Is the ICD-10 delay a benefit to your facility?

In April, the U.S. Department of Health and Human Services confirmed its intent to delay the ICD-10 compliance deadline, originally set for October 1, 2014. The new deadline for implementation will be October 1, 2015.

Is more time a benefit or a disadvantage?

The ICD-10 delay has received a mixed response from providers and has left many facilities wondering what they should do and whether the delay is actually a benefit in the long run.

The bigger providers and suppliers look at the delay as a financial catastrophe. Many have put in the time and money to prepare for the transition, only to have the goalposts moved at the last minute. Some of them may essentially have to start from square one to invest in more training and software maintenance updates.

Many smaller facilities, meanwhile, are thankful for the delay because it gives them an opportunity to rebound from the financial impact.

Maureen McCarthy, RN, BS, RAC-CT, president of Celtic Consulting in Farmington, Connecticut, adds, “Providers are starting to get on board. People have done several levels of training, and trainers are beginning to convert from ICD-9 to ICD-10 to help relieve a potential crunch, but this change brings about less ‘now’ training because systems don’t need to switch immediately. Change always brings financial risk and complications, but teams were on the pathway to getting ready.”

The time and resources used in preparation for implementation of ICD-10 are just the beginning of the concerns regarding the delay. Other notable trouble spots and impacts include:

• **The continued delay of our healthcare system’s move toward better data.** ICD-9 is an antiquated coding system, which has a huge impact on the industry’s ability to move toward better data collection and better data use. This goes beyond the reimbursement issue as we are not only delaying improvements to data collection, but also allowing our current data to continue to deteriorate.

• **The increasing cost for implementation training.** The cost of training coders and other staff members has been significant. This cost will
only increase with the delay because staff members will have to maintain their new skills until the implementation is completed. After all, facilities cannot let their staff lose this knowledge and squander their existing training investments.

• **The impact of the coding freeze.** Many professionals are wondering if the coding freeze will be lifted so that the additional procedures and other medical breakthroughs that need new codes can be addressed.

• **How to approach initiatives that rely on ICD-10.** ICD-10 isn’t a stand-alone initiative, and many other efforts related to quality of care, such as meaningful use, will be affected by the delay. Building an infrastructure for these kinds of programs that will continue to carry poor data will not help to improve U.S. healthcare. Quality measures will only be useful when they can depend on ICD-10 coding. It must be determined whether these efforts should be temporarily suspended until ICD-10 is implemented.

• **Potential stall on academic programs.** This is a significant impact that many people have overlooked. Many colleges and universities have added staff members and changed their curriculums to coincide with the October 2014 implementation deadline. These organizations are left wondering how they should address this issue over the next few years.

There is no doubt that a number of facilities will benefit from the additional time granted by the ICD-10 delay. It is important, however, to take a look at the bigger picture to understand the delay’s full impact on facilities.

**Stay proactive**
A delay of the implementation deadline does not mean that your facility should ease up on preparation for the transition. The following are some tips to help your facility make the most of the delay while staying focused on ICD-10.
• **Communicate internally.** Make sure that all staff members involved in the ICD-10 transition are aware of the next steps in the process—including billers, coders, and clinical staff. To do so, facilities should consider the following:
  – Keep coders focused on ICD-9 and ICD-10. While they must expand and maintain their knowledge of ICD-10, they also have to maintain a focus on ICD-9 until the transition is complete.
  – Evaluate physicians’ documentation. With the delay, facilities have the opportunity to help ease clinical staff into new documentation practices. Take advantage of the time to work out any confusion or questions regarding new processes. Show them where and how the documentation must be changed.
  – Monitor conversion projects closely. They should not stall with this delay. Instead, facilities should use the time to take a close look at their projects and ensure they are on track.
  – Eliminate confusion. It is important for facilities to keep their training on track, now more than ever. There seems to be a lot of confusion among small- to medium-sized facilities, who are still stuck on the basic questions regarding ICD-10 and don’t appear to be moving along as quickly as larger facilities.
  – Evaluate coding tools and additional training aides. Many external companies will take advantage of the extra time to provide additional training tools for coders and other staff members impacted by the delay.

