ICD-10: Questions & Answers  
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Objectives

- Share ICD-10 coding queries among peers
- Demonstrate an understanding of rehab specific ICD-10 coding
- Review the impact of ICD-10 coding on 60% presumptive compliance
Thank you all for submitting your questions.

- We received 115 questions in 2 weeks
- A couple of themes were repeated in many of the inquiries. On the slides, we have attempted to combine similar questions. Some slides contain one question with multiple parts or similar questions on one slide submitted by different people.
- Questions are represented on the slides exactly as submitted.

Using this information:

- We pulled together information to answer your questions.
- In all cases, we responded to your general questions without looking at a medical record. Therefore the specific coding examples may not apply in to your case even if you are the one who asked the question because we did not have all of the information.
- Please use the information in this webinar as a guide for decision-making, but not as a road map for selecting individual codes.
- Focus on the concepts we present, not on the ICD-10 codes provided in the examples because the codes were not pulled from actual physician documentation or patient records.
**Question**

- **Stroke:**
  - Please review the process of coding a stroke patient, especially how to select the appropriate etiologic code and how to represent the comorbid conditions appropriately.
  - Possible sample:
    68 year old female with right basal ganglia infarct. No history of CVA. Presents with hemiplegia, hypertension, oral-phase dysphagia, dysarthria, facial droop, diabetes mellitus and ataxic gait.

**Answer**

- **Principal Diagnosis (UB-04): The condition that required the IRF admission**
  - Code that represents the impairment (hemiparesis, cognitive deficit, ataxia)
- **Etiologic Diagnosis (IRF-PAI): I63.9-Cerebral infarction, unspecified**
- **Comorbidities:**
  - Hemiplegia **G81.90 Hemiplegia, unspecified affecting unspecified side**
    - More specific information would allow for more specific coding:
      - Anatomic site (upper of lower limb)
      - Dominant vs. non-dominant
      - Laterality
      - Underlying cause
      - Flaccid vs. spastic
**Answer: Comorbidities cont’d**

- **Hypertension**  
  110-essential (primary) hypertension  
  - I10-I15 is documentation specifies:  
    - Related to heart disease, kidney/renal disease  
    - I27.0-primary pulmonary hypertension  

- **Oral Phase Dysphagia** R13.11  
  - R codes if acute; I codes if sequelae  
  - Other possibilities, if documentation is less specific:  
    - Oral, oropharyngeal, pharyngeal, pharyngoesophageal, etc  

- **Facial droop** R29.810 Facial weakness

**Answer-Comorbidities cont’d**

- **Diabetes** E10.9 Type I diabetes mellitus without complications  
  - Need more information:  
    - Clarify any cause and effect relationship between diabetes and other conditions such as: ketoacidosis, with or without coma, diabetic neuropathy or diabetic chronic kidney disease (stage the disease), diabetic proliferative or nonproliferative retinopathy, with or without macular edema, diabetic peripheral angiopathy with or without gangrene.  
    - Detail insulin underdosing or overdosing related to an insulin pump malfunction.  
  - E10.XXX Type I  
  - E11.XXX Type II  

- **Ataxic Gait** R26.0  
  - Compared to paralytic/spastic gait R26.1  
  - Difficulty in walking, not elsewhere classified R26.2  
  - Other abnormalities of gait and mobility R26.89  
  - Unspecified abnormalities of gait and mobility R26.9
In Summary

- **Etiologic Diagnosis**
  - I63.9-Cerebral infarction, unspecified

- **Comorbidities**
  - G81.90  Hemiplegia, unspecified affecting unspecified side
  - I10    Essential (primary) hypertension
  - R13.11 Oral Phase Dysphagia
  - R29.810 Facial weakness
  - E10.9  Type I diabetes mellitus without complications
  - R26.0  Ataxic Gait

Follow-Up Question

- **Stroke**
  - How would the coding be different if the patient had a history of stroke with right-sided hemiparesis and an acute stroke with the above comorbidities?
**Answer**

- **Codes from category I69 can be assigned with codes from I60-I67 when the patient has:**
  - A current cerebrovascular disease (I60-167) and deficits from an old cerebrovascular disease (I69)
  - For this example, it would be best to know what type of stroke occurred in the patient’s history as well as the dominant side.

- **Etiologic Diagnosis**  **163.9-Cerebral infarction, unspecified**

- **Comorbidities**
  - I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
  - I10 Essential (primary) hypertension
  - R13.11 Oral Phase Dysphagia
  - R29.810 Facial weakness
  - E10.9 Type I diabetes mellitus without complications
  - R26.0 Ataxic Gait

**Different Scenario Question**

- **Stroke**
  - How would the coding be different if the patient had a acute transfer – further extending the stroke – then returned to the IRF seven days later?
Answer

- The re-admission will have the same IRF-PAI coding as Slide 7 or the original admission.
- However, the IRF-PAI should code this admission as 'Continuing Rehab' in Item #14, Admission Class.

