Patient Driven Payment Model in Long Term Care Facilities

REQUIREMENTS FOR ICD-10-CM DIAGNOSTIC CODES

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Effective October 1, 2019, major changes are coming for long term care (LTC) facilities with the new Patient Driven Payment Model (PDPM) intended to modernize LTC reimbursement and make the focus of reimbursement more patient specific. Under the Centers for Medicare & Medicaid Services (CMS) *Patients Over Paperwork* initiative moving across the health care continuum, the minimum data set (MDS) currently in use based on the resource utilization group (RUG) reimbursement system will be revised significantly with a new assessment schedule and less MDS assessment during each LTC stay period.

ICD-10-CM codes will be the featured data source in the added primary diagnosis data field of the MDS 3.00.1. ICD-10-CM codes will categorize LTC patients and/or residents into one of ten clinical categories, which will determine reimbursement rates.

1. Major joint replacement or spinal surgery
2. Non-surgical orthopedic/ musculoskeletal
3. Orthopedic; surgical extremities not major joint
4. Acute infections
5. Medical management
6. Cancer
7. Pulmonary
8. Cardiovascular and coagulations
9. Acute neurologic
10. Non-orthopedic surgery

Of the more than 68,000 ICD-10-CM codes, awareness and caution must be exercised for 27,854 ICD-10-CM diagnostic codes that will be rejected as "return to provider" if reported as a primary diagnosis in the new PDPM MDS 3.00.1, effective for claims submitted October 1, 2019 and thereafter. Providers should also be aware and familiar with the 37,214 codes that will be accepted and mapped to a "default clinical category."

These numbers reflect the recent changes to CMS's mappings published in April 2019. CMS added several frequently used principal diagnoses codes to the "return to provider" list. A few examples seen with frequency include:

- M62.81 muscle weakness,
- R65.20 severe sepsis without septic shock, and
- F02.81 dementia in diseases classified elsewhere with behavioral disturbance

Adjustment changes were made by CMS to original mappings in response to HIM professionals' comments in Q1 2019 that certain diagnoses have guidelines instructing that they can never be used as a principal or first listed diagnosis in LTC. CMS is making changes as needed and it is crucial for LTC facilities to stay informed of changes as a key to ongoing PDPM success for the facility.

MDS Section I Layout
In MDS Section I, the new field for primary diagnosis requires an ICD-10-CM code. With 13 newly established primary medical condition categories, these categories all have a unique code listed that is not an ICD-10 code, such as 01 stroke, 03 traumatic brain dysfunction, and 09 hip and knee replacement.

HIM professionals should review PDPM and how ICD-10 drives the clinical category process. Now is the time to address the coding process in LTC facilities and secure proper training as needed. Do not be fooled into thinking "we must be coding correctly because all of our claims were paid."

An example of an incorrectly coded claim would be a principal diagnosis of Z96-presence of artificial joint, which has previously been allowed. Code Z96 code now will be rejected as "return to provider." The correct ICD-10-CM code assignment is Z47.1-aftercare following joint replacement, as the PDPM primary diagnosis on the new MDS field for item I0200B, to report the patient's primary diagnosis.

This new MDS item asks: What is the main reason this person is being admitted to the SNF? A solid process for sequencing of diagnoses to be

reported is needed for LTC facilities. A best practice adopted by many LTC facilities is to utilize a diagnosis worksheet to be completed by the director of nursing or MDS coordinator. Upon completion with diagnostic entries, this worksheet is then processed by the LTC HIM/medical records coding section.

To assure successful adoption of PDPM, a review of the coding process should be performed at each facility to ensure awareness of the new requirements for proper coding. Some dangerous pitfalls likely to create MDS completion and reimbursement delays include:

- Lack of current ICD-10-CM coding manuals as needed each fiscal year.

- Use of Google-type searches to obtain diagnosis codes. Page 1 of the 2019 ICD-10-CM Guidelines details that this improper practice fails to ensure that the HIPAA mandate is followed, which directs use of indexes and tabulars.

- Lack of a streamlined process for reviewing new LTC admits. The admission MDS for the first five days of the LTC stay is the most important and critical to establish a baseline, which requires proper diagnoses sequencing that is clinically accurate.

