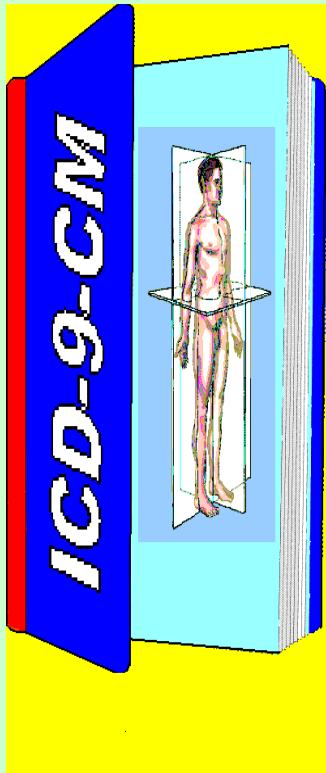


ICD-9-CM Coding Fundamentals – Part 3



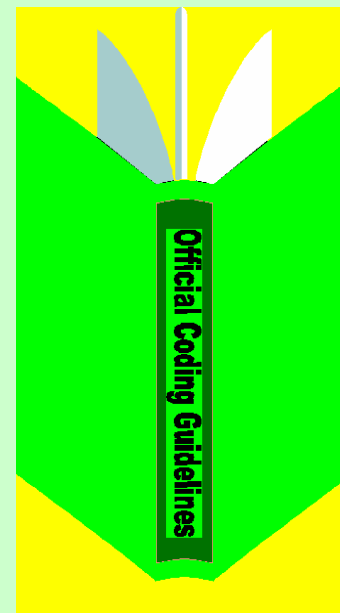
Developed By:



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HIPAA (LTCC).

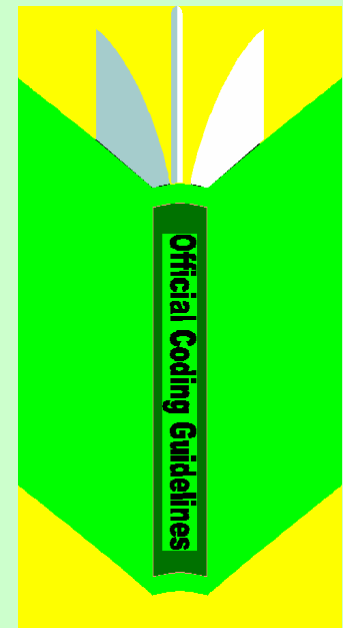
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ICD-9-CM Official Coding Guidelines for Coding and Reporting



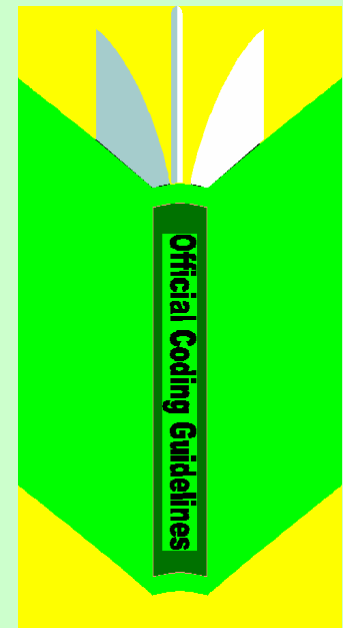
Official Coding Guidelines

- ICD-9-CM Official Guidelines for Coding & Reporting
 - Developed by:
 - Centers for Medicare & Medicaid Services (CMS)
 - National Center for Health Statistics (NCHS)
 - Approved by the Cooperating Parties
 - CMS
 - NCHS
 - American Health Information Management Association (AHIMA)
 - American Hospital Association (AHA)



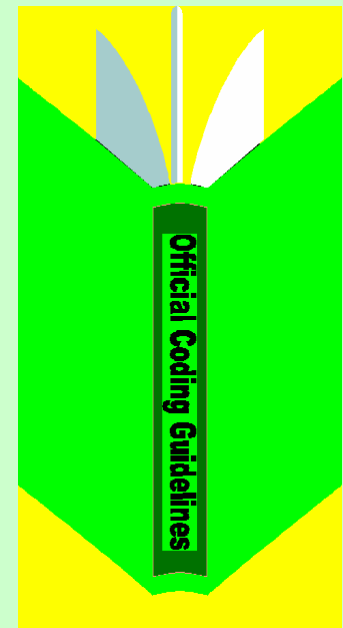
Official Coding Guidelines

- Published on Center for Disease Control & Prevention (CDC) web site
 - <http://www.cdc.gov/nchs/datawh/ftpser/ftpicd9/ftpicd9.htm#guidelines>
- Must be followed per HIPAA Transaction & Code Set (TCS) rule and per Section I coding instructions in the RAI manual
- Developed to assist in coding and reporting situations where the ICD-9-CM code book does not provide direction
 - Instructions published in code book Volumes 1, 2, & 3 take precedence over any guidelines



Official Coding Guidelines

- Organization:
 - Section I - ICD-9-CM
 - A. Conventions
 - B. General Coding Guidelines
 - C. Chapter-specific Guidelines
 - ***Applies to all care settings***

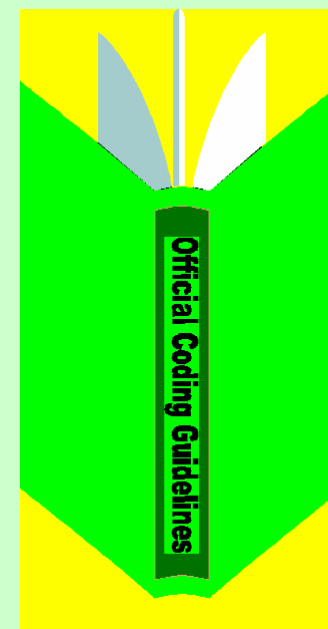


Official Coding Guidelines

- Organization cont.:
 - Section II - Selection of Principal Diagnosis
 - ***Applies to all inpatient care settings including LTC.***
 - Principal diagnosis is defined in Uniform Hospital Discharge Data Set (UHDDS) as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
 - In LTC where claims are submitted for extended stays, the principal diagnosis listed may change to the reason for which the resident remains in the facility.
 - Following transfer to the hospital with an anticipated return to the facility, the principal dx will be:
 - The “primary” reason that the resident is returning or remaining in the facility.
 - This *may* not be the reason for Medicare coverage.

Official Coding Guidelines

- Organization cont.:
 - Section III - Reporting Additional Diagnoses
 - ***Applies to all inpatient care settings including LTC.***
 - The definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care.