Question

- **Stroke**
  - Would you concur that hemiparesis following a stroke will always be an I code, regardless if they’ve previously received rehabilitation for the stroke, and the G code for hemiplegia is for other brain/cord injuries, NON cerebrovascular related?
  - The old 438.22 mapped to an I code (which is complaint as a co-morbidity but doesn’t tier) and the old 342.xx codes map to a G code which tiers the patient.
**Answer**

- Use the acute codes (G and/or R codes) for the hemiplegia, dyspraxia, dysphagia, etc. since we are treating the acute phase of the stroke.
- These will not result in additional payment because it is related to the stroke.
- The I69 codes are late effect codes. Use if patient has received rehab for this condition in the past.
- For non-stroke etiologic diagnoses, also use the G and/or R codes.
- These will tier if they are not paired with the stroke IGC.

**Additional Related Questions**

• Stroke
  - What about residual hemiparesis from an old stroke when the patient comes to rehab for another condition? It appears the descriptors for I codes vs. G codes aren’t acute or chronic, but more the etiology of the hemiparesis, true?
    - Answer: If the etiologic diagnosis is something other than a stroke, but you are looking to record an impairment, like hemiplegia, it is best to use the I code as the sequelae from the stroke.
**Additional Related Questions**

**Stroke**

- Is the code, I69.398 (other sequelae of cerebral infarction) a late effect code, which would then not be used on the IRF-PAI?
  - Answer: Yes; I69.398 is similar to a late effect code as noted by the definition that includes sequelae.
  - It should not be used on the IRF-PAI as an etiologic diagnosis if the patient was admitted due to a new stroke.
  - It can be used on the IRF-PAI as a comorbidity if the patient has a history of an old stroke. Consider other, more specific I69 codes (cognition, speech/language, monoplegia, hemiplegia). I69.398 best describes disturbances in vision and sensation after a cerebral infarction.

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**Question**

**Stroke**

- I'm no coder by any means, and the changes since October 1 sometimes leave me baffled. For example, my coder will sometimes give me codes for a stroke patient, with hemorrhage for an etiology, and then put the admit diagnosis 'hemiplegia'. That's always been a comorbidity before. However, when I queried CMS, they said that admitting diagnosis codes should go in etiology slots. I could use a little advice about what to put where.
Answer

- It sounds like the codes you are getting from the coder follow billing claims logic where you use the impairment as the principal diagnosis.

- On the IRF-PAI we continue to do as we have before. We code the acute condition that we are treating in rehab. For example, we code the acute stroke or acute fracture.

- On the claim, the principal diagnosis will be the hemiplegia or fracture, subsequent event

Question/Answer

Stroke

- Should a middle cerebral artery stroke be documented as middle cerebral artery syndrome in order to have a more specific CVA code that I63.9 (Cerebral infarction, unspecified)?
  - Answer: Depending on the other information you have about the MCA stroke, consider:
    - I60.10/ 11/12-Nontraumatic subarachnoid hemorrhage from unspecified/right/left middle cerebral artery
    - I63.311/12/19-Cerebral infarction due to thrombosis of right/left/unspecified middle cerebral artery
    - I63.411, 412, 419-Cerebral infarction due to embolism of right/left/unspecified middle cerebral artery
    - I63.511, 512, 519-Cerebral infarction due to unspecified occlusion or stenosis of right/left/unspecified middle cerebral artery
    - Otherwise, I63.9 is the most specific you can be for the stroke.
**Question**

- **Traumatic Brain Injury:**
  - Why are so many of the ICD-10 codes that I use for the Impairment Group 02.22, Traumatic Closed Injury, no longer complaint?
  - It seems the only compliant codes used for 02.22 must show that the patient had a loss of consciousness

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**Answer**

- When CMS translated their 60% rule methodology from ICD-9 to ICD-10 and built their lists of excluded diagnoses, there was a lot of (what we believe was) unintended by-catch, and a number of codes that should not have been excluded, were. For example, S06.5X0A.
- For example, we believe CMS was targeting ICD-9 code 852.29, which was one of the codes on their list to be removed from the ICD-9 presumptive compliance list, but was rarely used.
- That code maps to ICD-10 code S06.5X0A. Unfortunately, so do ICD-9 codes 852.20 and 852.21, which were two of the top diagnoses paired with 2.22. Other common diagnoses for TBI appear to be similarly affected.
- AMPRA is aware of the issue and is working on a strategy to have CMS fix this. There are a few IGCs that are similarly affected, but none are as heavily impacted as IGC 02.22.
Question

**Traumatic Brain Injury**

- For a diagnosis of traumatic subdural hematoma, **MUST** the diagnosis include a positive loss of consciousness for it to be presumptively compliant?

