PDPM

for Therapists

Part 1: Application of PDPM
Part 2: More Important Stuff

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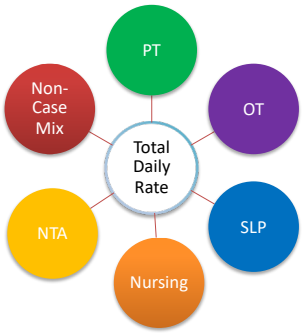
PDPM

for Therapists

Part 1
Application of PDPM



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Terms and Background

PDPM

PDPM Model

- Reimbursement driven by characteristics, not amount of minutes or disciplines
- If therapy services have been provided based on resident needs, then there will be no change in the minutes or disciplines delivered under PDPM.

Description of PDPM Terms

Clinical Category

ICD code in I0020B maps to one of these categories:

10 PRIMARY DIAGNOSIS CATEGORIES	4 COLLAPSED PT/OT CATEGORIES
Major joint replacement or spinal surgery	**Major joint replacement or spinal surgery**
Non-orthopedic surgery	**Non-orthopedic surgery and acute neurologic** *(if I0020B maps to acute neurologic, will contribute to SLP)*
Acute neurologic	
Non-surgical: orthopedic/musculoskeletal	**Other orthopedic**
Orthopedic surgery (except major joint replacement or spinal surgery)	
Medical management	**Medical Management**
Acute infections	
Cancer	
Pulmonary (i.e., pneumonia)	
Cardiovascular and Coagulation	

Description of PDPM Terms

- **Classification:** Each resident is **"classified"** into only one group for each of the 5 **case-mix adjusted components**.
  - One PT group
  - One OT group
  - One SLP group
  - One Nursing group
  - One NTA group
- And, each case-mix adjusted component has several case-mix groups within it.
- All classifications based on MDS data.
  - *Exception: AIDS/HIV not coded on MDS unless State requires it.*
  - *NTA points for AID/HIV derived from claim as B20 (8 pts), and nursing will receive the "add-on" of 18%.*

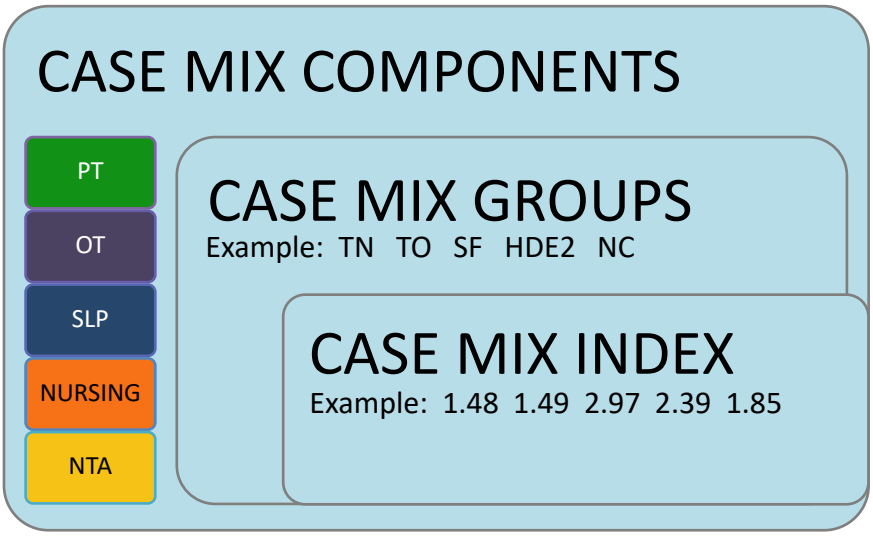
Description of PDPM Terms

- **Component** – There are 6 payment components that are added together for the PDPM daily rate.
  - PT Physical Therapy (case mix)
  - OT Occupational Therapy (case mix)
  - SLP Speech Language Pathology (case mix)
  - Nursing (case mix)
  - NTA Non-Therapy Ancillary (case mix)
  - Non-Case Mix
- **Case Mix** – This term means that clinical factors are used in the process.

Description of PDPM Terms

- **Case Mix Group or Group (CMG)** – Each component has several groups. Depending on the diagnosis, conditions, and services, each resident is classified into 1 group for each of the 5 out of 6 PDPM components. Each group has different criteria.
- **Case Mix Index (CMI)** – Each Case Mix Group is assigned a Case Mix Index (a number) that is used to calculate the daily rate for each component. The case mix index is then multiplied by the base rate. *The CMI represents the intensity of resources for that level of care.*
  - Example: A nursing case mix group of HDE2 has a CMI of 2.39
  - This CMI is then multiplied by a base rate, for example $103.46, to equal a daily rate of $247.3 for the nursing component. This will be added the other daily rates to determine the Total Daily Rate.