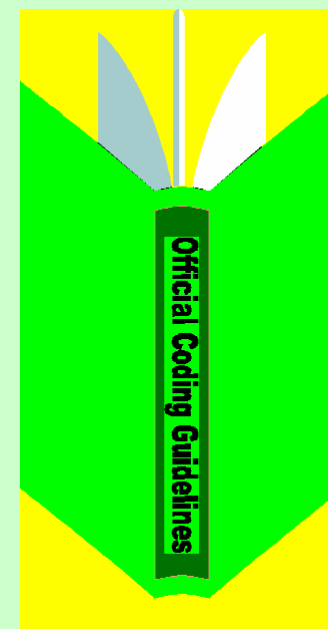


Official Coding Guidelines

- Organization cont.:
 - Section IV - Diagnostic Coding and Reporting Guidelines for Outpatient Services
 - ***These guidelines are for use by hospital-based outpatient services and provider – based office visits.***
 - ***These guidelines are not used in LTC***

Official Coding Guidelines

- Section I, General Coding Guidelines
 - Coding Signs & Symptoms
 - Use signs & symptoms codes (780 – 799) when:
 - A related, definitive diagnosis has not been established
 - Symptoms are not routinely associated with a disease process
 - Do not code signs and symptoms that are part of the disease process

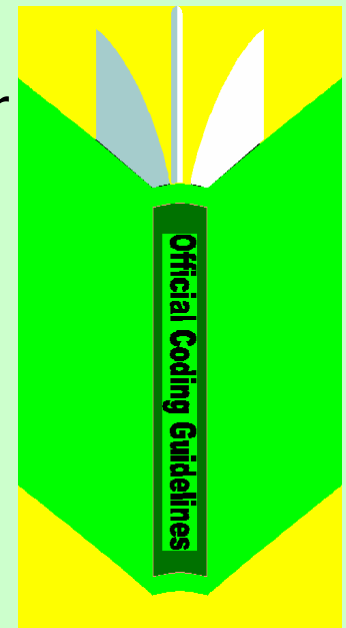


Official Coding Guidelines

- Section I, General Coding Guidelines – Multiple Codes for Single Condition
 - Some diagnoses require more than one code number to correctly identify the condition
 - Instructions in the Alphabetical Index or Tabular List identify need for additional codes
 - Generally, the second code is listed in *italics*.

Examples:

- | | |
|------------------------|-----------------|
| ■ Alzheimer's Dementia | 331.0, [294.10] |
| ■ Diabetic Neuropathy | 250.60, [357.2] |
| ■ UTI due to E. coli | 599.0, 041.4 |

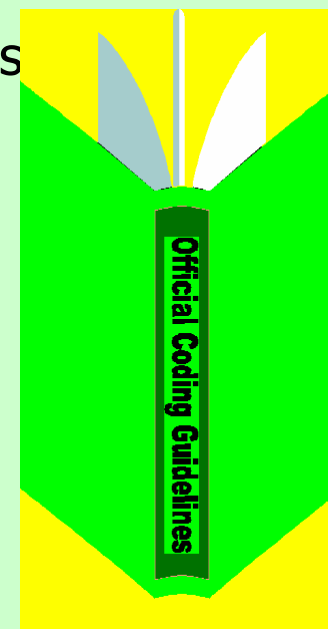


Official Coding Guidelines

- Section I, General Coding Guidelines - **Combination Codes**
 - A single, combination code can identify:
 - Two diagnoses
 - A diagnosis with an associated secondary process (manifestation)
 - A diagnosis with an associated complication
 - If the code fully identifies the conditions involved, assign only the combination code

Examples:

■ Asthma with COPD	493.20
■ Peptic ulcer with GI bleeding	533.40
■ Sleep apnea with Insomnia	780.51

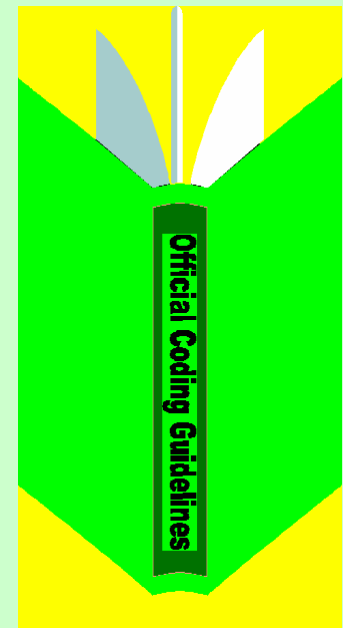


Official Coding Guidelines

- Section I, General Coding Guidelines
 - Late effects
 - Residual condition (late effect)
 - Condition that remains after acute phase of an illness
 - Sequenced first unless otherwise instructed
 - Cause of late effect listed second
 - Do not use code for the acute phase of illness

Example:

- Quadriplegia following Cervical Fracture
344.00 and 907.2



OFFICIAL CODING GUIDELINES

- Section I, General Coding Guidelines
 - Reporting Same Diagnosis Code More Than Once
 - Each unique ICD-9-CM diagnosis code may be reported only once for an encounter.
 - This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.

Official Coding Guidelines

- Section I, General Coding Guidelines

- Admissions/Encounters for Rehab

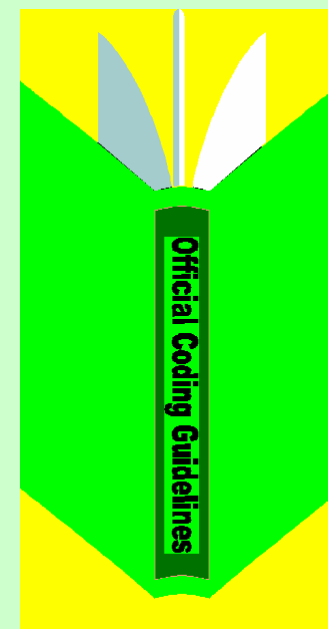
- When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures as the principal/first-listed diagnosis.
- The code for the condition for which the service is being performed should be reported as an additional diagnosis.
- Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter.

Official Coding Guidelines

- Section I, General Coding Guidelines
 - Documentation for BMI and Pressure Ulcer Stages
 - For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing patient's diagnosis).
 - BMI and pressure ulcer stages are typically documented by other clinicians involved in the care of the patient (i.e., dietician, nurse).
 - Associated diagnosis, (obesity, pressure ulcer) must be documented by the patient's attending provider.
 - BMI and pressure ulcer stage codes should only be reported as secondary diagnoses.