• **Make sure vendors are ICD-10 ready.** Now is the time to ensure that your software vendors are ICD-10 ready. With a focus on the electronic health record and other technologies, facilities have many systems that need to be ICD-10 compatible from the start, and it is far more expensive to retrofit software than to get it right the first time.

• **Review payer contracts.** These contracts are written for specialties. Don’t rely on your payer contracts and take advantage of the extra time.

• **Perform a gap analysis for office impacts.** Identify the areas where your facility is lacking in ICD-10 preparation. Determine where the facility needs to be at the implementation deadline and what steps still need to be taken to get there, then establish a plan of action to achieve compliance.

• **Evaluate impact on revenue and establish a line of credit.** It is critical to have a line of credit ready in situations like this. There is no doubt that the delay will have a financial impact on your facility, and you need to be prepared for it.

• **Work with organizations to keep ICD-10 a top priority.** While this transition might have been easier 10 years ago, with simpler technology and fewer competing initiatives, it is important to remember that this complex project is going to happen, so facilities and organizations need to work together to keep it a priority.

**Can’t we just skip to ICD-11?**

Since the announcement of the delay, there has been some buzz within the industry on whether it would be better to skip ICD-10 completely and focus on adopting ICD-11. Unfortunately, this is not a feasible option.

ICD-11 is built and based upon ICD-10. Skipping directly to ICD-11 will cause us to miss crucial foundational elements introduced in ICD-10. As well, ICD-11 isn’t anywhere near ready. We can’t wait too much longer because ICD-9 is running out of space. ICD-9 has outlived its usefulness, and we need ICD-10 to take its place.

**Diane L. Brown,** director of postacute education at HCPro in Danvers, Massachusetts, adds her guidance: “The transition to ICD-10 has been delayed until 2015, but considering the preparation and education in the LTC industry was lagging behind all other segments of healthcare, this opportunity affords us the time to be able to manage the transition, uncover the scope of its impact, and begin implementing the necessary processes and educational plans.”

Remember, even though it’s been delayed, the ICD-10 implementation deadline will still eventually arrive—so ensure that your facility has taken advantage of the additional time it has to eliminate any confusion or problems before October 2015 comes.
How to implement the triple-check system into your facility

Errors in Medicare billing can cost your facility a huge amount of money. They can also trigger a Medicare review or audit. The easiest way to avoid potential problems in the claims billing process is to implement regular triple-check meetings.

With the increase in audits, it is essential that claims are prepared and billed correctly, with the proper backup to support what you bill. The last thing any facility wants is to have to pay back large amounts of money. A properly designed and implemented triple-check system is one of the best methods to streamline the billing process and eliminate costly billing errors. In addition, a solid triple-check system designed to internally audit claims prior to submission may decrease the facility’s chances of being audited and improve cash flow to facility operations.

What is the triple-check system?

The triple-check system is a claims review process SNF personnel typically conduct in a group meeting. The system can eliminate technical issues such as inaccurate modifiers or incorrect ARDs, procedural errors, and documentation mistakes such as inconsistencies between documentation and the MDS. These problems are usually responsible for inaccurate claim submission.

To implement a triple-check system in your facility, begin by identifying the key personnel who contribute to the billing process. Usually, these individuals are any of the following:

- The business office manager
- The DON
- The MDS coordinator
- The administrator
- Members of the therapy department
- Members of the medical records department
- Members of the central supply department

These individuals are responsible for verifying the accuracy of claims prior to submitting them to the fiscal intermediary or MAC.

Triple-check meetings

The triple-check meeting is a key monthly process designed for reviewing all of a facility’s Medicare claims before they are submitted to Medicare. By bringing together representatives from participating facility departments, all claims are reviewed for quality and accuracy.