Components, CMG, CMI



Urban *(CMI is the same, rate differs)*

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes--URBAN

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$93.57	1.49	$84.83	0.68	$15.52	ES3	4.06	$432.96	3.24	$260.66
B	1.70	$103.97	1.63	$92.80	1.82	$41.55	ES2	3.07	$327.38	2.53	$203.54
C	1.88	$114.98	1.69	$96.21	2.67	$60.96	ES1	2.93	$312.46	1.84	$148.03
D	1.92	$117.43	1.53	$87.10	1.46	$33.33	HDE2	2.40	$255.94	1.33	$107.00
E	1.42	$86.85	1.41	$80.27	2.34	$53.42	HDE1	1.99	$212.21	0.96	$77.23
F	1.61	$98.47	1.60	$91.09	2.98	$68.03	HBC2	2.24	$238.87	0.72	$57.92
G	1.67	$102.14	1.64	$93.37	2.04	$46.57	HBC1	1.86	$198.35	-	-
H	1.16	$70.95	1.15	$65.47	2.86	$65.29	LDE2	2.08	$221.81	-	-
I	1.13	$69.11	1.18	$67.18	3.53	$80.59	LDE1	1.73	$184.49	-	-
J	1.42	$86.85	1.45	$82.55	2.99	$68.26	LBC2	1.72	$183.42	-	-
K	1.52	$92.96	1.54	$87.67	3.70	$84.47	LBC1	1.43	$152.50	-	-
L	1.09	$66.66	1.11	$63.19	4.21	$96.11	CDE2	1.87	$199.42	-	-
M	1.27	$77.67	1.30	$74.01	-	-	CDE1	1.62	$172.76	-	-
N	1.48	$90.52	1.50	$85.40	-	-	CBC2	1.55	$165.29	-	-
O	1.55	$94.80	1.55	$88.24	-	-	CA2	1.09	$116.24	-	-
P	1.08	$66.05	1.09	$62.05	-	-	CBC1	1.34	$142.90	-	-
Q	-	-	-	-	-	-	CA1	0.94	$100.24	-	-
R	-	-	-	-	-	-	BAB2	1.04	$110.91	-	-
S	-	-	-	-	-	-	BAB1	0.99	$105.57	-	-
T	-	-	-	-	-	-	PDE2	1.57	$167.42	-	-
U	-	-	-	-	-	-	PDE1	1.47	$156.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	$130.10	-	-
W	-	-	-	-	-	-	PA2	0.71	$75.71	-	-
X	-	-	-	-	-	-	PBC1	1.13	$120.50	-	-
Y	-	-	-	-	-	-	PA1	0.66	$70.38	-	-

Rural *(CMI is the same, rate differs)*

TABLE 7: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$106.67	1.49	$95.40	0.68	$19.56	ES3	4.06	$413.63	3.24	$249.03
B	1.70	$118.52	1.63	$104.37	1.82	$52.34	ES2	3.07	$312.77	2.53	$194.46
C	1.88	$131.07	1.69	$108.21	2.67	$76.79	ES1	2.93	$298.51	1.84	$141.42
D	1.92	$133.86	1.53	$97.97	1.46	$41.99	HDE2	2.40	$244.51	1.33	$102.22
E	1.42	$99.00	1.41	$90.28	2.34	$67.30	HDE1	1.99	$202.74	0.96	$73.79
F	1.61	$112.25	1.60	$102.45	2.98	$85.70	HBC2	2.24	$228.21	0.72	$55.34
G	1.67	$116.43	1.64	$105.01	2.04	$58.67	HBC1	1.86	$189.50	-	-
H	1.16	$80.88	1.15	$73.63	2.86	$82.25	LDE2	2.08	$211.91	-	-
I	1.13	$78.78	1.18	$75.56	3.53	$101.52	LDE1	1.73	$176.25	-	-
J	1.42	$99.00	1.45	$92.84	2.99	$85.99	LBC2	1.72	$175.23	-	-
K	1.52	$105.97	1.54	$98.61	3.70	$106.41	LBC1	1.43	$145.69	-	-
L	1.09	$75.99	1.11	$71.07	4.21	$121.08	CDE2	1.87	$190.52	-	-
M	1.27	$88.54	1.30	$83.24	-	-	CDE1	1.62	$165.05	-	-
N	1.48	$103.19	1.50	$96.05	-	-	CBC2	1.55	$157.91	-	-
O	1.55	$108.07	1.55	$99.25	-	-	CA2	1.09	$111.05	-	-
P	1.08	$75.30	1.09	$69.79	-	-	CBC1	1.34	$136.52	-	-
Q	-	-	-	-	-	-	CA1	0.94	$95.77	-	-
R	-	-	-	-	-	-	BAB2	1.04	$105.96	-	-
S	-	-	-	-	-	-	BAB1	0.99	$100.86	-	-
T	-	-	-	-	-	-	PDE2	1.57	$159.95	-	-
U	-	-	-	-	-	-	PDE1	1.47	$149.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	$124.29	-	-
W	-	-	-	-	-	-	PA2	0.71	$72.33	-	-
X	-	-	-	-	-	-	PBC1	1.13	$115.12	-	-
Y	-	-	-	-	-	-	PA1	0.66	$67.24	-	-

Description of PDPM Terms

- **Base Rate –** The base rate is updated annually in the Federal Register for the new Fiscal year. The base rate is then used in the daily rate calculation for each component.