- According to CMS list, S06.5X0A for traumatic subdural hematoma **without** loss of consciousness is presumptively compliant. However, it is noncompliant in eRehabData.

- In ICD-10, TBI impairment group patients without LOC are showing as non-compliant. Is this a function of new CMS 13 criteria or an eRehabData error?

Answer

- Yes; loss of consciousness must be stated in order to avoid non-compliance due to the exclusions.

- It is on the presumptive list and would be compliant as a comorbidity or with an IGC **other than TBI**, but it is excluded from compliance with TBI. Refer to the IGC list that includes compliant impairment groups and the diagnoses that are excluded from compliance with each IGC.
Question

**Traumatic Brain Injury**

- Is it acceptable to determine duration of loss of consciousness based on Glasgow Coma Scale levels documented by physician and/or nurses?

- We are having a lot of problems getting the information from the acute care hospitals. Any hints would be helpful. Our compliance percentage is suffering greatly due to the excluded codes for TBI.

Answer

- Yes, you can use Glasgow Coma Scale scores to determine loss of consciousness, but the key is that the physician has to document it, not the nurse.

- **Hints:**
  - Educate your liaisons about the details you need for ICD-10 coding. They are often at the acute hospital in the acute medical record to find loss of consciousness documented. If they include it on their pre-admission screening, your physician is more likely to be reminded to include it in his/her documentation.
  - Liaisons rarely look at EMS/ED paperwork when completing their pre-admission screening because you are accepting patients based on current needs and functional level. However, documents are good resources for loss of consciousness.
Question/Answer

Traumatic Brain Injury
- If you use a 7th character of "D" in the etiology with the noncompliant TBI’s, it will count as compliant. Why does the software allow that? This will unintentionally allow novice coders to gain compliance and skew regional outcomes data.

- Answer: It is possible that a patient will be admitted to rehab secondary to a late effect traumatic brain injury. eRehabData cannot prevent users from inputting a code with a D as the 7th character since we have no idea what the circumstances around the patient’s admission are.

Question/Answer

Non-Traumatic Brain Injury
- Is new combo code for Hepatic Encephalopathy going to be a red flag for 02.1 IGC?

- Answer: There is no single code that captures hepatic encephalopathy. Therefore, depending on your circumstances, you could code G92.49 - other encephalopathy along with K72.90 - hepatic failure without coma or K72.91 - hepatic failure with coma.

- I have no idea if it will be a red flag.
Non-Traumatic Brain Injury

- A patient is admitted to the inpatient rehab unit with encephalopathy following a seizure. The patient has a history of CVA with resulting seizure disorder and vascular dementia. The patient is found to have suffered a concussion s/p fall from the seizure with loss of consciousness of less than 30 minutes.

- Would the etiologic be encephalopathy, TBI sequelae, and vascular dementia comorbid conditions on the IRF-PAI?

- How would this be coded on the IRF-PAI and UB?

- Please discuss some instances when encephalopathy is used as etiologic condition.

Answer

- The physician would have to tell you whether the deficits were related to the fall/TBI or encephalopathy. If encephalopathy, code:
  - IRF-PAI Etiologic Diagnosis:
    - G93.40-Encephalopathy, Unspecified
      - Code more specifically as the physician’s documentation allows. Perhaps metabolic encephalopathy G93.41
      - Use this if the physician indicated it was the reason for the rehab admission
  - UB-04 Principal Diagnosis:
    - G93.40-Encephalopathy, Unspecified
      - Query physician for more specific as stated above
Answer

**Comorbidities:**
- IRF-PAI ONLY: S06.0X1A- Concussion with loss of consciousness of 30 minutes or less, initial encounter
- UB-04 ONLY: S06.0X1D- Concussion with loss of consciousness of 30 minutes or less, subsequent encounter
- F01.50 Vascular dementia without behavioral disturbance OR F01.51 Vascular dementia with behavioral disturbance
- R56.9- Seizure NOS
  - Seizures not diagnosed as a disorder or recurrent (i.e., non-epileptic) should specify the condition being: Febrile (simple or complex; new onset; single seizure or convulsion; post-traumatic or hysterical; autonomic; related to a conversion d/o
  - For known seizure disorders or recurrent seizures reference epilepsy in ICD-10
- I69.998 Other sequelae following unspecified cerebrovascular disease
  - Only code this if there are sequelae from the stroke
  - Query for specific sequelae, as I69 codes are very specific to type of stroke and the impairment that exists