Maureen McCarthy, RN, BS, RAC-CT, president of Celtic Consulting in Farmington, Connecticut, notes, “This is the second most valuable meeting at a facility. The Medicare meeting is your first.”

During triple-check meetings, each person should carefully review claims and supporting documentation, paying close attention to items associated with his or her area of expertise. The basic triple-check process includes review of the following for data accuracy, coding, and field placement on the form:

- MDS RUG code and applicable billing days
- MRS submission date and acceptance
- ARD and HIPPS code for accuracy and compliance

McCarthy adds, “Triple check is your invoice that goes to Medicare. If it’s not correct, you’re leaving yourself open to audits, appeals, liabilities.”

Education and monitoring

Formulating a proactive approach to identify and correct billing issues internally before they become problematic is always good practice.

Education and training on billing, coding, and documentation is essential. Monitoring the outcomes of triple-check system audits can pinpoint areas where additional staff training is needed. It is also best practice to track, trend, and remediate errors identified in the process.

Responsibilities under the triple-check system

One of the best ways to develop and maintain a successful triple-check system is to clearly identify the responsibilities of each individual involved. Creating a
tool describing these tasks, such as a checklist, can help focus SNF personnel and ensure that every aspect of the system is covered.

The SNF personnel and responsibilities involved in the triple-check process vary depending on whether the claims being reviewed are Medicare Part A or Part B. For example, the MDS coordinator’s involvement is essential when Part A claims are reviewed, but it would not be necessary when Part B claims are reviewed. Therefore, SNFs should establish separate triple-check systems for Part A and Part B claims.

Although the following outline is a comprehensive guide to each individual’s responsibilities under the Medicare Part A and Part B triple-check program, a facility may choose to add components based on its needs.

**Medicare Part A triple-check system**

The business office manager should verify that:
- A qualifying stay and days are available per the Common Working File/HETS
- The qualifying stay on the UB-04 matches the face sheet and hospital medical records
- The admit date and service dates are included on the UB-04
- The financial file includes a completed and signed Medicare Secondary Payer (MSP) form

The business office manager and MDS coordinator should work together to verify that the:
- RUG on the MDS matches the RUG on the UB-04
- ARDs for each MDS agree with the UB-04
- The financial file includes a completed and signed Medicare Secondary Payer (MSP) form

The business office manager, MDS coordinator, and facility director of rehabilitation should verify that the:
- Minutes on the MDS match the therapy log for each therapy discipline
- Minutes on the MDS and log match the units billed on UB-04 for each therapy discipline

The DON and the medical records staff should work together to verify that:
- The resident required Medicare skilled intervention through supporting clinical documentation during the dates of service
- Physician certification and recertification signatures and dates are present
- Physician orders were obtained and implemented

The facility director of rehab should verify that:
- Rehab services are stated on the physician orders
- Therapy evaluation includes prior level of function
- Clinical documentation states progress warranting continued skilled intervention

The administrator should:
- Ensure timeliness and effectiveness of the triple-check system
- Monitor communication effectiveness of facility processes between the interdisciplinary team

**Medicare Part B triple-check system**

The business office manager should verify that:
- The covered service dates on the claim match the census covered days
- The financial file includes a completed and signed MSP form

The business office manager and facility director of rehab should work together to verify that:
- The HCPCS code on the claim matches the HCPCS procedure performed per the therapy log
- The appropriate modifier was used
- The minutes and units on the claim match the therapy log
- Value, revenue, and occurrence codes are accurate

The business office manager and DON should work together to verify that:
- Certification and recertification are signed and dated
- Orders are documented and signed for all services being billed

The therapy department staff should verify that:
- Therapy services that are given are stated on physician orders
- Evaluation includes prior level of function
- Clinical documentation states progress toward goal

The business office manager and medical records staff should work together to verify that:
• Sequencing of principal diagnosis code on the claim and face sheet
• Service dates on the claim form

The business office manager and central supply staff should work together to verify:
• The ancillary charges on the claim form

The administrator should:
• Ensure timeliness and effectiveness of the system

The Benefits and Challenges with Medicare Advantage

Unlike the government-run traditional Medicare option, the current Medicare Advantage (MA) program requires CMS to contract with private health plans on a prospective payment basis. These health plans then contract with individual medical groups as well as preferred provider networks to deliver the care that beneficiaries would customarily be entitled to when enrolled under the traditional Medicare program.