FY2020 Unadjusted Federal Rates
Source: Federal Register Proposed Rule
Vol. 84, No. 80/Thursday, April 25, 2019, page 17624-17625

	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Urban	$61.60	$56.93	$22.83	$106.64	$80.45	$95.48
Rural	$69.72	$64.03	$28.76	$101.88	$76.86	$97.25

Description of PDPM Terms

Per Diem Adjuster

- An adjuster is used for 3 of the components.
- PT, OT, NTA
- Daily rate is adjusted throughout the stay.

Day In Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

Day In Stay	PT/OT Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Description of PDPM Terms

- **Function Score** – Derived from MDS section GG.
  - Dashes or blank = zero points
  - Not attempted codes (07, 09, 10, 88) = zero points
  - Dependent (01) = zero points*
  - *This may change in the future*
  - **PT/OT** uses 10 GG items
  - **Nursing** uses 7 of the 10 PT/OT GG items

Description of PDPM Terms

- **Cognitive Function Score (CFS)** – When BIMS is not valid, a CFS will be determined by MDS coding and used in the SLP component for cognitive status.
  - Combines BIMS and CPS (Cognitive Performance Scale is based on Staff Assessment) scores into one scale
  - ***If no BIMS interview or staff assessment, no HIPPS code.***
  - ***If no HIPPS code for any component, then no payment.***

Description of PDPM Terms

- **Principal/Primary diagnosis** - defined as "that condition established after study to be chiefly responsible for occasioning the admission to the hospital for care".
  - This will be coded on the MDS in I0020B to determine the payment category for PT, OT, SLP
  - I0020B Primary Diagnosis will match Principal Diagnosis on the claim, **most of the time.**
    Clinical Mapping File for I0020B must catch up with the ICD-10 Official Coding Guidelines.
  - Will use the PDPM Clinical Mapping file to ensure the ICD code in I0020B is valid, and to determine the clinical category
  - ICD-10 codes in I8000 will drive other PDPM comorbidity components in SLP and NTA

ICD-10 Official Coding Guidelines FY 2019

Clinically Relevant Data

- Driven almost exclusively from clinically relevant factors as basis for classification vs. volume of services.
- Identifies and adjusts 5 separate different case-mix components based on:
  - Diagnosis, comorbidities, characteristics of care.
- The **5 case mix components** are then **combined** with a **non-case-mix** component to determine per diem base rate.
- IDT will master ICD-10 and MDS Section GG coding.
- *Strategic Focus to Clinical Focus*

Revisions to Therapy Provision Policies

- Combined 25% limit on concurrent therapy and/or group therapy.
- **Example:**
  - PT 800 minutes delivered.
  - No more than 200 minutes could be provided as concurrent and/or group.
  - If 25% is exceeded, non-fatal warning will appear on final validation report during MDS submission process.
  - If this happens, check with therapy to ensure accuracy of coding.

FY20 Proposed Rule CMS-1718-P

The Proposed FY 2020 Rule

- Allow qualified rehabilitation therapists to form groups with as few as 2 and as many as 6 patients.
- The change would make SNF group therapy rules more consistent with other care settings and "create opportunities for site-neutral payments," according to CMS.
- Would go into effect October 1, 2019 if final.

ICD10 Coding: More Precision Needed

- More precision needed in ICD-10 but not compared to hospital coding
  - Hospital W108xxA traumatic hip fracture from fall on stairs
  - SNF S72.141D traumatic right intertrochanteric hip fracture
- Coding knowledge level needed based on what we need for quality care delivery and reimbursement
- Reimbursement no longer related to therapy minutes as main driver
- PT, OT, SLP, Nursing for clinical category, NTA for points
- GG will matter for PT, OT, Nursing
- Other MDS item coding for PT, OT SLP, NTA, Nursing

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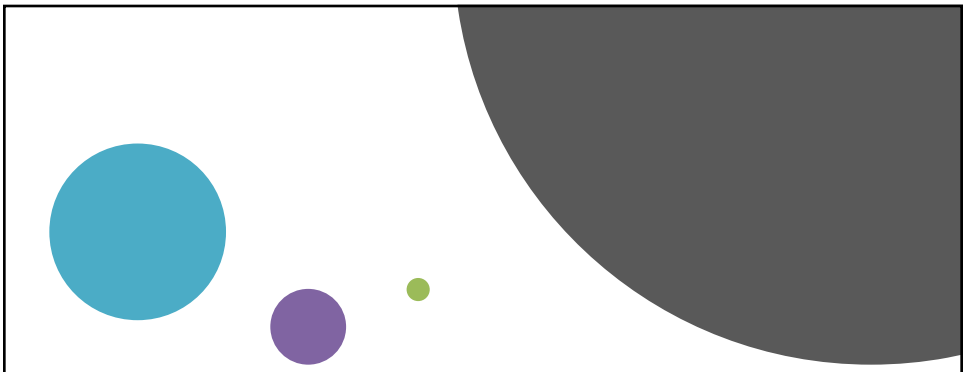


ICD-10 Mapping Files | PDPM

Utilize the Mapping Files

- SNFs do not often receive ICD specificity from the previous provider.
- Primary diagnosis in I0020B will determine the PT/OT category.
- If maps to Acute Neurologic, then will contribute to the SLP category.
- I8000 codes and MDS check boxes will determine Nursing and NTA case mix groups.