**If TBI, code:**

**IRF-PAI Etiologic Diagnosis:**
- S06.0X1A – Concussion with loss of consciousness of 30 minutes or less, initial encounter

**Principal Diagnosis:**
- Code primary impairment that led to IRF admission
- Example did not state deficits such as hemiplegia, cognitive deficit, ataxia
Answer

• Comorbidities:
  • G93.40 Encephalopathy, unspecified
  • F01.50 Vascular dementia without behavioral disturbance OR
    F01.51 Vascular dementia with behavioral disturbance
  • R56.9-Seizure NOS
    • Seizures not diagnosed as a disorder or recurrent (i.e., non-epileptic)
      should specify the condition being: Febrile (simple or complex; new
      onset; single seizure or convulsion; post-traumatic or hysterical;
      autonomic; related to a conversion d/o
    • For known seizure disorders or recurrent seizures reference epilepsy in
      ICD-10
  • I69.998 Other sequelae following unspecified cerebrovascular
    disease
    • Only code this is there are sequelae from the stroke
    • Query for specific sequelae, as I69 codes are very specific to type of
      stroke and the impairment that exists

Questions

• Hip fractures
  • I have noticed that almost all of my fracture of lower
    extremity cases (RIC 7; IGC 08.11) are now non-compliant
    with the 60% rule. Prior to 10/1/15, most of mine were
    complaint. Any suggestions?

  • Clarification: What etiologic diagnosis do you have with the
    IGC 08.11?

  • I noted that ICD-10 code S72.001A (unspecified neck of
    femur fracture) is not a compliant diagnosis for the Hip
    Fracture RIC (08.11). Any thoughts?
Answer

- Etiologic Diagnosis S72.001A fracture of unspecified part of the neck of femur is non-compliant.

- Physician documentation needs to specify location and give descriptors about the fracture such as:
  - Intracapsular (subcapital)
  - Epiphysis
  - Midcervical
  - Base of neck
  - Trochanteric
  - Lesser trochanteric
  - Aphophyseal
  - Intertrochanteric
  - Subtrochanteric

Question

- Pelvic fracture
  - What ICD 10-code would you enter for a left superior and inferior pubic ramus fracture?
  - What Impairment Group code would be appropriate, pelvic or multiple fractures?
Answer

• **S32.82XX** Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for open fracture
  • There are six codes below S32.82 that describe this diagnosis in greater detail
  • In this example, I would suggest querying the physician for specifics, such as:
    • Type of fracture (traumatic, pathological, stress, wedge compression, type II, burst, etc)
    • Clarify stable vs. unstable fracture
    • Specify any associated or underlying disease (e.g., osteoporosis)
    • Detail the healing progress (e.g., routine, delayed, nonunion)
    • Indicate if the encounter is for initial, subsequent, or sequelae treatment
  • Details like the above are likely to change the code.

• **IGC 08.3 Pelvic Fracture**
  • Do not use ICD 8.4 for multiple fractures of the same bone

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Question

• **Seventh Character**
  • I am seeking clarification generally concerning the seventh character extension (i.e. when and why to use initial and subsequent codes). Should we use the seventh character extensions ‘A’ for etiological and ‘D’ for comorbid conditions?
  • Is the etiological always ‘A’ because that is the reason we brought the patient to rehab?
  • When patient transferred from acute care following fracture treatment, what is the etiology code for the fracture?
  • What is the difference between the IRF-PAI and UB-04 in regards to using the seventh character extension?
  • And should we be concerned about our presumptive compliance based on the blanket prohibition against using ‘A’ for any condition in IRF?

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Answer

- The etiologic diagnosis is always 'A' unless you are admitting someone for late effect of something.

- On the IRF-PAI, the 7th character will be an A, but on the UB-04 it will be D. The coding clinic has always stated that rehab should not use acute treatment codes on the UB-04, so this is the translation of that same guideline. You cannot report the A on the UB-04 because that initial encounter took place in the acute hospital.

Answer continued

- Yes, you should be worried, but not very worried. Not only will it effect the presumptive compliance, but it will effect tiers, too. Reviewing the tiering list, there are only about 30 codes out of 2100 that have an 'A', and the frequency of use of their ICD-9 equivalent was less than 1%.