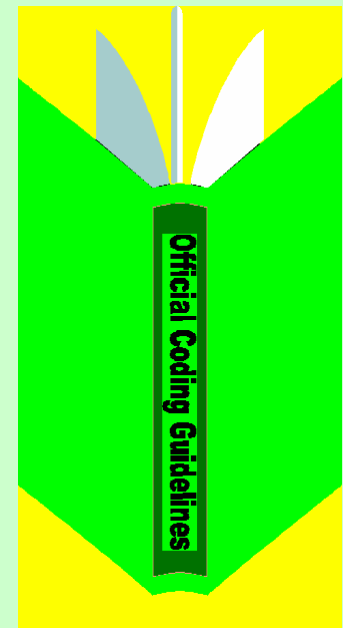
Official Coding Guidelines

- Section I, C. Chapter-Specific Coding Guidelines - **Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis and Septic Shock**
 - **Septicemia:**
 - Pathogenic microorganisms or their toxins in the blood
 - Code to category 038
 - Patient often transferred to hospital (potentially life threatening)



Official Coding Guidelines

- SIRS/Sepsis:
 - Clinical response to infection or trauma that can trigger an acute inflammatory reaction (usually in hospital)
 - Code to 995.9x
 - Code first underlying systemic infection
- Urosepsis:
 - Non-specific term
 - Code to 599.0 if no other description documented
 - Use additional code for causal organism if documented by physician

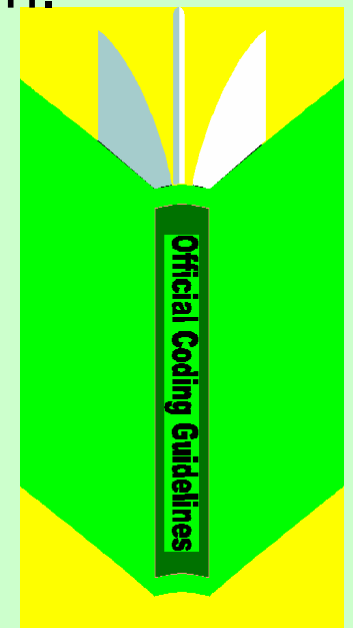


Official Coding Guidelines

- The terms *septicemia* and *sepsis* are often used interchangeably, however, they are not synonymous terms.
- Physician clarification may be merited if sepsis is the diagnosis received on hospital documentation.

Examples:

- | | |
|----------------------------|---------------|
| ▪ Streptococcal sepsis | 038.0, 995.91 |
| ▪ Streptococcal septicemia | 038.0 |
| ▪ Urosepsis | 599.0 |



Official Coding Guidelines

- Section I, C. Chapter-Specific Coding Guidelines – Methicillin Resistant Staphylococcus aureus (MRSA) Conditions
 - Combination codes for MRSA infection
 - When a patient is diagnosed with an infection that is due to methicillin resistant Staphylococcus aureus (MRSA), and that infection has a combination code that includes the causal organism (e.g., septicemia, pneumonia) assign the appropriate code for the condition.
 - Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins, as an additional diagnosis.

Examples:

- MRSA septicemia 038.12
- MRSA pneumonia 482.42

Official Coding Guidelines

- Other codes for MRSA infection
 - When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, select the appropriate code to identify the condition along with code 041.12, Methicillin resistant *Staphylococcus aureus*, for the MRSA infection.
 - Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins.

Example:

UTI due to MRSA

599.0, 041.12

Official Coding Guidelines

- Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization
 - The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier.
 - Colonization means that MSSA or MRSA is present on or in the body without necessarily causing illness.
 - A positive MRSA colonization test might be documented by the provider as “MRSA screen positive” or “MRSA nasal swab positive”.

Official Coding Guidelines

- Assign code V02.54, Carrier or suspected carrier, Methicillin resistant *Staphylococcus aureus*, for patients documented as having MRSA colonization.
- Assign code V02.53, Carrier or suspected carrier, Methicillin susceptible *Staphylococcus aureus*, for patient documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.
- Code V02.59, Other specified bacterial diseases, should be assigned for other types of staphylococcal colonization (e.g., *S. epidermidis*, *S. saprophyticus*).
- Code V02.59 should not be assigned for colonization with any type of *Staphylococcus aureus* (MRSA, MSSA).

Official Coding Guidelines

- MRSA colonization and infection
 - If a patient is documented as having both MRSA colonization and infection during an admission, code V02.54, Carrier or suspected carrier, Methicillin resistant *Staphylococcus aureus*, and a code for the MRSA infection may both be assigned.
 - History of MRSA – V12.04

Example:

Stitch abscess, postoperative – 998.59, V02.54

MRSA colonization

Official Coding Guidelines

Section I, C. Chapter-Specific Coding Guidelines Neoplasms

- Malignant neoplasm associated with transplanted organ
 - A malignant neoplasm of a transplanted organ should be coded as a transplant complication.
 - Assign first the appropriate code from subcategory 996.8, Complications of transplanted organ, followed by code 199.2, Malignant neoplasm associated with transplanted organ.
 - Use an additional code for the specific malignancy.

Official Coding Guidelines

- Section I, C. Chapter-Specific Coding Guidelines – Pressure ulcer stage codes
 - Pressure ulcer stage codes
 - Pressure ulcer stages
- Two codes are needed to completely describe a pressure ulcer:
- A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and
 - A code from subcategory 707.2, Pressure ulcer stages.
 - **The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer.**
 - **Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).**
 - **The ICD-9-CM classifies pressure ulcer stages based on severity, which is designated by stages I-IV and unstageable.**

Official Coding Guidelines

- Unstageable pressure ulcers
 - Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation.
 - Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.
 - This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

Official Coding Guidelines

- Documented pressure ulcer stage
 - Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index.
 - For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.
- Bilateral pressure ulcers with same stage
 - When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

Official Coding Guidelines

- Bilateral pressure ulcers with different stages
 - When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.
- Multiple pressure ulcers of different sites and stages
 - When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

Official Coding Guidelines

- Patients admitted with pressure ulcers documented as healed
 - No code is assigned if the documentation states that the pressure ulcer is completely healed.
- Patients admitted with pressure ulcers documented as healing
 - Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified.

Official Coding Guidelines

- If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
- Patient admitted with pressure ulcer evolving into another stage during the admission
 - If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site.