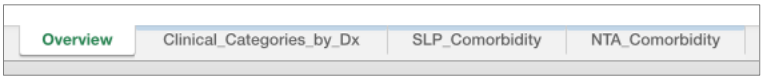
Mapping Files are in Constant Motion

Ask your software provider how often the built in mapping file is updated.

The ICD-10 Mapping File will continue to evolve and be revised to align with ICD-10-CM Official Guidelines for Coding and Reporting.

CMS PDPM Important Files Updated 04/04/19

- **Classification Walkthrough**
- **ICD-10 Mapping File**
  1. Clinical Category Mapping (I0020B)
  2. SLP Comorbidity List
  3. NTA Comorbidity Mapping



Updated versions continue to be periodically posted to cms.gov at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

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"Return To Provider" = invalid code for I0020B.

ICD-10 Mapping File

Clinical Category Mapping Crosswalk

- Used to map ICD-10 codes for I0020B.
- Purpose is to assign the PT/OT classification under PDPM.
- Includes instructions, clinical categories by diagnosis code, non-orthopedic surgery, orthopedic surgery.

Used for PT, OT, SLP
For SLP, **in addition to check boxes on MDS and primary diagnosis in I0020B, include related and additional diagnoses in** I8000.

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Principal Diagnosis and PDPM Clinical Category Mapping

Mapping: PDPM Clinical Categories to ICD-10 Diagnosis Codes for FY2019
Overview

ICD-10-CM Code	Description	Default Clinical Category
I69033	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69034	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69039	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69042		
I69043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69044		
I69049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side	Acute Neurologic
I69053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69061	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69062	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left dominant side	Acute Neurologic
I69063	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69064	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69065	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage, bilateral	Acute Neurologic
I69069	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider

Check your diagnosis code in I0020B
with the Clinical Category Mapping file!

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Clinical Category Mapping "Return to Provider"

Mapping: PDPM Clinical Categories to ICD-10 Diagnosis Codes for FY2019
Overview

ICD-10-CM Code	Description	Default Clinical Category
I69033	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69034	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69039	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side	Acute Neurologic
I69043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side	Acute Neurologic
I69053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider
I69061	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right dominant side	Acute Neurologic
I69062	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left dominant side	Acute Neurologic
I69063	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting right non-dominant side	Acute Neurologic
I69064	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting left non-dominant side	Acute Neurologic
I69065	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage, bilateral	Acute Neurologic
I69069	Other paralytic syndrome following nontraumatic subarachnoid hemorrhage affecting unspecified side	Return to Provider

Check your primary diagnosis code in I0020B
with the clinical mapping crosswalk file!

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Clinical Category Mapping I0020B "Return to Provider"

ICD-10 Coding Guidelines on Principal Diagnosis

- Unacceptable to use manifestations that are due to an underlying cause.
  - **F02.81** behavioral disturbance is a manifestation code.
  - **G20** Underlying condition is the disease causing dementia, Parkinson
- PDPM primary diagnosis in I0020B
  - **F02.81** = Return to Provider as of 04/04/19 (was previously Medical Management)
  - **G20** = Acute Neurological category (high CMI)

Clinical Category Mapping I0020B "Return to Provider"

- R13.10 Dysphagia
- R26.89 Other abnormalities of gait
- R26.9 Unspecified abnormalities of gait
- R27.9 Unspecified lack of coordination
- R29.6 Repeated falls
- R41.81 Age related cognitive decline
- R41.82 Altered mental status
- R53.1 Weakness
- R53.2 Functional quadriplegia
- R53.81 Malaise
- R54 Age related debility
- R62.7 Adult failure to thrive

Clinical Category Mapping I0020B "Return to Provider"

- I69.369 Other paralytic syndrome following cerebral infarction of unspecified side
- I69.359 Hemiplegia/hemiparesis following cerebral infarction affecting unspecified side
- M62.81 Muscle weakness
- Z87.81 Personal history of traumatic fracture
- Z48.89 Encounter for other surgical aftercare

Interesting…

- Historically we have been reluctant to use R27.8 (other lack of coordination) as a principal diagnosis on the claim.
- For PDPM purposes, R27.8 maps to Acute Neurologic. *At least as of today!*
- Less reimbursement than Major Joint Replacement or Spinal Surgery.

ICD-10 Mapping File

SLP Comorbidity List

- Lists all the SLP comorbidities to help determine SLP case mix group.
- Includes codes and descriptions of the condition.
- Additional comorbidities continue to be added.