- Regarding the presumptive compliance, if you look at the codes that result in presumptive compliance most frequently, they don’t even have a 7th character. Those that do have a 7th character are typically used as the etiologic diagnosis, not the comorbidity. The 'S' 7th character seems to be our friend when it comes to loss of consciousness and things related to brain injury.
Question

Major Multiple Fractures:

- Can I use T07 as the etiologic diagnosis if my patient has multiple fractures?
- Has anyone found a way to make multiple trauma with multiple fractures compliant in ICD-10?
- Why is code T07 not to be used in patients that meet the criteria for multi-fracture? When it is listed in the IRF-PAI manual and if that code is not to be used why is it in the IRF-PAI manual.
- For multiple fracture patients who were compliant in ICD-9 under 828.0 (two lower extremity fractures or upper and lower extremity fractures), how do we make them complaint through the eRD tab?

Answer

- Use T07 only when you do not know the specific location of the fractures per the CMS help desk.

- Whenever possible, the most descriptive codes should be used. Specifically, femoral neck fractures, acetabular fractures, and skull fractures (as a combination code) have specific codes that are also 60% compliant.
• **Multiple Fractures**
  - I have a patient with a femoral neck fracture, a left radius fracture, and humerus fracture, and I am using the impairment code 08.4. Do I put all the codes for the fractures under the etiologic diagnosis A, B, and C?
  - When the fractures are coded they should not have D as the 7th character, but an A because we are treating it. Is that correct?

**Answer**

- In the case of multiple fractures, you can code each of the qualifying fractures in item 22. That mirrors the logic we used in ICD-9 when we used 828.0 or 819.0.
- For multiple trauma, record the primary trauma in item 22, and record any secondary trauma in item 24 as comorbid conditions on IRF-PAI.
- Correct; 7th character will be an ‘A’ on the IRF PAI because you are treating it.
  - NOTE: UB-04 will have a different 7th character.
**Question**

- **Major Multiple Trauma**
  - Could you provide clarification on what the criteria for Impairment Group Code 14.2 (brain injury + multiple fractures) are?
  - The IRF PAI manual (section 6, pg. 41 or pg. 161 overall) states that the etiologic diagnoses need to include the appropriate ICD -10 code of TBI + the code for multiple fractures.
  - My confusion revolves around which fractures qualify.
  - Is it the presence of ANY fracture or does it have to be a fracture that is listed under the orthopedic fractures section (e.g., femur, pelvic, tibia, fibula)

**Answer**

- The manual is not an all-inclusive list.
- The tables are meant to give you an idea of some conditions that they feel meet the intension of the impairment group code. You should have documented evidence of a brain injury + two fractures. The fractures can be anything that requires impact weight-bearing status or activities of daily living.
- For the etiologic diagnosis, use the brain injury diagnosis. The fractures will be comorbidities.
Question

- **Major Multiple Trauma**
  - We are trying to get some clarification regarding the sequencing of TBIs and SCIs when they have an associated skull or vertebral fractures.
  
  - In these instances, should the fracture code be used as the etiologic diagnosis and/or sequenced before the intracranial or spinal cord injury?

Answer

- In the combinations codes, the skull and vertebral fractures are sequenced first.
Question and Answer

• Major Multiple Trauma

• In order to assign IGC 14.2, would a skull fracture plus other fractures/amputations be appropriate for 14.2 – Brain + multiple fracture/ amputation? My specific question is whether or not skull fracture = brain? What constitutes Traumatic Brain dysfunction? What would need to be documented by the physician in order to assign the 14.2 IPG? What documentation by the physician would support traumatic brain dysfunction?

• Answer: To be classified as a brain injury, the patient should have demonstrated symptoms like gait disturbance, cognitive impairment, difficulty with activities of daily living. A documented skull fracture does not indicate the patient sustained a traumatic brain injury.

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Question and Answer

• Major Multiple Trauma

• In order to assign IGC 14.3, would a vertebra fracture plus other fractures/ amputations be appropriate for 14.3 – Spinal cord + multiple fracture/ amputation? My specific question is whether or not vertebra fracture = Spinal cord? What constitutes Traumatic spinal cord dysfunction? What would need to be documented by the physician in order to assign the 14.3 IGC? What documentation by the physician would support traumatic spinal cord dysfunction?

• Answer: To be classified as a traumatic spinal cord injury, the patient should have demonstrated symptoms like paresis or paraplegia, neurogenic bowel and bladder, and difficulty with activities of daily living. A documented spinal fracture alone does not indicate the patient sustained a traumatic spinal cord injury.

