**Long term care coding issues for ICD-10-CM**

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Related Information

**Long Term Care Coding Issues for ICD-10-CM**

Coding guidelines and examples were provided in *Coding Clinic for ICD-9-CM*, Fourth Quarter 1999 with regards to the application of coding guidelines for long term care (LTC). Similarly, inquiries have been received regarding how coders should sequence the principal diagnosis when coding in the long term care (LTC) setting. The following have been developed and approved by the Cooperating Parties in conjunction with the Editorial Advisory Board of Coding Clinic, to standardize the process of data collection for LTC and to assist the coder in coding and reporting these cases using ICD-10-CM.

The diagnostic listing in long term care (LTC) is dynamic and dependent on many factors and has a longer time frame than an acute care stay. ICD-10-CM codes are assigned upon admission, concurrently as diagnoses arise, at the time of discharge, transfer, or expiration of the resident. The UHDDS definition of principal diagnosis (that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care) has been expanded since its initial development and now includes all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). Other diagnoses present (e.g., chronic conditions), which affect the resident’s continued care, should also be coded. The listing of diagnoses in the long-term care setting, may vary depending on the point in time when coding is being done.

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. For example, when coding an admission to the facility, the “first listed diagnosis” is the condition chiefly responsible for the admission to the facility. If coding diagnoses during the resident’s stay, it is the condition chiefly responsible for the continued stay in the facility.

**Question:**

A patient is discharged from the hospital and admitted to a long-term care facility (LTC) with a diagnosis of acute cerebral infarction with left-sided hemiparesis and dysphasia. The diagnosis on admission to the LTC is documented as acute CVA. What is the appropriate code assignment to describe this patient’s condition?

**Answer:**

Assign code I69.354, Hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, and code I69.321, Dysphasia following cerebral infarction, to completely describe the patient’s condition. The hemiparesis and dysphasia are considered sequelae of the
acute CVA for this LTC admission. Coding guidelines state that these “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. Codes from I60- I67 are reserved for the initial (first) episode of care for the acute cerebrovascular disease. Please refer to the 2013 edition of the coding guidelines for guidance as to the use of dominant/nondominant side for codes from category I69.

Question:

Does the medical documentation have to state “old CVA” in order to use the sequelae (I69) codes for the LTC admission?

Answer:

No, there is no time limit on when a late effect code may be used since the neurologic deficit caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to I60-I67. When the patient is admitted to long term care (LTC) following treatment of an acute CVA, a code from subcategory I69.3, Sequelae of cerebral infarction, is assigned for the LTC admission.

Question:

A patient is admitted to the LTC facility following treatment of an acute CVA. The patient made a complete recovery from the CVA. She was diagnosed with progressive senile dementia, coronary artery disease and congestive heart failure. Because of her deteriorating physical status and chronic medical conditions, she was admitted into a long-term care facility. How would you code and sequence these diagnoses?

Answer:

Any of the chronic medical conditions may be sequenced as the first-listed diagnosis. Therefore, assign codes F03.90, Unspecified dementia without behavioral disturbance, I50.9, Heart failure, unspecified, and I25.10, Atherosclerotic heart disease of native coronary artery without angina pectoris. A code from category I69, Sequelae of cerebrovascular disease, is inappropriate, because there are no residuals from the CVA. Code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, may be assigned as an additional diagnosis, to identify the history of CVA.

Question:

The patient is transferred to LTC for physical therapy following a hospitalization for treatment of an acute pelvic and clavicular fracture. How should the LTC stay be coded?

Answer:

When a patient is admitted to the LTC specifically for rehabilitative physical therapy following an injury, assign the acute injury code with the appropriate 7th character (for subsequent
encounter), as the first listed diagnosis. In this example, assign code S32.9XXD, Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing, or S42.009D, Fracture of unspecified part of unspecified clavicle, subsequent encounter for fracture with routine healing, as the reason for the admission. Assign the appropriate procedure code to show that the physical therapy was provided. It is inappropriate to assign aftercare Z codes for aftercare for traumatic fractures in ICD-10-CM. Refer to Section I.C.19.c., of the Official Guidelines for coding and Reporting for the Application of 7th characters for Chapter 19.

Question:

A patient is admitted to LTC following hospital treatment of a fracture of the right femur. The reason for the LTC admission is to allow the patient to regain strength and the fracture to heal. What code is used to describe the LTC admission?

Answer:

Assign code S72.90XD, Unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing, as the principal diagnosis. The 7th character “D” is used for encounters after the patient has received active treatment for the condition and is now receiving routine care during the healing or recovery phase. Code any other coexistent conditions that require treatment. Do not assign an aftercare Z code.

Question:

A resident in LTC facility develops a urinary tract infection (UTI), which is treated and resolved during the LTC stay. Should the UTI be coded?

Answer:

Assign code N39.0, Urinary tract infection, site not specified. The diagnosis would be part of the resident’s active problem list until the infection is resolved, at which time it would no longer be coded and reported.

