aortic valves** *Regurgitation; mitral (valve) – See Insufficiency, mitral* *Insufficiency; mitral (valve); with; aortic valve disease* **M40.209 Unspecified kyphosis, site unspecified**	I08.0 RATIONALE: The mitral regurgitation and aortic valve stenosis are coded to I08.0 rheumatic disorders of both mitral and aortic valves due to the includes note at category I08, which states that it “includes multiple valve diseases specified

				Kyphosis, kyphotic (acquired) **J45.909 Unspecified asthma, uncomplicated** *Asthma, asthmatic* **E88.81 Metabolic syndrome** *Resistance, resistant (to); insulin* **E66.3 Overweight** *Overweight*	as rheumatic or unspecified". M40.209 RATIONALE: The patient has documented kyphosis. J45.909 RATIONALE: The patient has documented mild asthma. E88.81 RATIONALE: The patient has documented insulin resistance, which codes to metabolic syndrome. E66.3 RATIONALE: The physician documents that the patient is overweight.
25	**EPISODE C:** Nine months following admission, the resident develops pneumonia requiring a hospital stay. The resident returns to the facility following a 3-day stay to receive PT and OT for weakness and to complete the course of antibiotics.	**G31.83 Dementia with Lewy bodies** *Parkinsonism; dementia*	At this point in the patient's nursing home stay, the patient qualifies for skilled nursing following a three day hospital stay for pneumonia. While the patient is continuing to receive antibiotic treatment for the pneumonia, the diagnosis of the progressing Parkinsonism dementia is still the overlying reason for the patient to be in the nursing home, and is also contributing the weakness for which the patient is receiving therapies.	**J18.9 Pneumonia, unspecified organism** *Pneumonia (acute)(double) (migratory) (purulent) (septic) (unresolved)* **I08.0 Rheumatic disorders of both mitral and aortic valves** *Regurgitation; mitral (valve) – See Insufficiency, mitral* *Insufficiency; mitral (valve); with; aortic valve disease* **M40.209 Unspecified kyphosis, site unspecified** *Kyphosis, kyphotic (acquired)* **J45.909 Unspecified asthma, uncomplicated** *Asthma, asthmatic* **E88.81 Metabolic syndrome** *Resistance, resistant (to); insulin* **E66.3 Overweight** *Overweight*	J18.9 RATIONALE: The patient is still receiving antibiotic therapy for the pneumonia. I08.0 RATIONALE: The mitral regurgitation and aortic valve stenosis are coded to I08.0 rheumatic disorders of both mitral and aortic valves due to the includes note at category I08, which states that it "includes multiple valve diseases specified as rheumatic or unspecified". M40.209 RATIONALE: The patient has documented kyphosis. J45.909 RATIONALE: The patient has documented mild asthma. E88.81 RATIONALE: The patient has documented insulin resistance, which codes to metabolic syndrome. E66.3 RATIONALE: The physician documents that the patient is overweight.

The information contained in this practice brief reflects the consensus opinion of the professionals who developed it. It has not been validated through scientific research.

Article citation:
Liebner, Carole S; Lowery, Amanda L; Maccariella-Hafey, Patricia C; Usher, Joan L; Ward, Maria; Young, Carol. "ICD-10-CM Coding Guidance for Long-Term Care Facilities" *Journal of AHIMA* 86, no.3 (March 2015): 46-50 [extended web version].

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