SLP Comorbidity List

Mapping of Comorbidities Included in PDPM SLP Component

Overview

Sort Order	Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
1	ALS	G12.21	Amyotrophic lateral sclerosis
2	Apraxia	I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
3	Apraxia	I69.190	Apraxia following nontraumatic intracerebral hemorrhage
4	Apraxia	I69.290	Apraxia following other nontraumatic intracranial hemorrhage
5	Apraxia	I69.390	Apraxia following cerebral infarction
6	Apraxia	I69.890	Apraxia following other cerebrovascular disease
7	Apraxia	I69.990	Apraxia following unspecified cerebrovascular disease
8	Dysphagia	I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
9	Dysphagia	I69.191	Dysphagia following nontraumatic intracerebral hemorrhage
10	Dysphagia	I69.291	Dysphagia following other nontraumatic intracranial hemorrhage
11	Dysphagia	I69.391	Dysphagia following cerebral infarction
12	Dysphagia	I69.891	Dysphagia following other cerebrovascular disease
13	Dysphagia	I69.991	Dysphagia following unspecified cerebrovascular disease
14	Laryngeal Cancer	C32.0	Malignant neoplasm of glottis
15	Laryngeal Cancer	C32.1	Malignant neoplasm of supraglottis
16	Laryngeal Cancer	C32.2	Malignant neoplasm of subglottis
17	Laryngeal Cancer	C32.3	Malignant neoplasm of laryngeal cartilage
18	Laryngeal Cancer	C32.8	Malignant neoplasm of other specified sites of larynx
19	Laryngeal Cancer	C32.9	Malignant neoplasm of larynx, unspecified
20	Oral Cancers	C00.0	Malignant neoplasm of external upper lip
21	Oral Cancers	C00.1	Malignant neoplasm of external lower lip
22	Oral Cancers	C00.3	Malignant neoplasm of upper lip, inner aspect
23	Oral Cancers	C00.4	Malignant neoplasm of lower lip, inner aspect
24	Oral Cancers	C00.5	Malignant neoplasm of lip, unspecified, inner aspect
25	Oral Cancers	C00.6	Malignant neoplasm of commissure of lip, unspecified
26	Oral Cancers	C00.8	Malignant neoplasm of overlapping sites of lip
27	Oral Cancers	C00.2	Malignant neoplasm of external lip, unspecified
28	Oral Cancers	C00.9	Malignant neoplasm of lip, unspecified
29	Oral Cancers	C01	Malignant neoplasm of base of tongue
30	Oral Cancers	C02.0	Malignant neoplasm of dorsal surface of tongue

Added in April 2019.

Added in April 2019

Stay current with the SLP comorbidity changes by checking the mapping file frequently.

ICD-10 Mapping File

NTA Comorbidity Mapping Crosswalk and List

- Maps co-morbidities to an ICD-10-CM code used for the NTA component.
- It is referenced in the Classification Walkthrough (classification worksheet) tool under NTA component.
- Includes codes and descriptions of the condition.

Used for NTA
Any additional comorbidities listed in I8000 as well as comorbidities in other check boxes of MDS Section I will impact payment. Earns points for the CMI.

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NTA Comorbidity Mapping

Mapping of Comorbidities Included in the Proposed PDPM NTA Component to ICD-10-CM Codes

Overview

The following mapping of CCs and RxCCs to ICD-10-CM codes is based on the 2017 Risk Adjustment model software found at https://www.cms.gov/MedicareHealth-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2017.html.

Sort Order	Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
1390	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
1391	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema
1392	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
1393	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
1394	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
1395	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
1396	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
1397	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
1398	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
1399	**RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage**	**E10319**	**Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema**
1400	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
1401	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
1402	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
1403	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
1404	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
1405	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
1406	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
1407	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
1408	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
1409	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
1410	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
1411	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
1412	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
1413	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
1414	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema
1415	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema
1416	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
1417	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
1418	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
1419	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
1420	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
1421	RxCC241: Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
1422	CC162: Severe Skin Burn or Condition	L1230	Acquired epidermolysis bullosa, unspecified

Check your I8000 NTA diagnosis codes with the NTA mapping crosswalk file!

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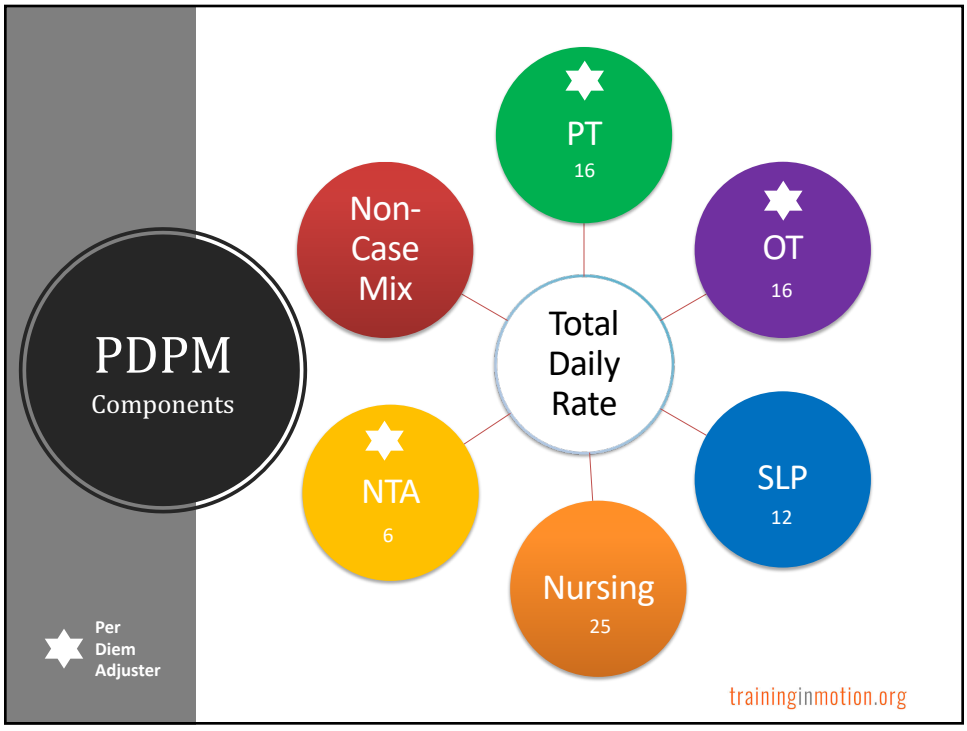
PDPM Components | PDPM