Question:

A resident returns to the LTC facility following hospital care for pneumonia. The physician’s orders state, “continue IV antibiotics for 3 days,” after which time the resident is to have a repeat x-ray to determine status of the pneumonia. Would you code the pneumonia?

Answer:

Yes, the pneumonia should be coded. If the physician does not identify a causal organism (e.g., staph, strep, pseudomonas, etc.), assign code J18.9, Pneumonia, unspecified organism, until the condition is resolved, after which time it would no longer be coded and reported.
**Question:**

A nursing home resident is transferred to the hospital for treatment of pneumonia. She returns to the nursing home and is still receiving antibiotics for the pneumonia. However, the main reason she is returning to the nursing home is because this has been her residence since developing a CVA with residuals several years ago. Which diagnosis should be listed first at the nursing home, the pneumonia or late effects of the CVA? Would it make any difference if the pneumonia was no longer receiving any treatment upon the resident’s return to the nursing home?

**Answer:**

Assign the appropriate code from subcategory I69.3, Sequelae of cerebral infarction, as the principal diagnosis to identify the neurologic deficits, which resulted from the acute CVA. Assign the appropriate code for the pneumonia as a secondary diagnosis, for as long as the patient receives treatment for the condition.

**Question:**

A nursing home resident fell and was transferred to the hospital for treatment of a left wrist fracture. After inpatient surgical treatment of the fracture, he is returned to the nursing home where he has resided for several years due to Alzheimer’s disease. The patient will receive occupational therapy at the nursing home, but the therapy is not the primary reason for the nursing home admission. How should this be coded?

**Answer:**

Code G30.9, Alzheimer’s disease, unspecified, should be the principal diagnosis. Assign code S62.102D, Fracture of unspecified carpal bone, left wrist, subsequent encounter for fracture with routine healing, as a secondary diagnosis, for the healing wrist fracture, and code W19.XXXD, Unspecified fall, subsequent encounter. Assign the procedure code to show that the patient received occupational therapy.

**Question:**

When patients are admitted to a nursing home for convalescence following an acute illness or injury, is code Z51.89, Encounter for other specified aftercare, appropriate? How would the condition that now requires convalescence be reported by the LTC? For reporting purposes, “status post” or “history of” data is often necessary.

**Answer:**

Code assignment is based upon the condition being treated as documented in the medical record. It would be appropriate to assign codes for any late effects, residual conditions, signs, or symptoms that are present. When the reason for the admission is strictly for convalescence and
there is no other definitive diagnosis, assign code Z51.89, Encounter for other specified aftercare, as the first-listed diagnosis.

**Question:**

When a patient is transferred to a nursing home for convalescence and strengthening following coronary artery bypass surgery, which diagnosis is first listed for the LTC? The aftercare codes seem to relate to post surgical wound care and generally, wound care can be provided at home. The main reason for admission to the LTC is the patient’s debility and inability to care for himself at home. Would code Z51.89, Encounter for other specified aftercare, be appropriate, or should symptom codes (e.g., weakness, debility, etc.) be assigned?

**Answer:**

In this case, assign code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, as the principal diagnosis. The condition that was treated surgically if still present would be coded. Assign also codes for any symptoms such as weakness, gait disturbance, pain, etc., as additional diagnoses.

**Question:**

When a patient is transferred from a hospital to a nursing home for continued recovery following an acute inferior wall myocardial infarction, what is the principal diagnosis at the nursing home? Would this be considered a “subsequent episode of care?”

**Answer:**

In this case, if the patient is in the recovery phase equal to, or less than, the four-week time frame for the acute myocardial infarction (AMI), continue to use code I21.19, ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall. Please note that for encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the patient requires continued care for the myocardial infarction, codes from category I21 may continue to be reported. However, if the AMI occurred more than four weeks before, assign code Z51.89, Encounter for other specified aftercare.

It is inappropriate to assign code I22.1, Subsequent ST elevation (STEMI) myocardial infarction of inferior wall, for the LTC admission, since codes in category I22 are reserved for when a patient who has suffered an AMI has a new AMI within the four week time frame of the initial AMI, and not for subsequent episodes of care.

**Question:**

When a patient is admitted to a nursing home for “deconditioning,” how should this be coded?
Answer:

Code the symptoms of the deconditioning, such as gait disturbance, weakness, etc.

Question:

A resident in a long-term care facility has a diagnosis of “mental status changes.” How should this be coded?

Answer:

Assign code R41.82, Altered mental status, unspecified, for the diagnosis of mental status changes. This code assignment may be located in the ICD-10-CM Index by referencing, Change(s), mental status.

Question:

A patient is admitted to a long-term care facility for nonspecific reasons such as generalized weakness, debility, or deterioration (or “old age”), rather than for a specific diagnosis. What is the appropriate principal diagnosis when the patient is admitted for these nonspecific complaints?

Answer:

It would be appropriate to assign codes for the symptoms (i.e., generalized weakness, gait disturbance, debility, etc.).