Official Coding Guidelines

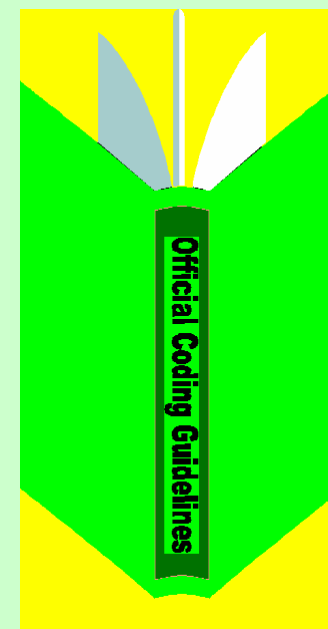
- Section I, C. Chapter-Specific Coding Guidelines – Nervous and Sense Organs
 - Pain symptoms – General coding
 - Use codes from category 338 in conjunction with other codes to provide more detail about pain.
 - If the pain is not specified as acute or chronic, do not use this category except for specific conditions identified in the Official Coding Guidelines (i.e. postoperative pain that is not routine or expected, post-thoracotomy pain or neoplasm related pain).
 - Codes from 338.1x and 338.2x should not be used if the underlying dx is known, unless the admission is for pain control
 - Refer to the Official Guidelines for Coding and Reporting for additional guidance.

Official Coding Guidelines

- Section I, C. Chapter-Specific Coding Guidelines – Disease of Musculoskeletal and Connective Tissue
 - Coding of Pathologic Fractures
 - Use aftercare codes (category V54) for encounters after active treatment has been received
 - Aftercare includes medication adjustment and follow up treatment
 - Subcategory 733.1 is used when the pathologic fracture is newly diagnosed only

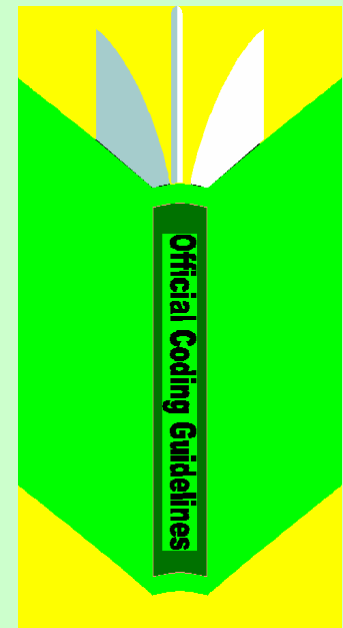
Official Coding Guidelines

- Section I.C Chapter Specific Guidelines – V codes
- **Aftercare**
 - Used when:
 - Initial treatment of disease or injury has been performed, *and*
 - Continued care required during the healing or recovery phase, *or*
 - Continued care required for the long-term consequences of the disease
 - DO NOT use if treatment is directed at a current, acute disease or injury
 - Use diagnosis code for current disease/injury



Official Coding Guidelines

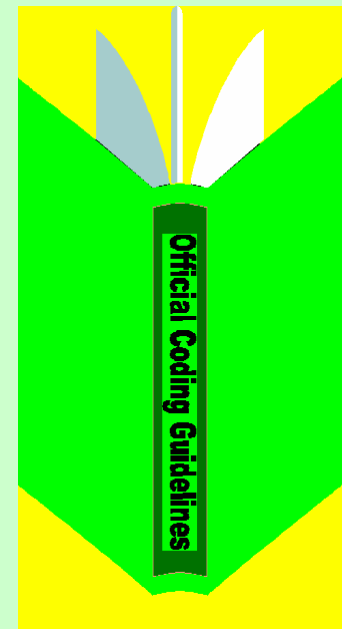
- Unconfirmed Diagnoses
 - Section II.H. and III.C. indicates that coding unconfirmed diagnoses applies only to short-term, acute, long-term, and psychiatric hospitals.
 - Do not code diagnoses documented as:
 - “probable”,
 - “possible”
 - “suspected,”
 - “questionable,”
 - “rule out,” or
 - “working diagnosis”



Official Coding Guidelines

Unconfirmed Diagnoses cont.

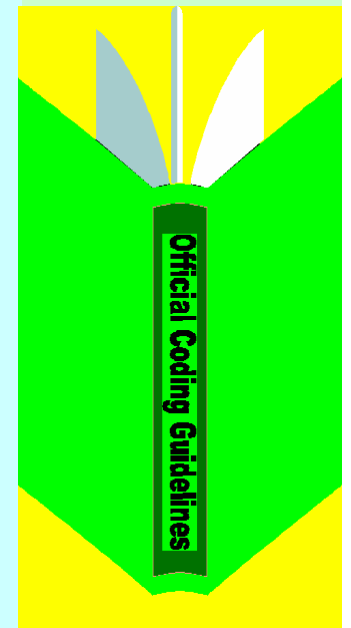
- Code condition(s) to the highest degree of certainty, such as:
 - symptoms,
 - signs,
 - abnormal test results, or
 - other reason for the visit



Coding Clinic

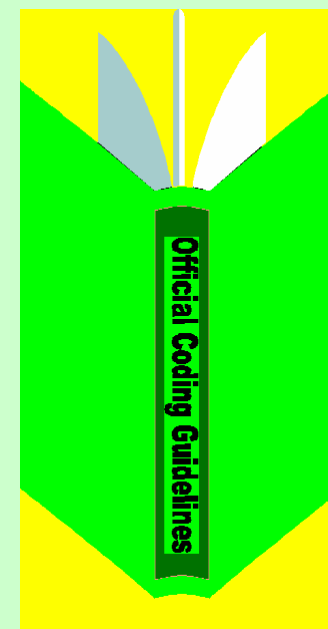
AHA Coding Clinic

- Published quarterly
- Provides guidance on use of ICD-9-CM codes
- Content approved by:
 - National Center for Health Statistics (NCHS)
 - Centers for Medicare & Medicaid Services (CMS)
 - American Health Information Management Association (AHIMA)
 - American Hospital Association (AHA)