The MA plan is another name for Medicare Part C. A beneficiary may select an MA plan versus a traditional fee-for-service plan, either initially or during open enrollment. All-inclusive plans include Parts A, B, and sometimes D. Private insurance carriers have special contracts with Medicare to provide this coverage. Medicare provides a fixed allocation for the beneficiary’s care to the MA carrier to manage.

While MA has its positives, it also presents some issues to the SNF community. Below we have detailed several important aspects of MA: its coverage, plans, advantages, and challenges.

Coverage

MA plans must cover all of the services that original Medicare covers except hospice care. An MA plan can choose not to cover the costs of services that aren’t medically necessary under Medicare. Monthly premiums include the Part B premium ($104.90) and the monthly premium for the MA plan. Advanced pre-authorized approval is at the discretion of the MA and is often completed with assistance from the hospital case manager or SNF representative. It’s very important to note that should this part of the process not be followed as the MA directs, the patient may be liable for payment of services.

A MA plan must provide coverage through a “home” SNF (defined at 42 CFR § 422.133(b)) of post-hospital extended care services to enrollees who previously resided in a nursing facility prior to the hospitalization, provided:
• The enrollee elects to receive the coverage through the home SNF.
• The home SNF either has a contract with the MA organization (MAO) or agrees to accept substantially similar payment under the same terms and conditions as applicable to similar nursing facilities that contract with the MAO. This requirement also applies if the MAO offers SNF care without requiring a prior qualifying hospital stay.

The scope of services, cost sharing, and access to coverage provided by the home SNF must be no less favorable to the enrollee than post-hospital SNF coverage that would be provided to the enrollee by a SNF that would be otherwise covered under the MA plan (42 CFR § 422.133(c)).

Types of MA plans

Types of MA plans include:
• Health maintenance organization (HMO) plans
• Preferred provider organization (PPO) plans
• Private fee-for-service (PFFS) plans
• Medicare special needs plans (SNP)

Less common types of MA plans include:
• HMO point of service (HMOPOS) plans
• Medicare medical savings account (MSA) plans
**HMO plans**

HMO plans must get care and services from doctors, other healthcare providers, or hospitals in the plan’s network. Subscribers may be able to go out of network for certain services, usually for a higher cost, which also results in a higher premium. This is called an HMO with a point-of-service (POS) option.

There are several items to note related to MA HMO plans. These include:

- Prescription drug services are usually included
- In-plan primary care doctors are usually required
- Except for preventive services, beneficiaries need referrals to specialists
- Beneficiaries may have to pay full cost for care received outside of the plan’s network

**PPO plans**

PPO plans are usually two-tiered coverage: in-plan coverage, which is less expensive, and out-of-network coverage, which has a higher copayment.

In most cases, healthcare may be obtained from any doctor, other provider, or hospital in PPO plans. Patients may or may not need to name their primary care provider. These plans may offer extra benefits above the Medicare level for an additional premium.

**PFFS plans**

PFFS plans aren’t the same as original Medicare or Medigap. The plan (insurance company) determines how much it will pay and how much the beneficiary pays. A subscriber can go to any Medicare-approved doctor, other healthcare provider, or hospital that accepts the plan’s payment terms and agrees to treat you. Not all providers will accept PFFS plans.

**Demonstrated care coordination and superior clinical outcomes**

Operating with a global budget and leveraging their capability to measure and report both quality performance and beneficiary satisfaction, MA plans have demonstrated increased care coordination and superior clinical outcomes. As a result, these plans are becoming increasingly attractive options for Medicare beneficiaries. In fact, 50% of new Medicare enrollees end up choosing an MA option—enrollment in the program now exceeds 16 million beneficiaries.