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**Question and Answer**

- **Major Multiple Trauma**
  - Brain + Spinal cord Injury - What would need to be documented by the physician in order to assign the 14.1 IGC?
    - Answer: As noted in prior slides, documentation of symptoms of both a brain injury and spinal cord injury would need to be documented to use IGC 14.3

- **Major Multiple Trauma**
  - 14.9 – Other multiple Trauma - What would need to be documented by the physician in order to assign the 14.9 IPG? *Two or more ICD-10-CM codes for trauma to multiple systems or sites, but not to brain or spinal cord*
    - Answer: Documentation should reflect which systems or sites were traumatized during the incident. To qualify, the injuries must have been sustained at the time of the trauma.
Question and Answer

Combination Codes

- Besides 08.4 Major Multiple-Fracture and Major Multiple Trauma (14.1, 14.2, 14.3 & 14.9), are there any other IGCs that should include combination codes for the etiologic diagnosis?
  - Answer: Yes; there are combination codes for brain injury and spinal cord injury as well.
  - Those that trigger presumptive compliance or a tier can be found on the CMS website.
  - Available from the “Data Files” section of the CMS website:
    http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html

Question and Answer

Cardiac

- If a patient was admitted to acute care with NSTEMI, cardiac cath and CABG were performed, and patient was transferred to rehab for continued therapy -- would it be appropriate to use the NSTEMI as etiologic diagnosis? Or would you use the coronary artery disease and code the NSTEMI as a second diagnosis on the IRF. I would use the aftercare code on the UB.
  - Answer: If it is stated that the patient has coronary artery disease, use that as the etiologic diagnosis.
Question

Debility

- If a patient was admitted due to debility from surgery for a bowel resection due to ischemic bowel, are we still using the acute condition of ischemic bowel as the principal?

- I would like some clarification on when a patient is deconditioned/debilitated due to an acute condition such as for surgery, COPD exacerbation, MS, encephalopathy, acute kidney injury, what is used first.

Answer

- The physician should indicate in the history and physical what led to the need for rehab. If the ischemic bowel is what led to the debility, code that as the etiologic diagnosis.

- I have seen many records that list multiple conditions that led to the need for the inpatient rehab stay, so I understand your concern. Query the physician if it is unclear.

- Code the primary issue that brought the patient to the hospital unless there is a more pertinent condition that arose during the rehab stay.

- If the reason for admission is multiple sclerosis or encephalopathy, remember that the IGC will not be 16-debility, so be sure the documentation clearly states that as the primary diagnosis.
Debility

- Is ICD-10 code R53.81 (Other malaise), which appears to be the equivalent of the previous ICD-9 code 799.3 (debility), ever recommended for use as a principal diagnosis?
  - Answer: No; code the medical condition that led to the need for rehab as the etiologic diagnosis.

Questions

- **Multiple Etiologic Diagnoses**
  - If a patient has a cerebral infract with hemorrhagic transformation, would that be an instance when you use 2 of the 3 spaces (on the IRF-PAI) for the etiologic diagnosis (1 for the ischemic event & 1 for the hemorrhage)?
  - Or would that be an instance when you would use the 7th character for sequelae?
    - Normally you would identify the one diagnosis supporting the most significant reason patient came to rehab. Utilize the infarct as the etiologic diagnosis and any complications that result from the hemorrhage as comorbidities.
    - However, if the infarct did not result in significant deficits, but the hemorrhage did, code the hemorrhage as the etiologic diagnosis.
Question and Answer

- **Multiple Etiologic Diagnoses**
  - For skull fracture with SDH and SAH, do you think I should use all 3 of the etiologic diagnosis spaces on the IRF-PAI?
    - 22A-skull fracture
    - 22B-SDH
    - 22C-SAH

- The skull fracture requires a combination code to be presumptively compliant. It does not matter whether it is the SDH or SAH, just as long as there is one coded along with the skull fracture as the etiology. Determine whether the subdural hemorrhage or the subarachnoid hemorrhage was the source of the greatest impairment and code that along with the skull fracture.
- I would advise double-checking the presumptive compliance list to ensure you have captured the right codes to meet compliance.

**IRF-PAI**

- **Using 3 spaces for the etiologic diagnosis**
  - Single code to classify
    - Two diagnoses
    - Diagnosis with manifestation
    - Diagnosis with associated complication
  - Assign only the combination code when all elements documented are identified by the code
  - If combination code does not describe the specificity necessary to describe the manifestation or complication, assign an additional code

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Lack of Documentation

- Our physicians are not documenting primary osteoarthritis when the patient is admitted for TKR/THR. We are currently using M17.9 (Osteoarthritis of knee, unspecified) & M16.9 (Osteoarthritis of hip, unspecified) for osteoarthritis of the hip and knee, respectively. Can we assume the arthritis is primary even if it is not stated?