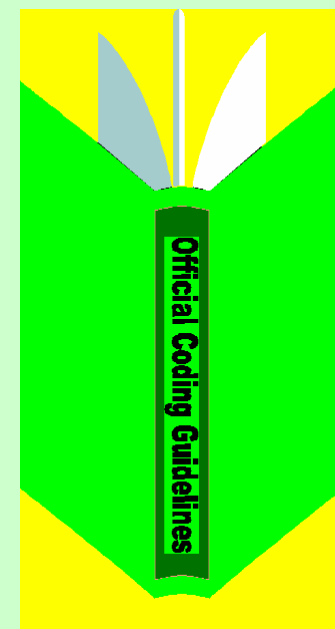
Coding Clinic

- Coding Clinic, Fourth Quarter 1999
 - Rules for using V codes published
 - Addressed use of V-codes in LTC
- Coding Clinic, Fourth Quarter 2003:
 - Further clarified coding fractures in the healing phase:
 - Guidelines require use of aftercare (V) code for all subsequent encounters after the initial encounter for care of a fracture
 - For statistical purposes, **a fracture should only be coded once**



Coding Clinic

- Coding Clinic, future issues
 - Article on V codes to be published each fourth quarter to instruct coders on:
 - New V codes that will become effective each October 1
 - Any pertinent changes to V codes that will be included in the Official Coding Guidelines



ICD-9-CM Coding In Long-Term Care



Where To Find Diagnoses

Review clinical record, including but not limited to:

- Discharge Summary
- MD progress notes
- Consultations
- H & P
- Orders



Coding Process in LTC



- Create a listing of diagnoses and codes
 - Select principal diagnosis and list first
 - The “first listed diagnoses” is the diagnoses that is chiefly responsible for the admission to, or continued residence in, the nursing facility and should be sequenced first.
 - List additional diagnoses that reflect services provided or clinical conditions
 - Do not list diagnoses that are not pertinent to nursing facility stay
 - Do not list diagnoses that have been resolved or are historical unless clinically significant to staff

Coding Process in LTC



- Do not code conditions documented as “suspected”, “rule out”, and/or “probable”
 - Only established diagnoses are coded in LTC

- Consider LTC coding guidelines:
 - Use V57.xx for admission for therapy services
 - Aftercare fracture code vs. acute fracture code

Coding Process in LTC

Subsequent Admissions (Readmits)

Following transfer to the hospital with anticipated return to the facility, the principal dx will be:

- The "primary" reason that the resident is returning or remaining in the facility.
- This may not be the reason for Medicare Coverage

Example:

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 CVA?

Assign the appropriate code from category 438, Late effect of cerebrovascular disease, as the first listed diagnosis to identify the neurologic deficits, which resulted from the acute CVA. Assign the appropriate code for the pneumonia. The pneumonia may be reported as a secondary diagnosis for as long as the patient receives treatment for the condition.

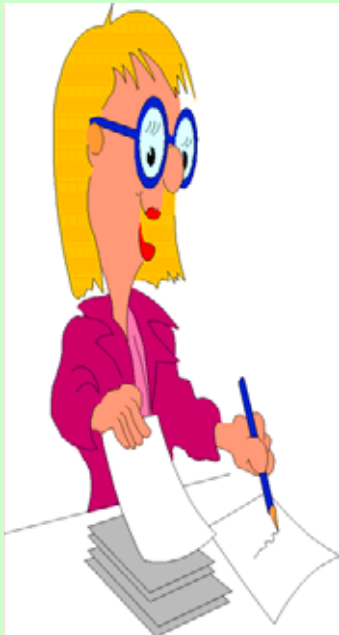
Coding Clinic, 4th quarter, 1999.

Code Sequencing Definitions in LTC

Secondary diagnoses for LTC:

- Any and all conditions that co-exist when resident is admitted to the facility, or
- Develop subsequently during a resident's stay, or
- Affect treatment the resident receives or the resident's length of stay
- Diagnoses that relate to an earlier episode which have no bearing on the current stay are to be excluded.

Coding Process in LTC



- Review diagnosis list with clinical staff as applicable:
 - Nursing representative (MDS or other)
 - Therapy
 - Inclusion of therapy treatment and medical diagnoses
 - May want to label treatment diagnoses/ codes from therapy

Coding Process in LTC



- Best practices for when to assign codes:
 - Long-term care residents
 - Upon admission & readmission
 - When new diagnoses arise
 - Quarterly (with MDS schedule)

Coding Process in LTC

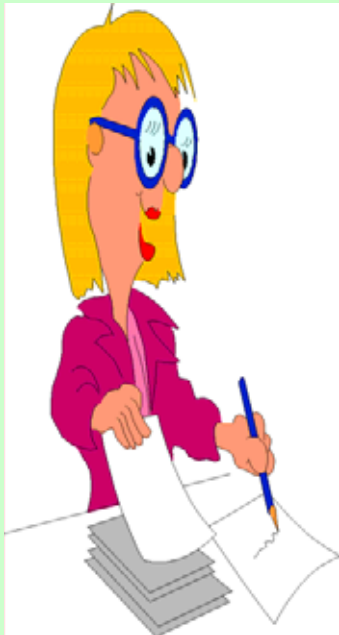


- High acuity residents (i.e. Medicare or managed care)
 - Review codes monthly

Codes on MDS, billing claim forms (i.e. UB04/837), and in medical record need to support:

- Medical necessity
- Skilled services provided (may include therapy treatment diagnosis)
- Resource Utilization Group (RUG) selection as applicable

Coding Process in LTC



- Triggers for concurrent coding:
 - Change, addition or discontinuations of therapy services
 - Recent hospitalization
 - New diagnoses documented by the medical staff
 - Significant changes in condition
 - Resolved diagnoses

Use of Diagnoses on the MDS

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

(If none apply, CHECK the NONE OF ABOVE box)

1. DISEASES	ENDOCRINE/METABOLIC/ NUTRITIONAL	<input type="checkbox"/>	Hemiplegia/hemiparesis	v.
		<input type="checkbox"/>	Multiple sclerosis	w.
	Diabetes mellitus	a.	Paraplegia	x.
	Hyperthyroidism	b.	Parkinson's disease	y.
	Hypothyroidism	c.	Quadriplegia	z.
	HEART/CIRCULATION	<input type="checkbox"/>	Seizure disorder	aa.
	Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
	Cardiac dysrhythmias	e.	Traumatic brain injury	cc.
	Congestive heart failure	f.	PSYCHIATRIC/MOOD	<input type="checkbox"/>
	Deep vein thrombosis	g.	Anxiety disorder	dd.
	Hypertension	h.	Depression	ee.
	Hypotension	i.	Manic depression (bipolar disease)	ff.
	Peripheral vascular disease	j.	Schizophrenia	gg.
	Other cardiovascular disease	k.	PULMONARY	<input type="checkbox"/>
	MUSCULOSKELETAL	<input type="checkbox"/>	Asthma	hh.
	Arthritis	l.	Emphysema/COPD	ii.
	Hip fracture	m.	SENSORY	<input type="checkbox"/>
	Missing limb (e.g., amputation)	n.	Cataracts	jj.
	Osteoporosis	o.	Diabetic retinopathy	kk.
	Pathological bone fracture	p.	Glaucoma	ll.
NEUROLOGICAL	<input type="checkbox"/>	Macular degeneration	mm.	
Alzheimer's disease	q.	OTHER	<input type="checkbox"/>	
Aphasia	r.	Allergies	nn.	
Cerebral palsy	s.	Anemia	oo.	
Cerebrovascular accident (stroke)	t.	Cancer	pp.	
Dementia other than Alzheimer's disease	u.	Renal failure	qq.	
		NONE OF ABOVE	rr.	
			ss.	
			tt.	
			uu.	
			vv.	
			ww.	
			xx.	
			yy.	
			zz.	
			aaa.	
			bbb.	
			ccc.	
			ddd.	
			eee.	
			fff.	
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			xxx.	
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			hhh.	
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			vvv.	
			www.	
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Use of Diagnoses on the MDS