There are three reasons why the MA program is so successful. They include:

- **Beneficiaries enjoy abundant choice and predictable costs.** In 2014, beneficiaries have an average of 18 MA options. They can choose between this plethora of options by using the CMS website, which offers an online marketplace, including comparisons of quality and cost. According to recent Kaiser Family Foundation research, beneficiaries last year paid average monthly premiums of only $49, and most of these MA plans included Part D drug coverage.

  Additionally, unlike traditional Medicare, MA enrollees benefit from a limit on out-of-pocket costs. This gives enrollees—who are often living on fixed monthly incomes—more predictable costs and greater financial security.

- **Program structure provides incentives for superior quality outcomes and service.** The structure of MA creates incentives for providers to deliver comprehensive preventive services (resulting in superior clinical quality) and offer an excellent patient experience. They know that satisfied beneficiaries will stay with the same plan and delivery system during the next annual selection process—which translates into positive financial outcomes for the provider. Further, since government payments are based on the age of patients and the diseases they have—not the number of procedures performed—MA programs do best when physicians and hospitals provide comprehensive preventive services, intervene early for patients with chronic illnesses, and avoid complications.

  Although it’s difficult to compare overall outcomes, data from the National Committee for Quality Assurance shows that MA organizations that score the highest tend to use a dedicated, integrated delivery system, and deploy a comprehensive electronic medical record (EMR).

- **The Five-Star Quality Rating System holds delivery systems accountable.** An important feature of the MA program is the use of a Five-Star Quality Rating System. Organizations
participating in the MA program must report quality and patient satisfaction data to CMS on an annual basis. Based on this information, each MA program is awarded between one to five stars. The Five-Star system rewards the highest-rated organizations—the ones that demonstrate superior quality and service results—with additional payments. With these dollars, they can invest further in the care of their members. Over time, this approach encourages every program to strive for higher quality and helps direct patients to the delivery systems that successfully do so. Most importantly, it results in patients obtaining even better medical care and more comprehensive preventive services.

**Learning from Medicare Advantage**

A lot goes into achieving superior performance, increased care coordination, and improved quality outcomes.

For starters, care providers can’t allow patients to “fall through the cracks” when they receive treatment from multiple doctors or in multiple venues. Achieving this increased degree of safety requires a dedicated delivery system committed to seamlessly transitioning patients and their medical information from one provider or venue to the next. It also requires the deployment and meaningful use of a comprehensive EMR that provides vital information at every point of contact. Having this information allows gaps in prevention to be addressed immediately and by all physicians involved in the patient’s care. Additionally, prospective payment creates incentives to provide appropriate preventive services, minimize complications, and ensure patients recover as soon as possible.

The MA program offers a model for broader delivery system reform as we continue the journey from a fee-for-service/pay-for-volume “sick care” system to a pay-for-value/health-promoting approach.

**The challenges**

Although beneficiaries are choosing MA plans, it is becoming increasingly difficult for LTC facilities to deal with the multitude of plans, navigate benefit options, learn start and stop dates, and deal with benefit denials.

**Maureen McCarthy, RN, BS, RAC-CT,** president of Celtic Consulting in Farmington, Connecticut, says, “At a recent CMS Open Door Forum, someone asked a question about claims for Part A service, which turned into another question about following up with vendors, which ran to an answer that there would be a committee to deal with managed care questions/issues.”

“It’s very common to hear from the SNF providers the frustrations in dealing with MA coverage rejections or denials for services that otherwise would be covered by traditional Medicare insurance. It seems that the requirement of these plans to provide the same coverage benefits that the traditional program does isn’t always the case. This is an important item to point out when having to respond to denial letters to the MA programs.”