Drivers of PDPM

Per Diem Adjuster	★	★			★
Factor	PT	OT	SLP	NSG	NTA
Primary diagnosis (ICD code) in I0020B to determine Clinical Category	1st	1st	1st		
Specific SLP comorbidities coded in I8000: CVA, TIA, hemiplegia, hemiparesis, TBI, trach, vent, laryngeal cancer, apraxia, dysphagia, ALS, oral cancers, speech/language deficits			2nd		
Section C Cognition (Resident BIMS or Cognitive Function Scale)			3rd		
Clinical qualifiers used as hierarchical classification - Extensive services, special care high, special care low, clinically complex, behavioral/cognitive, physical functioning				1st	
Section D Depression Score used as a front split for special care high, special care low, and clinically complex				✓	
Section O Restorative Nursing Services used as front split for behavioral/cognitive and physical functioning				✓	
Function Score from GG	2nd	2nd		2nd	
GG0130A1 Eating	✓	✓		✓	
GG0120B1 Oral Hygiene	✓	✓			
GG0120C1 Toileting Hygiene	✓	✓		✓	
average — *GG0170B1 Sitting to lying*	✓	✓		✓	
average — *GG0170C1 Lying to sitting on side of bed*	✓	✓		✓	
average — *GG0170D1 Sit to stand*	✓	✓		✓	
average — *GG0170E1 Chair to bed/bed to chair*	✓	✓		✓	
average — *GG0170F1 Toilet transfer*	✓	✓		✓	
average — *GG0170J1 Walk 50 feet with 2 turns*	✓	✓			
average — *GG0170K1 Walk 150 feet*	✓	✓			
K0100 A-D Swallowing disorder and/or K0510C Mechanically altered diet			4th		
Health conditions coded on MDS (50)					1st
Specific NTA comorbidities coded in Section I (K,O,M,H) and I8000					✓
K0710A2 = 3, 26-50% calories through parenteral/TF (high intensity)					✓
K0710A2 = 2, 26-50% calories through parenteral/TF and K0710B2 = 2, 501 cc/day or more (low intensity)					✓
HIV/AIDS (B20) *on claim only, not on MDS (8 pts NTA, 18% add-on Nursing)*				✓	✓

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PT

OT

The PT CMG/CMI

The OT CMG/CMI

First Determine

- Primary Diagnosis in I0020B to determine the Clinical Category, using the ICD-10 Clinical Mapping File

Then Determine

- PT/OT GG Function Score

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Physical Therapy

PT COMPONENT			
Clinical Category	**Function Score**	**PT Case Mix Group**	**CMI**
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53
Major Joint Replacement or Spinal Surgery	6-9	TB	1.70
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92
Other Orthopedic	0-5	TE	1.42
Other Orthopedic	6-9	TF	1.61
Other Orthopedic	10-23	TG	1.67
Other Orthopedic	24	TH	1.16
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

Orthopedic surgery = (not major joint replacement or spinal)

Points Assigned to Section GG Responses	
Section GG Responses	**Function Score**
Independent	4
Set-up Assistance	4
Supervision or touching assistance	3
Partial/moderate assistance	2
Substantial/maximal assistance	1
Dependent	0
Refused	0
N/A	0
Not Attempted	0

PT and OT will result in same Case Mix Group, but not always same Case Mix Index.

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Occupational Therapy

OT COMPONENT			
Clinical Category	**Function Score**	**OT Case Mix Group**	**CMI**
Major Joint Replacement or Spinal Surgery	0-5	TA	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.69
Major Joint Replacement or Spinal Surgery	24	TD	1.53
Other Orthopedic	0-5	TE	1.41
Other Orthopedic	6-9	TF	1.60
Other Orthopedic	10-23	TG	1.64
Other Orthopedic	24	TH	1.15
Medical Management	0-5	TI	1.18
Medical Management	6-9	TJ	1.45
Medical Management	10-23	TK	1.54
Medical Management	24	TL	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.50
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.09

Orthopedic surgery = (not major joint replacement or spinal)

Points Assigned to Section GG Responses	
Section GG Responses	**Function Score**
Independent	4
Set-up Assistance	4
Supervision or touching assistance	3
Partial/moderate assistance	2
Substantial/maximal assistance	1
Dependent	0
Refused	0
N/A	0
Not Attempted	0

PT and OT will result in same Case Mix Group, but not always same Case Mix Index.