PDPM Action Items
HIM coding professionals should be equipped with the current edition ICD-10-CM codebooks and should read Coding Clinic 4th Quarter 2012 "Long Term Care Coding Issues." This article was originally published as Appendix J in the 2017 and 2018 skilled nursing facility (SNF) expert codebooks. For 2019, codebook publishers moved this into the acute hospital codebooks. One of the authors, William Roush, RHIA, in his role as an experienced HIM consultant focused on LTC facilities, has diligently worked with the codebook development team to ensure that the 2020 SNF expert codebooks will include this important Coding Clinic article.

Professionals should review useful resources to help assist with this change. AHIMA's Body of Knowledge article "AHIMA'S ICD-10 Coding Guidance for LTC" is a highly recommended read as it addresses LTC coding and how it is a concurrent process. The article also has a 25-scenario coding self-assessment with answer key; these scenarios illustrate correct application of coding guidelines and Coding Clinic LTC instructions. The CMS PDPM website contains several helpful resources and tools, such as a six-page fact sheet that summarizes the changes to the MDS that are going into effect.

As part of the changeover from RUG-IV to PDPM, all current SNF patients admitted prior to the PDPM effective date (October 1, 2019) must receive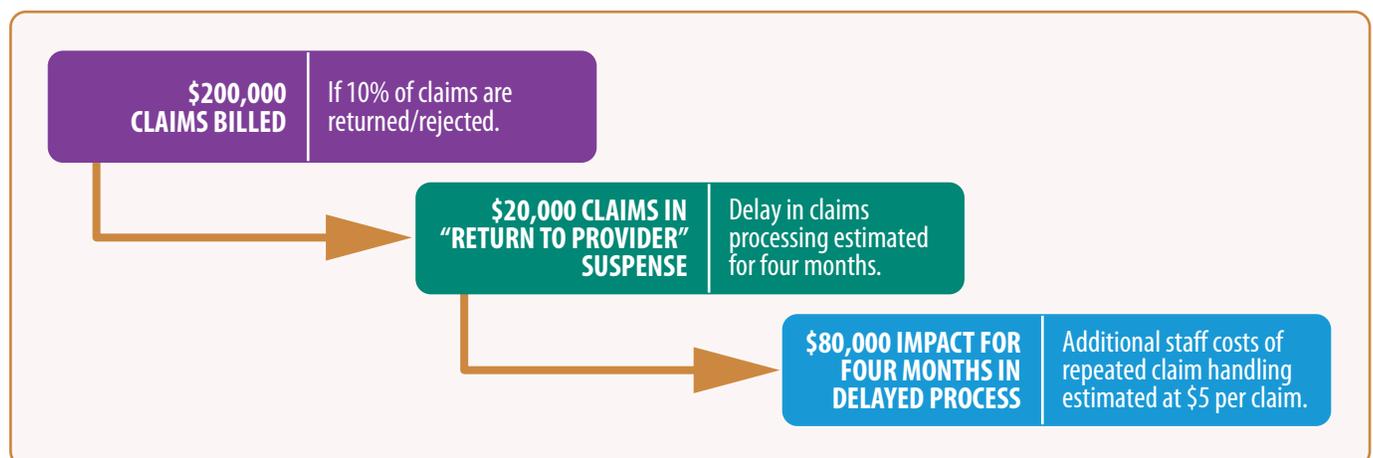 a new interim payment assessment (IPA) under the PDPM, even though they may have already been assessed under the previous RUG-IV model. All residents in-house as of the effective date who are covered under Medicare Part A must have a new IPA form in the format of the new MDS 3.00.1.

HIM professionals should also consult with LTC electronic health record software vendors regarding PDPM implementation and discover if vendors will have alerts on the 27,814 codes that are flagged in the PDPM mapping spreadsheet as "return to provider." If the facility has been less than impressed with the software vendor or is stuck with a hybrid paper/electronic record system, now is the time to consider a more effective software solution.

Example of Potential Costs of Coding Errors
For every patient's MDS that requires insurance payer follow-up due to multiple claim submissions for reimbursement, the delays in reimbursement can be man-power intensive and financially devastating. The adage for successful revenue cycle management to handle the claim submission once and accurately stands for LTC and acute care facilities.

To emphasize the potential cumulative costs of coding errors at an LTC facility, the example below illustrates the risk to a facility with 100 claims billed totaling $200,000 per month. If 10% of a typical LTC facility claims are returned and these claims are

$200,000 CLAIMS BILLED	If 10% of claims are returned/rejected.
$20,000 CLAIMS IN "RETURN TO PROVIDER" SUSPENSE	Delay in claims processing estimated for four months.
$80,000 IMPACT FOR FOUR MONTHS IN DELAYED PROCESS	Additional staff costs of repeated claim handling estimated at $5 per claim.