—Reta Underwood, ADC

Having a committee to handle queries, paperwork issues, and other related information could potentially circumvent some of the challenges that MA poses. Right now, providers have to go back to the vendors themselves, and doing so can have mixed results.

McCarthy adds, “There is significant revenue at stake. SNF providers were happy to hear that there will be a dedicated committee to help with queries and paperwork issues, but we have to wait to see how that plays out.”

**Reta Underwood, ADC,** president of consultants for Long Term Care, Inc., in La Grange, Kentucky, notes, “It’s very common to hear from the SNF providers the frustrations in dealing with MA coverage rejections or denials for services that otherwise would be covered by traditional Medicare insurance. It seems that the requirement of these plans to provide the same coverage benefits that the traditional program does isn’t always the case. This is an important item to point out when having to respond to denial letters to the MA programs.”
Prepayment medical review results yield high denial rates for therapy services

Due to an increase in the denial rates for therapy claims, providers who render therapy services need to be aware of some of the issues and provide information to address these denials.

Many denials are the result of documentation that:
• Is missing or incomplete
• Does not support medical necessity for the services provided
• Does not support that the skills of a therapist were required for the described services to be carried out

The following information will assist you in the event your facility experiences denials for therapy claims.

Therapy coverage
Coverage for skilled therapy services does not depend on the presence or absence of a beneficiary’s potential for improvement from therapy services, but rather on the beneficiary’s need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. These skilled services may be necessary to improve or maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition. There are situations in which the patient’s potential for improvement would be a reasonable criterion to consider, such as when the goal of treatment is to restore function. An “expectation of improvement” should not be applied when determining Medicare coverage for maintenance claims in which skilled care is required. As always, documentation needs to fully support that the therapy services are medically necessary and that the skills of a therapist are required for these services.

Submitting documentation
To address denials for missing or incomplete documentation, the appropriate staff members at your facility must be aware of what documentation to submit when responding to National Government Services additional development requests (ADR). See the May Billing Alert for Long-Term Care article, “Frustration and paperwork surround ADR requests,” for more detailed information.

Signature guidelines
Issues have been noted with the physician’s signature in the beneficiary’s medical record, including missing or illegible signatures in the plan of care, certification, notes, and flow sheets. To review signature requirements and guidelines, refer to MLN Matters article MM6698, “Signature Guidelines for Medical Review Purposes.” Become familiar with the signature requirements for therapy services in the CMS Internet-Only Manual Publication 100-02, and the Medicare Benefit Policy Manual, Chapters 8 and 15.

2014 therapy cap
Annual limitations on per-beneficiary incurred expenses for outpatient therapy services under Medicare Part B are commonly referred to as “therapy caps.” Since the therapy caps are determined on a calendar year basis, all beneficiaries began a new cap year on January 1, 2014. For physical therapy and speech-language pathology services combined, the 2014 limit on incurred expenses is $1,920. For occupational therapy services, the 2014 limit is $1,920. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

Provider action
Please share this information with the appropriate departments who might be involved in ordering, providing, billing, or reviewing medical records and documentation for therapy services. To help decrease this error rate and to avoid additional claim denials, we encourage providers to update any internal procedures or policies with this information.
Continued high levels of claim denials in one particular area can lead to a medical review and provider-specific edit for these types of claims. This review process can slow the timely payment of Medicare claims. It is important to provide the correct billing information in order to get reimbursed appropriately and to avoid the potential for continued prepayment probes and provider-specific prepayment edits.

**CMS proposes fiscal year 2015 payment and policy changes for Medicare SNFs**

**Overview**

On May 1, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [CMS-1605-P] outlining proposed Fiscal Year (FY) 2015 Medicare payment rates for skilled nursing facilities (SNFs). The FY 2015 proposals and other issues discussed in the proposed rule are summarized below.

