QUALITY ASSESSMENT/PERFORMANCE MEASURES

FACILITY: _____

TOPIC: Quality of ICD-10-CM Coding

Review Date: _____ Location: _____

Population/Sample Size: _____

Report Prepared By: _____ F Tag: F582

Record Number for each resident			
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

LEGEND: + = Met; 0 = Not Met
N/A = Not Applicable

*Key Items	RESIDENT										Measure	Percent	Percent
Perforance Measures	1	2	3	4	5	6	7	8	9	10	0% or 100%	Met (of 5)	Met (of 10)
1. Principal diagnosis correctly selected/Clinical Category Maps											100		
2. Principal diagnosis correctly coded, as specified by Physician											100		
3. Top 10 secondary diagnoses correctly coded, included all skilled diagnoses.											100		
4. Top 10 diagnoses correctly sequenced, based on coding guidelines.											100		
5. NTA/SLP Comorbidities- all coded correctly											100		
6. NTA/SLP Comorbidities- all sequenced correctly											100		
7. Therapy treatment diagnoses coded and in computer timely (7 days).											100		
8. Therapy evaluations reflect correct medical condition diagnoses.											100		
9. Aftercare codes assigned correctly, based on coding guidelines. Aftercare codes are not used in conjunction with codes with a seventh character extension for the episode of care (Fractures, Injuries)											100		
10. Injuries correctly coded, with correct 7th character, based on coding guidelines and chart specificity.											100		
11. Non-traumatic head injuries (CVD) correctly coded with I69 code.											100		
12. If CVD, all residual effects coded.											100		
13. Hypertension correctly coded, per coding guidelines.											100		
14. CHF correctly coded, per chart specificity.											100		
15. All DM complications correctly coded, per coding guidelines and chart specificity.											100		
16. History/Status codes correctly sequenced (not principal diagnosis)											100		
17. Infections coded correctly with causal organisms included (if documented)											100		

Percent Met = (total number met/*total number reviewed) × 100

*Do not include N/A in total number reviewed.

QUALITY ASSESSMENT/PERFORMANCE INDICATORS

FACILITY: _____ DATE: _____

TOPIC: Coding errors/Corrections Rationale

CONCLUSION/RECOMMENDATIONS:

Attachment _____

Page _____ of _____

#1-2	Principal diagnosis coding: Guideline (p. 29) for Admission for Rehab #K – sequence first the code for the condition for which the service is being performed. 1. Look for an acute and/or skilled diagnosis 2. Assigned ICD-10 code / check for Clinical Category / If Maps to "return to Provider" this is not an acceptable principal dx. 3. Principal diagnosis matches physician documentation for specificity.
#3-4	Secondary diagnoses correctly coded and sequenced, per guidelines 1. Only code conditions that coexist at the time of admit or that affect the treatment rec'd and/or the length of stay 2. Diagnoses that relate to an earlier episode which have no bearing on the curent stay are to be excluded
#5	NTA and SLP Comorbidities- documented/pertinent comorbidities are coded correctly
#6	NTA and SLP Comorbidities- documented/pertinent comorbidities are sequenced correctly (higher points coded first- in descending points order)
#7	Therapy tx dx's should reflect reason for therapy 1. These dx's should be resident specific 2. Dx's should be as specific as possible, avoiding use of unspecified codes, if possible (for example, dysphagia, unspecified and generalized weakness)
#8	Therapy evals assigned medical diagnosis matches facility assigned principal medical diagnosis
#9	Z codes will frequently be assigned for aftercare following surgical procedures performed in the hospital for which the patient is sent to the LTC facility to recover. 1. Aftercare Z codes cover situations "when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease." 2. If the condition was resolved by the surgery, then it is not coded. 3. The aftercare codes are generally first-listed to explain the specific reason for the encounter. 4. Aftercare Z codes are not used for aftercare following injuries or fractures. For aftercare of an injury, see #10.
#10	Injury Coding: Aftercare Z codes are not used for aftercare following injuries or fractures. 1. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter). For example, for patients with traumatic fractures, the fractures are coded using the appropriate 7th character for subsequent care encounter after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. 2. Check the surgical and/or X-ray report to get the specificity needed to code accurately.
#11-12	1. Codes from I60-I63, are for acute care coding, and not acceptable for use in LTC coding. The SNF is not treating the acute stroke, but the sequelae of the stroke. 2. If the purpose for admission is rehabilitation, sequence first the code for the condition for which the therapy is being delivered. 3. To look up Sequela/late effects of CVD codes: In alpha index, start with the word sequela, then look for the type of hemorrhage that occurred, then the sequela itself. Example: >sequelae>subarachnoid, intracerebral, intracranial hemorrhage or cerebral infarction/stroke>residual effect (hemiparesis, etc.) 4. With hemiplegia, need to know which side was affected, and whether dominant or non-dominant, if mono or hemiparesis I69. 5. Do NOT code "unspecified" late effects 6. Have therapy verify ALL late effects they are treating.
#13	▪**I10 Essential hypertension**= *only code if no CKD or heart disease/CHF documented ▪**I11- Hypertensive heart disease**= *implied relationship if both HTN and heart disease documented. Heart conditions classified to I50.- to I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease (includes: all CHF and Myocarditis, Myocardial degeneration, Takotsubo syndrome, Carditis and Pancarditis).*Must also assign additional code for the heart disease or heart failure (CHF) in addition to the I11- combo code for hypertension. The same heart conditions with hypertension are coded separately* ***IF*** *the provider has specifically documented a different cause.* ▪**I12- Hypertensive chronic kidney disease**= *implied relationship if both HTN and CKD documented. Must also code the appropriate code from category N18 (CKD)s with the code from category I12 to identify the stage of chronic kidney disease. CKD should NOT be coded as hypertensive IF the physician has specifically documented a different cause.
#13 cont.	▪**I13- Hypertensive heart and chronic kidney disease** *Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with BOTH heart and kidney involvement *AKA cardiorenal disease. *If heart failure is present, assign as additional code from category I50 to identify the type of heart failure.The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code to identify the stage of chronic kidney disease.* ▪**I15- Secondary hypertension** *high BP that's caused by another medical condition, documented as such by MD
#14	▪I50.1- Left ventricular failure, L heart failure, pulmonary edema with heart failure ▪I50.2- Systolic CHF* [HFrEF] Heart failure with reduced ejection fraction ▪I50.3- Diastolic CHF* [HFpEF] Heart failure with normal/preserved ejection fraction ▪I50.4- Combined systolic and diastolic CHF* Heart failure with reduced ejection fraction and diastolic dysfunction ▪I50.8- Other heart failure (biventricular, high output, end stage), inc right heart failure, acute and chronic ▪I50.9- Heart failure, unspecified *only use if no other MD doc! Do NOT use for principal dx!! *Need 5th character for acute, chronic, acute on chronic. Refer to physician documentation for specificity as to type and whether acute, chronic or acute on chronic. Sequencing instruction to code first heart failure following surgery (I97.13-), Heart failure due to Hypertension (I11.0), Heart failure due to hypertensive CKD (I13-), and Rheumatic heart failure (I09.81).
#15	Diabetes coding assumes a cause-and-effect relationship between diabetes and certain other diseases. So, if diabetes and ANY of the listed conditions in the alphabetic index are indicated by the MD (can be documented separately), then use the diabetic complication code(s). Make sure coder knows how to look at type of diabetes in alpha index with manifestations listed below to understand all potential associated dx's. Some also require a secondary code, i.e., chr ulcer. If the physician documentation specifies diabetes is NOT the underlying cause of the other condition, the condition should not be coded as a diabetic complication.
#16	**Status Z-codes** are unacceptable as principal diagnoses. Some key words are "presence of" or "status". These codes convey further information about the resident or another diagnosis. **History Z-codes** have two types, family history and personal history. Do not code family history. They explain pts past medical condition that no longer exists, and is not rec'ing tx, but has potential for recurrence and may require continued monitoring. These are unacceptable to use as principal diagnosis and should not be sequenced high.
#17	**Infections** – Code first the infection only if actively treating. If no organism is identified as part of the infection code, use an additional code to identify the organism, if known. Code only if documented in the record. Infections Resistant to Antibiotics – Code first the infecion then a Z-code indicating Infections with drug-resistant microorganisms or use a combination code.