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Determining the Primary SNF Diagnosis

I0020B is the first step in determining the PT/OT Category

- Primary reason from the SNF stay **may or may not be** the same as the reason for the prior inpatient hospital stay
  - May be a secondary condition that arose during the hospital stay
- When reason for SNF is rehabilitation for condition related to prior hospital stay, code for that condition
  - e.g. rehabilitation following hip fracture would use the code for the fracture (subsequent encounter) as the primary
- When reason for SNF is aftercare following a joint replacement, code aftercare "Z-code"
  - e.g. aftercare following joint replacement surgery as primary/principal diagnosis **unless due to fracture**

Determining the Primary SNF Diagnosis

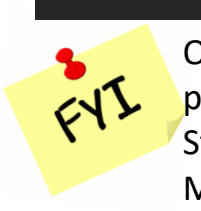
Ask, "What is the main reason this person is being admitted to the SNF?"

- Interdisciplinary process
- Diagnosis must be documented by physician or physician extender
- Follow MDS rules for "active diagnosis"
- Discussion with IDT to determine primary diagnosis

Who Can Diagnose?

- Physicians
  - Attending
  - Medical Director
  - Radiologists
  - Specialists
  - Etc.
- Physician Extenders, if state allows:
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Physician Assistants
- PDPM will result in **more physician queries** to obtain accurate ICD codes

Who Can Code?



Once the diagnosis is confirmed by the physician, a code may be assigned by staff. Still must meet MDS 2-step criteria to code on MDS. For example:

- No hospital documentation referencing dysphagia
- Upon evaluation by SLP, dysphagia is identified
- Nursing has documented symptoms of swallowing problems
- Physician query is completed to add the diagnosis of dysphagia and the query documentation is scanned into the medical record
- The coder (MDS or coding designee) assigns the correct code based on documentation and SLP treatment
- The **"active"** diagnosis is coded on the MDS

MDS Rules for Coding "Active Diagnosis"

Two-Step Process

1. Diagnosis Identification: Code diseases that have a documented diagnosis in the last 60 days by the physician or physician extender. In the absence of specific documentation, may use positive tests, procedures, hospitalization for symptoms (i.e., chest x-ray confirms pneumonia).
2. Diagnosis Status: Has a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Does not include conditions that are resolved.

Exception: I2300 UTI uses 30-day look-back and has specific criteria of physician/extender documentation and evidence-based criteria.

MDS Rules for Coding "Active Diagnosis"

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
- For example, intermittent claudication (lower extremity pain on exertion) with a diagnosis of peripheral vascular disease would indicate active disease
- A symptom must be specifically attributed to the disease.
- For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

MDS Rules for Coding "Active Diagnosis"

- Listing a diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status.
- To determine if arthritis is an "active" diagnosis, check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

MDS Rules for Coding "Active Diagnosis"

- A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.
- This includes medications used to limit disease progression and complications.
- If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

Why do Therapists need to know this?

- Because it's the diagnoses that will validate medical necessity to be in the SNF for therapy and you cannot skill for an inactive diagnoses.
- Because it's the diagnoses that will determine payment.
- Because therapists use Medical Diagnoses to validate their Treatment Diagnoses
- Because both disciplines (Therapy and Nursing) will need to match up their "active" diagnoses so that the MDS and Claim is accurate.
- Because Therapy diagnoses must match the MDS diagnoses and the Claim diagnoses.

How will our processes change?

- No longer will list all conditions found in medical records from hospital since many may not be "active".
- Collaboration with MDS to determine "active" diagnosis for I0020B and other MDS appropriate conditions.
- Collaborate on diagnoses once:
  - Each discipline (Therapy and Nursing) complete their evaluations/assessments
  - Resident, family, medical records
  - Look for meds/treatments without conditions
  - Look for conditions without meds/treatments
  - Review hospital MARs, TARs, Therapy documentation, physician documentation, nursing documentation, etc.
- Generate new diagnosis list with every readmission.

Determining the PT/OT Clinical Category

MDS I0020B will map to one of the Primary Diagnosis Clinical Categories.

Section I | **Active Diagnoses**

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code: 0 1

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

I 6 9 . 8 5 1

Hemiparesis following CVA, affecting right dominant side.