**CMS is proposing policy changes to the following 4 areas:**

1. **Changes to Payment Rates under the SNF Prospective Payment System (PPS)**
   
   Based on proposed changes contained within this rule, CMS projects that aggregate payments to SNFs will increase by $750 million, or 2.0 percent, from payments in FY 2014, which represents a higher update factor than the 1.3 percent update finalized for SNFs last year. This estimated increase is attributable to 2.4 percent market basket increase, reduced by the 0.4 percentage point multifactor productivity adjustment required by law.

2. **Wage Index Update**
   
   On February 28, 2013, the Office of Management and Budget (OMB) issued OMB Bulletin No. 13-01, which contained a number of significant changes related to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation of these areas. To align with these changes, CMS is proposing revisions to the wage index based on the newest OMB delineations for the FY 2015 SNF PPS wage index. CMS is also proposing to use the new OMB delineations to identify a provider’s urban or rural status for the purpose of determining which set of rate tables would apply to the provider. This is consistent with other Medicare payment rules which will also include similar revisions this year as a result of the new OMB delineations.

   In an effort to mitigate the potential negative wage index impacts for some providers of this proposed adoption of the revised OMB delineations, CMS is proposing to implement these changes by providing a one-year transition with a blended wage index for all providers. The wage index for each provider would consist of a blend of 50 percent of the FY 2015 wage index using the current OMB delineations and 50 percent of the FY 2015 wage index using the revised OMB delineations. A similar transition wage index was used when CMS adopted the OMB’s Core-Based Statistical Area (CBSA) definitions in FY 2006.

3. **Change of Therapy assessment policy update**
   
   The Change of Therapy (COT) Other Medicare Required Assessment (OMRA) is used to classify a resident into a new resource utilization group (RUG) when, based on the therapy services provided during the previous seven days, the resident no longer qualifies for the RUG into which they are currently classified for payment. Recently, some providers have raised concerns regarding a technical aspect of the rules governing when the COT OMRA may be completed, which generally limits the use of the COT OMRA to instances where the resident is already classified into a therapy RUG.

   Therefore, CMS is proposing a revision to the current COT OMRA policy to address this concern, which would permit providers to use the COT OMRA to reclassify a resident into a therapy RUG from a non-therapy RUG, but only in certain limited circumstances.
Q&A: Long-term care ICD-10 coding specifics

Editor’s note: This month’s “Q&A” was modified from the HCPro book ICD-10 Essentials for Long-Term Care, written by Karen L. Fabrizio, RHIA, CPRA. ICD-10 Essentials for Long-Term Care provides you with a three-step plan that takes you from understanding the differences between ICD-9 and ICD-10 to full-scale ICD-10 readiness at your facility. For more information or to order, call customer service at 800-650-6787 or visit www.hcmarketplace.com. To submit a question for upcoming issues, email Managing Editor Olivia MacDonald at omacdonald@hcpro.com.

Q: How are the primary and secondary diagnoses critical to developing the plan of care and accurate reimbursement?

A: Establishing the correct primary and secondary diagnoses is critical to developing the plan of care and accurate reimbursement. The Uniform Hospital Discharge Data Set (UHDDS) provides definitions for primary and secondary diagnoses. Acute care short-term hospitals use the UHDDS definitions to report inpatient data elements in a standardized manner. The definitions are referenced in the July 31, 1985, Federal Register (Vol. 50, No. 147) on pp. 31,038–31,040.

Since 1985, the UHDDS definitions have been expanded to include all non-outpatient settings. Long-term care and skilled nursing facilities (SNF) are included in this list of affected facilities. Principal diagnosis is defined as “the condition established after study to be chiefly responsible for occasioning the admission to the facility.” In determining the principal diagnosis, the coding conventions in ICD-10-CM’s Volumes I and II take precedence.

The length of stay for residents in a SNF is variable. The reason for admission is often different from the reason for continued stay. Diagnosis codes are assigned to diagnoses at the time of admission, concurrently as diagnoses arise, and at the time of discharge from the facility. At any time, the principal diagnosis may represent the admission diagnosis, the reason for continued stay, or a discharge diagnosis. Many facilities use the term primary diagnosis in lieu of principal diagnosis because the timing of code assignment differs from facility to facility.