- Diseases and conditions reported in I1, I2, and I3 must be:

SECTION I. DISEASE DIAGNOSES	
Check only those diseases that have a relationship to current ACL status, cognitive status, mood and behavior issues, medical treatments, nursing monitoring, or risk of death. Do not list inactive diagnoses.	
1. DISEASES (If none apply, CHECK the NONE OF ABOVE box)	
ENDOCRINE/METABOLIC	Hemiplegia/hemiparesis
NUTRITIONAL	Multiple sclerosis
Diabetes mellitus	Paraplegia
Hypothyroidism	Parkinson's disease
	Quadruplegia
HEART/CIRCULATION	Seizure disorder
Arteriosclerotic heart disease (Atherosclerosis)	Transient ischemic attack (TIA)
Cardiac dysrhythmias	Traumatic brain injury
Congestive heart failure	PSYCHIATRIC/MOOD
Deep vein thrombosis	Anxiety disorder
Hypertension	Depression
Myocardial infarction	Manic depression (bipolar disease)
Peripheral vascular disease	Schizophrenia
Other cardiovascular disease	PULMONARY
MUSCULOSKELETAL	Asthma
Arthritis	Emphysema/COPD
Fracture	SENSORY
Missing limb (e.g., amputation)	Cataracts
Osteoporosis	Diabetic retinopathy
Polio/myelomeningocele	Glaucoma
NEUROLOGICAL	Meckel-Gruber syndrome
Alzheimer's disease	OTHER
Epilepsy	Allergies
Cerebral palsy	Anemia
Coma/vascular accident (stroke)	Cancer
Dementia (other than Alzheimer's disease)	Renal failure
	NONE OF ABOVE
2. INFECTIONS (If none apply, CHECK the NONE OF ABOVE box)	
Antibiotic-resistant infection (e.g., Methicillin-resistant Staph)	Sexually transmitted diseases
Chlamydia (diff. to diff.)	Tuberculosis
Conjunctivitis	Urinary tract infection in last 30 days
HIV infection	Viral hepatitis
Pneumonia	Wound infection
Respiratory infection	NONE OF ABOVE
3. OTHER CURRENT OR MOST DETAILED DIAGNOSES AND ICD-9 CODES	

- Documented by the physician in the clinical record
 - Consistent with definitions found in RAI Manual
 - Follow "Official Guidelines for Coding and Reporting" for I3
- Review clinical record for *current*, physician-documented diagnoses
 - Transfer documentation, including hospital progress notes and discharge summary
 - Physician medication and treatment orders
- Follow Official Guidelines for Coding and Reporting

Use of Diagnoses on the MDS

SECTION I. DISEASE DIAGNOSES
Check only those diseases that have a relationship to current ACL status, cognitive status, mood and behavior issues, medical treatments, nursing monitoring or risk of death. Do not list inactive diagnoses.

1. DISEASES		<small>If none apply, CHECK the NONE OF ABOVE box</small>	
ENDOCRINE/METABOLIC	<input type="checkbox"/>	Hemiplegia/hemiparesis	<input type="checkbox"/>
NUTRITIONAL	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	Paraplegia	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>
Hypoparathyroidism	<input type="checkbox"/>	Quadruplegia	<input type="checkbox"/>
HEART/CIRCULATION	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>
Arteriosclerotic heart disease (A-CHD)	<input type="checkbox"/>	Transient ischemic attack (TIA)	<input type="checkbox"/>
Cardiac dysrhythmias	<input type="checkbox"/>	Traumatic brain injury	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	PSYCHIATRIC/MOOD	<input type="checkbox"/>
Deep vein thrombosis	<input type="checkbox"/>	Anxiety disorder	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Myocardial infarction	<input type="checkbox"/>	Major depression (bipolar disease)	<input type="checkbox"/>
Other cardiovascular disease	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>
MUSCULOSKELETAL	<input type="checkbox"/>	PULMONARY	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	SENSORY	<input type="checkbox"/>
Missing limb (e.g., amputation)	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Diabetic retinopathy	<input type="checkbox"/>
Pathological bone fracture	<input type="checkbox"/>	Dementia	<input type="checkbox"/>
NEUROLOGICAL	<input type="checkbox"/>	Muscular degeneration	<input type="checkbox"/>
Alzheimer's disease	<input type="checkbox"/>	OTHER	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Guinea worm infection	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Renal failure	<input type="checkbox"/>
Other neurological disease	<input type="checkbox"/>	NONE OF ABOVE	<input type="checkbox"/>
2. INFECTIONS	<input type="checkbox"/>	<small>If none apply, CHECK the NONE OF ABOVE box</small>	<input type="checkbox"/>
Antibiotic-resistant infection (e.g., Methicillin-resistant Staph)	<input type="checkbox"/>	Septicemia	<input type="checkbox"/>
Chlamydia (diff. to diff.)	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
HIV infection	<input type="checkbox"/>	Urinary tract infection in last 30 days	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Viral hepatitis	<input type="checkbox"/>
Respiratory infection	<input type="checkbox"/>	Wound infection	<input type="checkbox"/>
	<input type="checkbox"/>	NONE OF ABOVE	<input type="checkbox"/>
3. OTHER CURRENT OR MOST DETAILED DIAGNOSES AND ICD-9 CODES	<input type="checkbox"/>		

- When diagnosis is more specific than item description in I1 or I2:
 - Check the more general diagnosis in I1 or I2, and
 - Enter more detailed diagnosis, with ICD-9-CM code, in I3 *if space available*

Example:

- Gouty Arthritis:
 - I1 - Check item I11, arthritis
 - I3 - Enter "Gouty Arthritis 274.0"

Use of Diagnoses on the MDS

- Process for Question I1 - Diseases

SECTION I. DISEASE DIAGNOSES
Check only those diseases that have a relationship to current ACL status, cognitive status, mood and behavior issues, medical treatments, nursing monitoring or risk of death. Do not list inactive diagnoses.