Answer

- If the osteoarthritis is in the joint, which has been replaced because of the OA, you can code it as primary.

Hints:
- You should not code based on assumptions.
- Physician documentation in IRF record does not contain needed information documented in acute hospital record
  - Review CT scan, MRI, etc. for specifics
  - Review documentation from acute care hospital
  - Advise rehab physician about location of documentation and need for documentation in IRF record
- Physician did not document
  - Query the physician
  - Be consistent - Do not confuse the physician
- Provide education for pre-admission screeners about:
  - Information required by physicians and coders
  - Medical record documentation needed from acute care hospital – including ER report, physician H&P, operative reports, laboratory and imaging studies, medications, etc.
Arthritis Reminder

• If the physician documents Arthritis, remember there are additional qualifiers for Arthritis codes to be considered in the 60% compliance.

• You will be asked the following on the IRF PAI:

  • Item #24A: Are there any arthritis conditions recorded in items #21, #22 or #24 that meet all of the regulatory requirements for IRF classification. _____________ (0=No, 1=Yes)
    • If Yes, claim may be selected by MAC for review of documentation in medical record
    • IRF expected to obtain copies of therapy notes from outpatient therapy or from therapy services in less intense setting and include in IRF record in section for prior records

Question

Lack of Documentation

• If the physician only documents right temporal stroke, but does not state the vessel involved, should we be using I63.50 (Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery) or I63.9 (Cerebral infarction, unspecified)?
**Answer**

- First, query the physician for more specific details
- Otherwise, without more information code
- I63.9 (Cerebral infarction, unspecified) because occlusion or stenosis is not indicated in the example

**Questions**

**Etiology on IRF-PAI vs. UB-04**

- Etiology is debility due to aspiration pneumonia, acute renal failure or acute CHF-

- When we code the diagnosis on the UB-04, do we continue to use the acute diagnosis?

- Does it depend on how they are being treated?
Answer

- Principal Diagnosis: The condition that required the IRF admission
  - Code that represents the impairment (hemiparesis, cognitive deficit, ataxia)
  - Code that represents the condition treated (multiple sclerosis, rheumatoid arthritis)
- Use traditional coding guidelines when coding the UB; do not duplicate the acute condition that was addressed in the hospital

Question

Etiologic Diagnosis

- What do you recommend for assigning the correct etiologic diagnosis on the IRF-PAI when the coding summary has only one ICD-10 code for admitting diagnosis? Are your coders assigning the second and/or third etiology on the UB?
- If your PPS coordinator picks the codes from the coding summary for the IRF-PAI, how do you ensure a combination code hasn’t been accidentally assigned as a single code (without going blind from scanning through the IRF-PAI Training Manual for each and every PAI)?
Answer

- In most instances, that one code will be the only etiologic diagnosis for the IRF-PAI. There are not many requiring combination codes.

- Unfortunately, it is going to take everyone time to recognize these codes, and learn which require combinations and which do not.
  - Consider altering your process and having the coder indicate the combination codes on the coding summary for the PPS coordinator
  or
  - PPS coordinator has to be the REHAB EXPERT, which require more research on each PAI.

Question

- **Etiologic diagnosis coding**
  - I have a question for you now that the DM and gangrene codes are in combination with ICD-10.

  - If the etiology is E1152 type 2 DM with DM PVD with Gangrene s/p BKA, do I change to E1151 type 2 DM with DM PVD without gangrene for the UB?

  - In ICD-9, I would have removed the sole gangrene code.
Coding Tip/Clarification

- First, be cautious about entering the dot (.) for ICD-10
  - E1152 is not a code
  - E11.52 is Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene

- Placement of the dot (.) is imperative as some ICD-10 codes without the dot (.) are recognized as ICD-9 codes
  - For example: ICD 9 E871 (foreign object left in body vs. ICD-10 E87.1 (hypo-osmolality and hyponatremia)

Answer

- **For the UB-04**
  - Principal Diagnosis: Z47.81 Encounter for orthopedic aftercare following surgical amputation
  - Additional diagnosis: Z89.612 Acquired absence of left leg, above knee
**Question**

**Tiering Comorbidity**

- Patient admitted with a dehisced wound, which is being treated with a wound vac.

- Are we required to code T81.31XD (Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter), or is it acceptable to use T81.31XA (Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter) to get payment tier?

**Answer**

- First, it has to be determined if the treatment in the IRF is active versus routine care.
  - Is the IRF physician actively managing the care of the wound, possibly changing orders based on assessments, etc.?
  
  Or
  
  - Is the physician and other clinical staff simply following the orders written from the acute setting?