The following terms are relatively common among SNFs:

- Admission diagnosis: The condition that necessitated the resident’s admission to the facility and for which the resident needs care.
- Primary diagnosis: The condition responsible for the resident’s admission to the facility. It also represents the reason for the resident’s continued stay in the facility after the admission diagnosis has resolved. The Medicare Program Integrity Manual provides a third definition of primary diagnosis as the reason for therapy services, also known as the medical diagnosis.
- Discharge diagnosis: Assigned when the resident is discharged home or transferred to another facility, or at the time of death. When the resident dies or is transferred to another facility, the discharge...
diagnosis is considered the cause of death or reason for transfer. When a resident is discharged home, the discharge diagnosis is the same as the principal diagnosis.

- Secondary diagnoses (also known as additional diagnoses): All conditions that coexist at the time of admission, develop during the resident’s stay, or affect the treatment the resident receives. Currently, there is no indication or modifier attached to the additional diagnoses to identify whether they were present on admission or arose during resident stay.

It should be noted that, unlike in other settings, diagnostic coding in SNFs is not directly related to reimbursement. Reimbursement is determined upon completion of the Minimum Data Set (MDS) 3.0 and assignment of a Resource Utilization Group IV (RUG-IV) category.

Q What is needed for the admission diagnosis?
A A majority of the information collected for admission to a long-term care facility is related to a resident’s preceding hospital stay. The hospital’s final diagnosis indicates the reason the individual was treated in the hospital. The hospital’s principal diagnosis may not be the reason long-term care is needed. For instance, an individual may be treated for an infection in an acute care setting but be admitted to a SNF for increased care needs or a cognitive decline. Many nursing home admissions follow a surgical intervention in acute care.

The hospital will assign a principal diagnosis for the acute care condition, and the nursing home will assign the appropriate aftercare code.

As facilities transition to ICD-10-CM, the use of V-codes to show aftercare may be replaced by the assignment of an aftercare code beginning with Z or assignment of a condition code with a seventh digit indicating subsequent care.

Example: Hospital treats patient for closed fracture of right intertrochanteric and assigns code of S72.131A. The SNF providing aftercare will assign a code of S72.131D.

With the expansion of diagnostic coding in ICD-10-CM, health information professionals should review specifics with the admissions staff. This will reinforce the need for gathering as much specific data as possible for correct code assignment.

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**The Medicare Boot Camp—Long-Term Care Version**

The Medicare Boot Camp—Long-Term Care Version follows a Medicare patient from preadmission through discharge, addressing the function of each department and uncovering the pitfalls along the way. Our exceptional instructors provide positive reinforcement and ensure that every student learns, regardless of experience level.

Prepare your staff to seamlessly manage blending scheduled and unscheduled MDS assessments while keeping up to date on the latest Medicare regulations and rules.

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- **Focus on the actual rules**—The course focuses on learning how to find and apply CMS rules and guidelines to ensure skilled nursing services furnished to Medicare beneficiaries are assessed and billed accurately and appropriately.
- **Hands-on learning**—At the conclusion of each course module, participants work through a set of exercises to ensure they understand the concepts and know how to apply them to real-world situations.
- **Custom-designed course materials**—Materials are developed by instructors and editors specifically for this intensive learning format. Each participant receives comprehensive course materials and convenient access to current Medicare statutes, regulations, and guidelines.
- **Small class size**—Class size is limited to ensure individual attention.
- **Highly rated**—Course participants consistently give the course an overall rating of 4.8 or higher (on a 5-point scale).
- **Well-established program**—We conduct over 12 Medicare Boot Camp—Long-Term Care Version courses each year.
- **Post-program support**—Two weeks after the program, you’ll have the opportunity to participate in a follow-up call with your instructor, in which you can ask additional questions about what you learned, address any implementation issues, or get help prioritizing your to-do list.

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