View a Sample: LTC ICD-10 Diagnosis Worksheet online at californiahia.org/cdq

Key Takeaways

The skills of the coding professional in LTC facilities, in coordination with the HIM consultant and clinical team, will increasingly become important for supporting the accuracy of coding related to the specificity of the diagnosis/conditions, and developing, updating and creating documentation guides for those clinical conditions. Involving the medical director at the facility along with physician staff in education for clinical documentation to support diagnoses in a SNF clinical documentation improvement (CDI) system is crucial. Although CDI may focus on those most common conditions where specificity is an issue, it can still be a valuable undertaking for a facility to support the billing and reimbursement due the facility on behalf of the resident.

The PDPM is a resident right that ensures the medical record is clinically documented completely and accurately to support coding claim submission and reimbursement on their behalf. Complete LTC coding of the MDS is a collaborative effort, not just involving the coding professional. As a best practice, it involves a minimum of a three-person team to achieve accurate diagnostic code selection, including the director of rehabilitation, MDS coordinator, and the medical record/HIM coding designate.

For LTC facilities, 2019 is the year when denials related specifically to improper coding are likely to finally materialize. Even though many facilities trained coding professionals through in-service instruction in 2015, many did not and instead have chosen to rely on denials to indicate a need for training. This was a flawed strategy as the payors have allowed many claims that should have been rejected due to failure to adhere to established coding guidelines. This environment creates a unique opportunity for HIM professionals to support the PDPM implementation. All HIM consultants in LTC settings must commence

held in a delayed/pending/suspended status greater than four months, the illustrated revenue cycle should be considered.

ICD-10-PCS Codes in LTC

The proposed rule for PDPM issued on April 27, 2018 included language requiring LTC coding professionals to also report, when relevant, an ICD-10-PCS code to describe any procedure done during the acute hospital stay that preceded the LTC stay. ICD-10 trainers have observed the challenges to learning and mastering ICD-10-CM for LTC staff. An uncredentialed LTC coding professional suddenly being able to learn and assign ICD-10-PCS codes accurately would have increased the burden on LTC providers. The expense for a $120 ICD-10-PCS codebook as well as obtaining additional training on ICD-10-PCS would be an extreme demand.

The CHIA Continuum of Care Committee brought this concern to CHIA leaders in May 2018. CHIA addressed this in a letter to AHIMA, which provided an official letter to CMS in June 2018 with comments regarding the HIPAA mandate that ICD-10-PCS codes were intended to be used for hospital inpatients. AHIMA also addressed the lack of requirements in many states,

such as California, that HIM staff in LTC hold an AHIMA credential, or have access to a credentialed consultant. AHIMA also noted that even seasoned credentialed coding professionals grapple with mastering ICD-10-PCS correctly.

It was great news for LTC with the release of the CMS PDPM Final Rule on July 31, 2018. CMS dropped the requirement for LTC assignment of ICD-10-PCS codes on the new MDS. With the Final Rule for PDPM, providers will use a "check box style mechanism" on the MDS to indicate the "surgical category" of which there are 30 different choices. Some categories included are:

- Hip replacement – partial of total,

- Ortho Surgery repair but not replace joints,

- Cardiopulmonary surgery – respiratory system, including bronchi, trachea, larynx or vocal cords – open and endoscopic.

It should be noted, if only for LTC coding history, that the deletion of ICD-10-PCS code requirement saved each facility $120 for an ICD-10-PCS codebook, and the cost of ICD-10-PCS training would have been hundreds of dollars per coding professional as well.

audits of current coding compared to the PDPM mappings now available and make LTC facilities aware of codes in the principal diagnosis field currently in use that will likely be rejected effective claims submitted for service dates commencing October 1, 2019. The priority is to identify coding that deviates from approved and established coding rules and guidelines. All LTC staff involved in MDS completions are advised to stay plugged into all of the CMS and AHIMA PDPM resources available.

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CHIA Educational Calendar

AUGUST

The Patient-Driven Payment Model and ICD-10

29 Live Webinar

SEPTEMBER

FY2020 ICD-10-CM/PCS Update

24 Southern California TBD

26 Northern California TBD

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Diaries of a Professional Fee Coding Compliance Auditor

8 Live Webinar

CHIA Student Chat

8 Live Webinar

NOVEMBER

Confidentiality and the ROI in California

13 Southern California TBD

14 Northern California TBD

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