1. DISEASES		IF NONE APPLY, CHECK THE NONE OF ABOVE box	
ENDOCRINE/METABOLIC	<input type="checkbox"/> Hemiplegia/hemiparesis	<input type="checkbox"/>	<input type="checkbox"/>
NUTRITIONAL	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypoparathyroidism	<input type="checkbox"/> Quinapril	<input type="checkbox"/>	<input type="checkbox"/>
HEART/CIRCULATION	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Atherosclerotic heart disease (A-CHD)	<input type="checkbox"/> Spinal cord stroke (SCS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cardiac dysrhythmias	<input type="checkbox"/> Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Congestive heart failure	PSYCHIATRIC/MOOD	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Deep vein thrombosis	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Manic depression (bipolar disease)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other cardiovascular disease	PULMONARY	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High fracture	SENSORY	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Missing limb (e.g., amputation)	<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pathologic fracture/fracture	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscular degeneration	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL	OTHER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aphasia	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cerebrovascular accident (stroke)	<input type="checkbox"/> Renal failure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dementia other than Alzheimer's disease	<input type="checkbox"/> NONE OF ABOVE	<input type="checkbox"/>	<input type="checkbox"/>
2. INFECTIONS	IF NONE APPLY, CHECK THE NONE OF ABOVE box	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Antibiotic-resistant infection (e.g., Methicillin-resistant staph)	<input type="checkbox"/> Septicemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chlamydia (diff. to diff.)	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HIV infection	<input type="checkbox"/> Urinary tract infection in last 30 days	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Viral hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respiratory infection	<input type="checkbox"/> Wound infection	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> NONE OF ABOVE	<input type="checkbox"/>	<input type="checkbox"/>
3. OTHER CURRENT OR MOST DETAILED DIAGNOSES AND ICD-9 CODES		<input type="checkbox"/>	<input type="checkbox"/>

- Using a 7-day look back period
 - Check all diseases/conditions that apply in I1
 - If none of the conditions apply, check item I1rr (NONE OF ABOVE)
 - Code more specific diagnoses in I3 if space available

Use of Diagnoses on the MDS

- Section I and quarterly MDS Assessments

SECTION I DISEASE DIAGNOSES
Check only those diseases that have a relationship to current ACL status, cognitive status, mood and behavior issues, medical treatments, nursing monitoring or risk of death. Do not list inactive diagnoses.

1. DISEASES		If none apply, CHECK the NONE OF ABOVE box	
ENDOCRINE/METABOLIC			
Diabetes mellitus	A	Hemiplegia/hemiparesis	Y
Hypothyroidism	B	Multiple sclerosis	Y
HEART/CIRCULATION		Paraplegia	Y
Arteriosclerotic heart disease (A-CHD)	A	Parkinson's disease	Y
Cardiac dysrhythmias	B	Quadriplegia	Y
Congestive heart failure	C	Seizure disorder	Y
Deep vein thrombosis	D	Transient ischemic attack (TIA)	Y
Hypertension	E	Traumatic brain injury	Y
Peripheral vascular disease	F	PSYCHIATRIC/MOOD	
Other cardiovascular disease	G	Anxiety disorder	Y
MUSCULOSKELETAL		Depression	Y
Achilles	A	Manic depression (bipolar disease)	Y
Arthritis	B	Schizophrenia	Y
Ingrown toe	C	PULMONARY	
Missing limb (e.g., amputation)	D	Asthma	Y
Osteoporosis	E	Emphysema/COPD	Y
Pathological bone fracture	F	SENSORY	
NEUROLOGICAL		Cataracts	Y
Alzheimer's disease	A	Diabetic retinopathy	Y
Epilepsy	B	Glaucoma	Y
Cerebral palsy	C	Macular degeneration	Y
Cerebrovascular accident (stroke)	D	OTHER	
Dementia other than Alzheimer's disease	E	Allergies	Y
	F	Anemia	Y
	G	Cancer	Y
	H	Renal failure	Y
	I	NONE OF ABOVE	Y
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	CJ		Y
	CK		Y
	CL		Y
	CM		Y
	CN		Y
	CO		Y
	CP		Y
	CQ		Y
	CR		Y
	CS		Y
	CT		Y
	CU		Y
	CV		Y
	CW		Y
	CX		Y
	CY		Y
	CA		Y
	CB		Y
	CC		Y
	CD		Y
	CE		Y
	CF		Y
	CG		Y
	CH		Y
	CI		Y
	CJ		Y
	CK		Y
	CL		Y
	CM		Y
	CN		Y
	CO		Y
	CP		Y
	CQ		Y
	CR		Y
	CS		Y
	CT		Y
	CU		Y
	CV		Y
	CW		Y
	CX		Y
	CY		Y
	CA		Y
	CB		Y
	CC		Y
	CD		Y
	CE		Y
	CF		Y
	CG		Y
	CH		Y
	CI		Y
	CJ		Y
	CK		Y
	CL		

Use of Diagnoses on the MDS

- Section I and the Quarterly MDS Assessment
 - Report diagnoses based on instructions printed at Section I
 - Some quarterly MDS forms have the following instruction for Section I3 "Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death".

Diagnosis Codes on the UB-04/837

- Support reimbursement of claims
- Serve as a means of communication between the provider & payer
- Describe the conditions that qualify for reimbursement
- Support medical necessity

The image shows a portion of the UB-04/837 claim form. It is a complex grid of boxes and lines, with various fields for data entry. The form is divided into several sections, including patient information, provider information, and a large section for diagnosis codes. The text is small and difficult to read, but the overall structure is clear.

Diagnosis Codes on the UB-04/837

- List diagnosis codes that support services provided during claim dates of service
- Items/services billed on the UB-04/837 should be supported by a diagnosis code
- Follow Official Guidelines for Coding and Reporting and instructions within the code book to sequence and report diagnoses codes as necessary.

