PROPRIETARY STATEMENT

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ICD.10 Coding Policy

I. Policy Statement and Purpose

The medical record of each resident will contain accurate and complete ICD-10-CM diagnosis codes. The purpose of this policy is to ensure that coding professionals apply accurate, complete, and consistent coding practices for the production of high-quality healthcare data and in support of individual care needs.

II. Policy

This policy applies to all patient care in nursing facilities with regard to documentation related to ICD-10-CM diagnosis coding regardless of payor source.

III. Procedures

1. General rules for ICD-10-CM coding accuracy will be followed which include, but are not limited to:

All healthcare data elements (e.g., diagnosis and procedure codes) required for external reporting purposes (e.g., reimbursement and other administrative uses, quality and patient safety measurement, and research) will be reported completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.

The circumstances of inpatient admission always govern the selection of principal diagnosis. The 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."

For residents who continue to stay in facility long-term, the condition requiring them to stay should be sequenced first as the principal diagnosis.

Staff will assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable ICD-10-CM coding conventions, guidelines, and rules.

The physician or other qualified healthcare practitioner will be queried by a member of the facility interdisciplinary team for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the medical record regarding a diagnosis.

Staff will not participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statues, regulations, and official coding rules and guidelines.

Staff responsible for assigning ICD-10-CM diagnosis codes will demonstrate coding knowledge and practice through continuing education.

The facility designee responsible for assigning ICD-10-CM codes will communicate applicable coding information to the RAI coordinator, therapy, and the billing office.

If any diagnoses are updated during the skilled nursing stay and/or rehabilitation course, the interdisciplinary team will be notified to ensure appropriate updates are applied during assessments and for care planning purposes.

2. MDS Guidance

The MDS staff is responsible for coding diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. The MDS is the assessment used to generate an accurate summary of the resident's current health status.

The medical record is reviewed to identify the patient's primary medical condition(s) associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, diagnostic reports and other resources as available.

For purposes of the MDS, coding will reflect diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which is a 30-day look-back).

Diagnoses are to be coded and/or listed by major disease category (Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision).

The designated coder will understand the importance of coding accuracy to the greatest specificity with appropriate knowledge of guidance related to OT/PT Clinical Categories, SLP Acute Neurologic and Co-Morbidity Groups, Nursing Classification Groups, and Non-Therapy Ancillary (NTA) under the Patient Driven Payment Model (PDPM) effective October 1, 2019.

Effective October 1, 2019 the designated coder will utilize item I0020B to enter the patient's primary diagnosis, which is used to classify the patient into a PDPM clinical category.

3. Therapy Guidance

ICD-10-CM diagnosis codes relevant to the therapy treatment plan will be assigned and or updated on all patients upon start of care and documented on the therapy plan of care. The rehab software ICD-10-CM coding search feature will be used to select the relevant resident specific diagnosis codes for the post-acute setting, with reference to the ICD-10-CM coding manual as needed.

The clinician(s) administering therapy evaluations will identify relevant primary medical and treatment diagnoses.

- The medical diagnosis that identifies the reason for therapy services should be listed on the plan of care. Other ICD-10-CM codes for chronic conditions that affect the patient's progress may also be reported to support the therapy services.
- The treatment diagnoses will effectively describe symptoms to the highest specificity impacting the need for skilled therapy at the current level of care and setting to clearly support the plan established.

A rehab designee will review ICD-10-CM diagnosis codes assigned by therapy staff with the facility RAI coordinator to ensure accurate assignment of ICD-10-CM codes based on provider documentation present in the medical record, and to ensure all applicable diagnosis codes are updated in the facility medical record.

4. Guidelines for ICD-10 sequencing will be followed which include, but are not limited to:

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed.

For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis.

- For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.

- If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation.

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

APPROVALS	**Printed Name**	**Signature**	**Date**
Executive Leadership			
Chief Compliance Officer			
REVIEW and REVISIONS			
Version #: Date:			
Summary of changes:			
Version #: Date:			
Summary of changes:			

Source Documents & References	
Federal Regulations	
OBRA Regulations	
Related Documents	ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 AHIMA Standards of Ethical Coding, OIG Compliance Program