Solving LTC Coding Challenges

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After an acute illness or injury, patients are often transferred from the hospital to a skilled care bed or nursing facility for continued care. In rural areas, the local hospital and skilled nursing facility are often located within the same building and may even be the very same bed (many rural facilities have a "swing bed" program that allows a patient to change acuity without leaving the room).1 Separate records are prepared when a patient changes status from acute inpatient to extended care, and separate claim forms must be filed to health plans for payment. This can present challenges in assigning codes. In this article, we'll examine commonly encountered coding questions in long-term care (LTC).

Ongoing Code Selection Issues

There is a critical need for communication between the coding and business office staff when billing and coding questions arise. The codes for each resident's monthly statement and insurance claim should be assigned by personnel with proper coding instruction and be based on the documentation in the resident's current medical record. Codes should not be assigned by a billing clerk using the same codes as the previous month's billing statement or referencing the patient's hospital UB-92, because they won't give an accurate picture of the patients' encounters. Previous studies show the need for greater coding accuracy in this setting.

MDS and UB-92 issues

The LTC facility coding guidelines and reporting rules are unique because the treatment focus differs from other more acute healthcare settings. The Minimum Data Set (MDS), as the data-gathering instrument, is separate from the UB-92 billing instrument.

It is a misconception that the diagnosis codes used for these two reporting formats must match exactly in all instances. While a certain amount of consistency should occur, there are a few instances where these codes may not match. According to *Coding Clinic*:2

the diagnostic listing in LTC is dynamic, dependent on many factors and has a longer time frame than an acute care stay. ICD-9-CM codes are assigned upon admission, concurrently as diagnoses arise, at the time of discharge, transfer, or expiration of the resident. Other diagnoses which affect the resident's continued care, such as chronic conditions, should also be coded. The UHDDS definition of principal diagnosis (as used in the acute care setting) does not apply to LTC. The "first listed diagnosis" is the diagnosis which is chiefly responsible for the admission to, or continued residence in the nursing facility and should be sequenced first.

Not all the codes submitted on Section I of the MDS will correlate to Medicare coverage to be reported on the UB-92 billing form. The most common example is fracture care. An acute fracture code should be listed on Section I of the MDS form, while a therapy V code should be listed on the UB-92 billing form, due to the coding guidelines that apply to facility reporting for reimbursement. While V codes are acceptable on the MDS form, a fracture is one instance where the V code for therapy may not provide enough diagnosis detail for the MDS form; the use of an acute fracture code provides more specific information. The MDS form requires a list of the conditions that impact the resident's current activities of daily living (ADL) status and care needs. V codes do not list a resident condition, but represent a service provided. Another example of this is a resident with arthritis who undergoes plastic joint replacement in the hospital, but returns to the skilled level for care following the surgery.

Other difficulties include coding the appropriate therapy code for 700 and 701 therapy plan of treatment forms. Both a medical diagnosis and a treatment diagnosis should both be listed. These therapy codes may not be the same as the first listed code on

the UB-92 or on the problem list. The treatment diagnosis on the 700 or 701 form is likely to be reflected on the functional assessment of the MDS.

Another MDS reporting issue is the correlation of the diagnosis in box I1 with the codes in box I3. Box I1 may contain a code for an acute condition, such as CVA, while box I3 will contain the detail level of specific residual conditions the resident still has that require evaluation and/or management. This is inconsistent with acute care coding conventions, so it may be confusing to some coding professionals. The instructions for completing the MDS state to first complete box I1, and if the actual code is more specific, give that more specific code in box I3. For example, if a resident has diabetes mellitus and related conditions, box I1 would be "diabetes," which would correlate to the code 250.00. Then box I3 would be needed to record the more specific diabetes code.

Fracture Aftercare Coding

Coding for fracture aftercare also presents challenges. For example, if a patient suffered a fracture, was admitted and treated as a hospital inpatient, and is later admitted to the skilled facility for care to allow her to regain strength and heal, the code V54.8, Other orthopedic aftercare should be the first listed code. The acute fracture code should not be used.[3]
However, if the same type of patient is admitted to the skilled care facility specifically for rehabilitative physical therapy, assign the code V57.1, Care involving use of rehabilitation, other physical therapy, as the first listed code.[4]

There may be instances when a resident falls and sustains a fracture in the skilled facility and is transferred to acute care for evaluation of the fracture. The patient may not be a candidate for surgical intervention and is transferred back to the skilled facility for continued care of other medical conditions, such as Alzheimer's disease. In this instance, the first listed code would be 331.0, Alzheimer's disease, because the fracture was not treated. A secondary diagnosis code may be V57.21, Care involving use of rehabilitation procedure, encounter for occupational therapy.

If the fracture required any continued management, evaluation, or treatment it would be reported as a diagnosis code until it is resolved. When no treatment or evaluation is used, it need not be reported.[5] When the patient is admitted to an extended care facility for the purpose of therapy following a hospitalization, the V code for the therapy encounter is reported as the reason for the stay.

Infections

The use of infectious disease codes continues to be a common diagnosis coding challenge in the LTC industry. Only infections for which a resident is currently being treated should be reported with a diagnosis code. To avoid using codes for resolved conditions, a current resident problem list should be developed to identify when a condition is resolved and no longer needs to be reported to any external agency for payment.

Because skilled care or nursing home residents often have chronic infections that are difficult to treat there are some special considerations for code selection. If the patient has an infection that has developed a resistance to routinely used treatment drugs, a V code should be added to show this condition. Complete coding requires the coder to assign:

- the condition
- the microorganism
- an additional code indicating the resistance to a particular antibiotic

For example, if the resident has a non-healing amputation site with medication-resistant staphylococcal aureus (MRSA), the assigned codes would be 997.62, 041.11, plus a code from the V09 code category (Infection with drug-resistant microorganisms). u

Notes

1. For more information about Medicare guidelines concerning swing beds, go to www.hcfa.gov/pubforms/07%5Fsom/somap%5Fa%5F131%5Fto%5F131.htm. To review the skilled nursing facility prospective payment system requirements, go to the Centers for Medicare and Medicaid Web site at www.hcfa.gov/medicare/snfpps.htm and www.hcfa.gov/pubforms/progman.htm.

2. *Coding Clinic* 16, no. 4. Chicago, IL: American Hospital Association, 1999.
3. *Ibid*.
4. *Ibid*.
5. *Ibid*.

Reference

The Official ICD-9-CM Guidelines for Coding and Reporting can be found at www.cdc.gov/nchs/data/ icdguide.pdf.

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