The image shows a portion of the UB-04/837 claim form, which is a grid-based structure. It contains various fields for patient information, service details, and diagnosis codes. The form is divided into several sections, with a large central area for listing services and their corresponding diagnosis codes. The text is small and difficult to read, but the overall structure is a complex grid of boxes and lines.

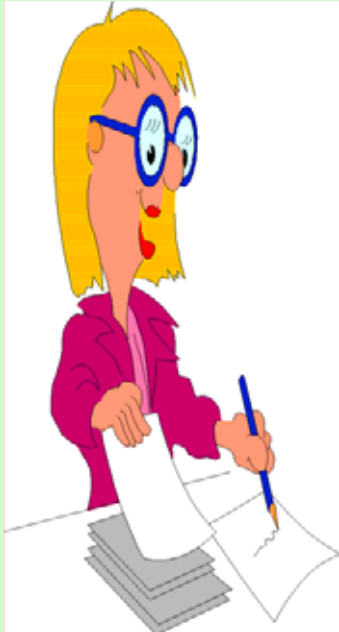
Diagnosis Codes on the UB-04/837: CMS Transmittal 437

- Chapter 6, Section 30 of the Medicare Claims processing manual includes the following:
 - Principal Diagnosis Code- Code must be reported according to Official ICD-9-CM Guidelines, including proper use of V- codes
 - Other Diagnosis Codes Required- Enter 8 additional diagnoses - CMS does not have additional requirements regarding reporting or sequencing of codes other than those in the guidelines



Diagnosis Codes on the UB-04/837

- Recommendations:
 - Create a list of diagnoses and codes upon admit, readmit and as needed (condition change, MDS schedule, billing cycle)
 - HIM review diagnoses list with nursing and therapy as applicable
 - Discuss diagnoses in Medicare or other appropriate meeting, finalize diagnosis sequencing



Diagnosis Codes on the UB-04/837

- Recommendations:
 - Communicate diagnoses selected/sequenced to:
 - Business office – for inclusion on billing claim form (i.e. UB-04/837)
 - Medical record – for continuity of care
 - Others as appropriate for your facility



Diagnosis Codes on the UB-04/837

- Sample Coding Sequencing & Communication Form

BILLING DIAGNOSIS SEQUENCING COMMUNICATION TOOL

Instructions: HIM, MDS, Therapy (as applicable) discuss diagnosis selection at regular intervals (daily/weekly for Medicare A residents and every 90 days for non-Medicare A) and provide accurate diagnosis information to billing office and medical record (update this sheet and candidate diagnosis listing as appropriate).

Coding Sequencing guide:

Billing First diagnosis:

When a resident is admitted/admitted primarily for rehab services, rehab V-code (V57.XX) should be sequenced first per Coding Clinic Instructions. V codes for therapy should also be resolved within 90 days of discontinuation of therapy services. If not admitted for therapy, list first the medical condition most related to the need for skilled care or SNF admission.

Billing Secondary diagnosis:

- Medical diagnosis that support need for skilled services (therapy or nursing)
- Therapy treatment diagnoses (when resident receive therapy services)
- Complications (acute conditions such as infections or chronic conditions with exacerbations such as COPD - these conditions tend to cause or lengthen acute hospitalizations)
- Comorbidities (acute and chronic conditions affecting care such as diabetes, dementia etc.)

RESIDENT: John Q. Public

DATE OF ADMIT OR READMIT: June 18, 2007

DATE OF SEQUENCING: June 20, 2007

PERSON(s) COMPLETING FORM: Mary Health Information

Payor:

- PART A
- PART B
- OTHER (Medicaid)

Therapy involved:

PT Therapy treatment dr: 438.11

OT Therapy treatment dr: 728.85

SLP Therapy treatment dr: _____

DIAGNOSIS DESCRIPTIONS: _____ **ICD-9 CODES**

Please number final billing diagnoses 1-18 for sequencing on the UB04 or other billing statement and list any resolved diagnoses if known.

UB04 UB #1, omit from MDS - (Section 7 Int: PT and OT minutes)	401.1 UB # 6, MDS Section I	Resolved diagnoses (please list date if known)
438.11 UB # 2, MDS Section I	244.0 UB #7 MDS Section I	
438.80 UB # 3, MDS Section I	438.0 UB # 8, MDS Section I	
728.85 UB # 4 MDS Section I	250.00 UB # 9, MDS Section I	
998.0 UB # 5 MDS Section I (this code will be resolved once antibiotic course is completed and symptoms are resolved)		

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Accurately Reporting ICD-9-CM Codes



Accurately Reporting ICD-9-CM Codes

- Accurate reporting of ICD-9-CM codes affects:
 - Accurate claim submission (e.g. Medicare)
 - Quality Indicators
 - Data collected for long term care residents
 - Overall accuracy of your MDS/RUG categories



Accurately Reporting ICD-9-CM Codes

- Report correct & complete diagnosis code numbers
- Report correct number of digits
 - Assign 4th & 5th digits as required
 - Do **NOT** add zeros or nines as “fillers” to an ICD-9-CM code
 - Changes the meaning of diagnosis



Accurately Reporting ICD-9-CM Codes: MDS vs Billing Claim Forms

- Not all diagnoses reported on MDS are appropriate for billing claim forms (i.e. UB-04/837)
 - Some diagnosis codes on MDS do not relate to reasons for claim coverage
- Keep in mind time frame of MDS vs. billing claim form



Accurately Reporting ICD-9-CM Codes: Billing Claim Forms

- Inaccurate and/or incomplete codes can prompt a suspension or rejection of a claim
- Inaccurate codes can cause denials or medical reviews
 - Each FI determines diagnoses to be targeted
- Examples of diagnoses targeted for medical review in the past:
 - Bowel Obstruction 560.9
 - Dementia 294.8



Accurately Reporting ICD-9-CM Codes: DAVE

CMS Data Assessment and Verification (DAVE 2) project:

- Post payment review of accuracy of MDS and Medicare claims
 - Reports of monies taken back by CMS as a result of inappropriate reporting of diagnoses in Section I of the MDS



Accurately Reporting ICD-9-CM Codes: DAVE

- Specific findings from DAVE 2 Project regarding Section I:
 - Diseases or infections reported that are not current or are not active
 - Diagnoses reported without physician documentation
 - Diagnoses documented but not reported



Acknowledgments...

Primary Contributors to this training:

- Monica Baggio Tormey, RHIA, CHP
- Linda Bauer, RHIA
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- Michelle Dougherty, RHIA, CHP
- Jamie Husher, RHIA
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