



POLARIS PULSE

20 YEARS

An Informational Bulletin Brought To You By Polaris Group

Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in health care consulting, puts Polaris Group in a limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.



ICD-9-CM ANNUAL UPDATE

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases. ICD-9-CM is the official system of assigning codes to diagnoses and procedures in the United States.

ICD-9-CM codes are required for all professional claims (physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers) and for all institutional claims (UB-04). ICD-9-CM codes are not required for ambulance supplier claims.

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. Governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM. Major updates to include new, revised and deleted codes are published annually. The updated codes are effective for dates of service on or after October 1 for individual providers and for discharges on or after October 1 for institutional providers including Skilled Nursing Facilities.

CMS and NCHS also update the ICD-9-CM Official Guidelines for Coding and Reporting annually. These guidelines are to be used as a companion document to the ICD-9-CM code updates. The guidelines are based on the coding and sequencing instructions in Volumes I, II and III

of the ICD-9-CM, but provide additional instructions. Adherence to these guidelines when assigning ICD-9-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). In the context of these guidelines, the term encounter is used for all settings, including hospital admissions and the term provider is used to mean physician or any qualified health care practitioner who is legally accountable for establishing the diagnosis.

The guidelines are organized into sections.

- Section I includes the structure and conventions of the classification and general guidelines that apply to outpatient and non outpatient settings (acute care, short term, long term care and psychiatric hospitals, home health agencies, rehab facilities, nursing homes, etc.).
- Section II includes guidelines for selection of principal diagnosis for non-outpatient settings.
- Section III includes guidelines for reporting additional diagnoses in non-outpatient settings.
- Section IV is for outpatient coding and reporting.

Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The application of the UHDDS definition has been expanded to include all non-outpatient settings.

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.

General Rules for Other (Additional) Diagnoses

For reporting purposes the definitions for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:



- Clinical evaluation
- Therapeutic treatment
- Extended length of stay
- Increased nursing care and/or monitoring

Key additions to FY 2009 ICD-9-CM include new subcategory for Pressure Ulcer Stages and additional codes for Methicillin Resistant / Susceptible Staph Aureus.

Pressure Ulcer Stages – Two codes will be 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.

- Codes from 707.2 may not be assigned as a principal or first-listed diagnosis.
- 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.
- 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.
- 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.
- No code is assigned if the documentation states that the pressure ulcer is completely healed.
- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage based on the documentation in the medical record. If the documentation does not provide the information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified. 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 physician/non physician practitioner.
- If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.
- The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).
- Code assignment for pressure ulcer stage 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 the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., nurses often documents the pressure ulcer stages). However, the associated diagnosis (pressure ulcer) must be documented by the patient's provider.

Methicillin Resistant Staphylococcus Aureus (MRSA)

- When a patient is diagnosed with an infection that is due to MRSA, and that infection has a combination code that includes the causal organism (e.g., pneumonia) assign the appropriate code for the condition (e.g., 482.42, Methicillin resistant pneumonia due to Staphylococcus aureus).
- 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.
- The condition or state of being colonized or carrying MSSA (Methicillin Susceptible Staph. Aureus) 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 MSRA 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".
- 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.

Additional new codes include Secondary Diabetes Mellitus, Hematuria, Disorders of Soft Tissue, Fever, Personal History of Fracture, Renal Dialysis Status, and Wheelchair Dependence. The complete lists of new, revised and deleted ICD-9-CM codes and the ICD-9-CM Guidelines for Coding and Reporting are available at: http://www.polaris-group.com/news_releases.asp



ICD-10 Code Set

The Department of Health and Human Services (HHS) announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets currently used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2011.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help to enable the implementation of electronic health records because they will provide more detail in the electronic transactions. This granularity will also help to improve efficiencies by helping to identify specific health conditions such as Methicillin-Resistant Staphylococcus aureus (MRSA) and other conditions. The ICD-10 code set currently includes 125 separate codes for capturing size, depth, and location of pressure ulcers.

“Now is the right time to move forward with the transition from ICD-9 to ICD-10,” said CMS Acting Administrator Kerry Weems. “We recognize that the transition to ICD-10 will require some upfront costs, but each year of delay would create additional costs, both because of the limitations of ICD-9 and because of the need to employ the greater precision that ICD-10 codes provide to support value-based purchasing of health care and other initiatives. We will continue to work collaboratively across the health care system to ensure a smooth transition to use of the updated transaction standards and ICD-10.”

Q & A

“Where No Question Goes Unanswered!”

- Q. Are MDS transmission validation reports available on the state transmission site indefinitely?
- A. It is recommended that the facility save and maintained all MDS validation reports. Validation reports are retained in the state repository for 90 days only. Although it is possible to access information contained in older reports, there is a charge for the information. You will need to contact your state RAI automation coordinator for assistance if you require access to older reports. (Source: Medicare Data Communication Network [MDCN] Help Desk)

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following **CEU approved** teleconference trainings
Live Teleconference Trainings

Topic	Date
Culture Change	9/10
Accidents and Supervision	9/11
Part II Medicare Practicum Part A&B	9/11
Anatomy of a Chart	9/16
Part III No Pay Bills	9/16
Behavior Assessments Care Plan	9/17
MDS for TILES Nurses	9/17
Public Quality Measures	9/18
New Sanitation Survey Protocol	9/23
MDS 3.0	9/24
Documentation for RUG 34	9/24
Taming the Care Plan Monster	9/25
Part IV Consolidated Billing	9/25

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