# Diagnostic Dilemmas…

**Choosing the correct diagnosis and assigning the accurate code.**

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# Primary Diagnosis

*This term is often used to indicate the reason for the continued stay in the LTC facility. It is also used interchangeably with principal diagnosis.*

# Principal Diagnosis in Other Regulations

- *The Medicare Program Integrity Manual refers to the term "primary diagnosis" as the diagnosis that is the reason for therapy services. This diagnosis is also known as the medical diagnosis.*
- *The Therapy Evaluation and Plan of Care document for new Medicare Part A stays require the medical reason to support the therapy services as documented by the physician or qualified practitioner. The diagnosis code representing the medical reason may be identified as "primary diagnosis" or "medical diagnosis" on the therapy plan. This medical diagnosis may not be the same diagnosis as the reason for the continued stay (principal, primary, or first-listed diagnosis) in the facility.*

## Principal Diagnosis in Other Regulations
*(continued)*

- *For example, a patient with Parkinson's disease returns after a hospitalization for pneumonia to start a new Medicare Part A stay. Pneumonia is identified as the medical diagnosis on the therapy evaluation and plan of care to support the skilled therapy services along with the appropriate therapy treatment diagnoses. However, Parkinson's disease is the reason for the continued facility stay and continues to be sequenced first on the record and the UB-04. The reason for the new focus of care and Medicare Part A stay (i.e., pneumonia) is sequenced second.*

# Continued Treatment of Acute Conditions in the LTC Facility

- **Any acute condition treated at the hospital that continues to require follow up or ongoing monitoring should be coded with an acute diagnosis code as long as the condition persists and requires follow up. In general, the status of the acute condition would be assessed whenever the MDS is updated (i.e., patient status change or at monthly review for billing).**

## Continued Treatment of Acute Conditions in the LTC Facility (continued…)

- Codes for the acute medical condition treated and resolved in the hospital are assigned and reported by the hospital (i.e., cholecystitis, abdominal aortic aneurysm) but not coded or reported in the LTC facility. The LTC facility reports Z codes to identify the provision of aftercare. It is inaccurate to report an acute code for a resolved condition on the health record or claim because it directly contradicts the Official Guidelines for Coding and Reporting. It is also non-compliant with HIPAA regulations.

# Diagnosis List and UB-04 Claim Form

- **Prior to submission of the UB-04 claim, facilities must validate that the ICD-10-CM diagnoses reported on the claim are consistent with the health record documentation and MDS information. This is commonly referred to as a triple-check process. Reporting ICD-10-CM diagnosis codes supported by health record documentation and the MDS will support the claim submitted for therapy services. The facility's reimbursement is determined by the Resource Utilization Group (RUG) category based on the MDS assessment data. The triple-check process ensures that the diagnosis data submitted for each payment mechanism is consistent.**

# Question

**A patient is discharged from the hospital and admitted to a LTC with a diagnos of acute CVA with left sided hemiparesis and dysplasia. The diagnosis on admission to the LTC is documented as acute CVA. What is the appropriate assignment to describe the patient's condition?**

# Answer

**Assign code I69.354. Hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and code I69.321, Dysphasia following cerebral infarction, to completely describe the patient's condition. The hemiparesis and dysphasia are considered sequalae of the acute CVA for this LTC admission. Coding guidelines state that these "late effects" include neurological deficits that persist after initial onset of conditions classifiable to categories 160-167. Refer to guidance as to the use of dominant/nondominant side from category I69.**

# Question

- **The patient is transferred to LTC for PT following a hospitalization for treatment of an acute pelvic and clavicular fracture. How should the this be coded?**

# Answer

**When a admitted to the LTC for PT following an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter), as the first listed diagnosis.. (S32.9XXD and S42.009D) It is inappropriate to assign Z codes for aftercare for traumatic fractures.**

# Question

- **A patient is admitted to LTC following treatment of an acute CVA. The patient made a complete recovery from the CVA. She was diagnosed with progressive senile dementia, CAD and CHF. Because of her deteriorating condition , she was admitted into the LTC. 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, dementia without behavioral disturbance, I50.9 Heart Failure, I25.10 Atherosclerotic heart disease of native coronary artery. Code Z86.73 for CVA without residual deficits, may be used to identify the history of CVA.**

# 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 resident will receive OT at the nursing home, but the therapy is not the primary reason for the nursing home admission. What should be coded?**

# Answer

- **Code G30.9, Alzheimer's Disease, should be principal diagnosis. Assign S62.102D for fracture of unspecified carpal bone, left wrist, subsequent encounter with routine healing as a secondary diagnoses.**

Thank you!!!

QUESTIONS?