- This determination would dictate the seventh character for the IRF-PAI.

- For the UB-04, T81.31XD should be used.
Comorbidities

- Our internal coding audit stated that we should not code primary hypertension if we have also coded hypertensive chronic kidney disease. And would that mean that we also would not include chronic kidney disease (if hypertensive kidney disease was already listed)?

  - Answer: Yes; eliminate duplication
  - However, if the conditions are stated separately, code them separately. You should not create a causal link.
  - Be cautious that you are not eliminating a Tiering Comorbidity (based on specific ICD-10 codes).

Question

Comorbidities

- Do Z codes and W codes belong on the IRF-PAI?

- For example, should I include codes such as: Z79.4 (long term current use of insulin) or W19.XXXD (Unspecified fall, subsequent encounter) on the IRF PAI?
Answer

• **Comorbidities**
  - A comorbidity is a specific condition that affects a patient in addition to the principal diagnosis or impairment that places a patient into the rehabilitation impairment category.
  - List ALL comorbid conditions that meet the definition for reporting, not just those that affect Medicare payment.

Better outcomes for everyone.

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Question

**Aftercare Codes**

- In ICD-10 for the UB-04 coding, I often used aftercare codes such as V58.73 (aftercare following surgery of the circulatory system) for a rehab patient that was s/p surgery for a peripheral bypass and, of course, would code the deficits debility etc. I liked these codes to show the patient was a post-surgical patient.
- But I do not like the wording of the ICD-10 counterpart, Z48.812 (encounter for surgical aftercare following surgery on the circulatory system). Rehab is not surgical aftercare. Although some attention is given to the surgical wound. I have not been coding the Z48 category for the UB-04 coding on our post-surgical patients so far.
- What are your thoughts on using the Z48 category? Or is there another code I could use instead?

Better outcomes for everyone.
Answer

- Procedure codes do not affect the CMG
- Considering coding that supports the medical necessity for the IRF admission
- If the other codes paint this patient as a post-surgical patient based on the detailed descriptions within the codes, then it is not necessary to use the Z48 codes.
  - Example: I97.130 Postprocedural heart failure following cardiac surgery
- However, Z48 codes may provide the best options for illustrating the patient’s needs-support the medical necessity of the IRF admission.
- In the end, this is an internal decision, and each facility must decide which procedures codes to assign

Question

- Adverse Effects
  - Would adverse effects (i.e. T50.2X5A) be something to include in the comorbidities? Or does it fall under the same category as encounters and past procedures, which do not get included in the comorbidities?
**Answer**

- If complications caused by the substance (ex: cardiac arrest, convulsions, arrhythmias, etc) are being managed during the patient’s rehab stay, include it in the comorbidities.
- If there are no unresolved complications, do not include the conditions on item 24 of the IRF-PAI.
- Be sure to use the subsequent encounter T50.2X5D – Adverse effects of carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, subsequent encounter.

**Question**

- **Procedure codes/V57.89**
  - Do you know if we need specific procedure codes for the type of therapy PT, for example, gave a patient or can the general PT, OT, SLP codes be used?

  - "There are some changes in the ICD-10 procedure coding regarding the physical, speech, occupational therapy, etc. to several degrees of specificity, and before we break down all of these options, we wanted to check to see if the procedure codes continues to be recommended for data/and or reimbursement purposes?"
**Answer**

- ICD-9-CM – V57.89 Care involving multiple therapies
- ICD-10-CM - No comparable code to report admission for multiple rehabilitation therapies
- ICD-10-CM does not have separate diagnosis codes for physical, occupational or speech therapy or a code specific for admission for rehabilitation therapies
- Report a code for the condition that required the therapy
- Since we do not get paid on the rehab DRG 945, it is not necessary to use procedure codes or their equivalent

**Better outcomes for everyone.**

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**Question**

**Billing/Payment**

- Does the UB-04 need to be billed with a DRG in 945/946 series – which is a Rehab DRG – even though we are paid by CMG?
  
  (there is a list on the CMS website regarding principal diagnosis from MDC 23 along with procedure code for rehab that will put the account in the rehab DRG; but, the diagnoses on this list do not always reflect the scenarios we see)

- Are bills being denied for IRF stays because DRG does not fall within the Rehab DRG?

**Better outcomes for everyone.**
• For Medicare patients, it is not necessary to use a procedure code to get DRG 945 or 946.
• In rare circumstances, if an insurance provider pays you the DRG rate, you may need to code relevant procedures to trigger DRG 945/946.
• Some commercial insurances are requiring DRG 945/946 to be present on the bill even if your contract rates are not DRG related.