Using the ICD10 Clinical Mapping File for I0020B

- Use the PDPM ICD10 clinical category mapping file from cms.gov to further classify into Primary Diagnosis Clinical Category.
- Crosswalk between ICD-10 code and the 10 clinical category that leads to the therapy clinical category
- Some codes may map to more than one clinical category depending on inpatient procedure history.
  - *May be categorized into surgical clinical category if primary reason for SNF stay is related to the surgical procedure, dependent on J2100 coding (J2300-J5000)*
- "Return to Provider" codes are invalid for I0020B

ICD10 Clinical Mapping File

Mapping: PDPM Clinical Categories to ICD-10 Diagnosis Codes

I69842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side	Acute Neurologic
I69843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side	Acute Neurologic
I69844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side	Acute Neurologic
I69849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side	Return to Provider
I69851	**Hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side**	**Acute Neurologic**
I69852	Hemiplegia and hemiparesis follow	
I69853	Hemiplegia and hemiparesis follow	
I69854	Hemiplegia and hemiparesis follow	
I69859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side	Return to Provider
I69861	Other paralytic syndrome following other cerebrovascular disease affecting right dominant side	Acute Neurologic
I69862	Other paralytic syndrome following other cerebrovascular disease affecting left dominant side	Acute Neurologic
I69863	Other paralytic syndrome following other cerebrovascular disease affecting right non-dominant side	Acute Neurologic
I69864	Other paralytic syndrome following other cerebrovascular disease affecting left non-dominant side	Acute Neurologic
I69865	Other paralytic syndrome following other cerebrovascular disease, bilateral	Acute Neurologic
I69869	Other paralytic syndrome following other cerebrovascular disease affecting unspecified side	Return to Provider
I69890	Apraxia following other cerebrovascular disease	
I69891	Dysphagia following other cerebrovascular disease	
I69892	Facial weakness following other cerebrovascular disease	
I69893	Ataxia following other cerebrovascular disease	
I69898	Other sequelae of other cerebrovascular disease	
I6990	Unspecified sequelae of unspecified cerebrovascular disease	Acute Neurologic
I69910	Attention and concentration deficit following unspecified cerebrovascular disease	Medical Management
I69911	Memory deficit following unspecified cerebrovascular disease	Medical Management
I69912	Visuospatial deficit and spatial neglect following unspecified cerebrovascular disease	Acute Neurologic
I69913	Psychomotor deficit following unspecified cerebrovascular disease	Acute Neurologic
I69914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease	Medical Management
I69915	Cognitive social or emotional deficit following unspecified cerebrovascular disease	Medical Management
I69918	Other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease	Medical Management
I69919	Unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease	Medical Management
I69920	Aphasia following unspecified cerebrovascular disease	Acute Neurologic
I69921	Dysphasia following unspecified cerebrovascular disease	Acute Neurologic

Classifies into Acute Neurologic Category

Note: "Return to Provider" Codes are Invalid for I0020B

Determining the PT/OT GG Function Score based on 10 GG items

Self Care

- GG0130A1 Eating
- GG0130B1 Oral Hygiene
- GG0130C1 Toileting Hygiene

Mobility

- Bed Mobility (Average)
  - GG0170B1 Sit to Lying
  - GG0170C1 Lying to Sitting on side of bed
- Transfer (Average)
  - GG0170D1 Sit to stand
  - GG0170E1 Chair to bed/bed to chair
  - GG0170F1 Toilet transfer
- Walking (Average)
  - GG0170J1 Walk 50 ft with 2 turns
  - GG0170K1 Walk 150 ft

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Coding MDS Section GG

Self Care and Mobility
01-06 The higher the score, the higher the function

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Do not dash fill. If not attempted, must use one of the "Not Attempted "codes.

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PT/OT payments may be higher for moderate level of functional independence.

- PT and OT utilization is highest for patients with moderate functional independence.
  - This likely reflects patients whose functional abilities are **too impaired to receive intensive therapy**.
- PT and OT utilization is lower for patients with both the highest levels of functional dependence and highest independence.
  - This likely corresponds to patients who require less therapy because they **already have a high level of functional independence**.
- PDPM appropriately assigns payment according to the observed relationship between functional independence and PT/OT utilization.

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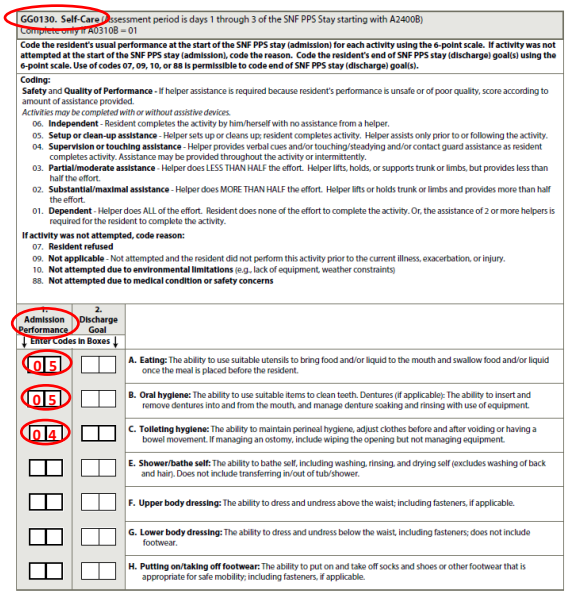
PT/OT Function Score



GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	(Enter Codes in Boxes)	
05		A.	**Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
05		B.	**Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
04		C.	**Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E.	**Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F.	**Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
		G.	**Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
		H.	**Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Column 1 Coding	Score
05,06	4
04	3
03	2
02	1
01, 07, 09, 10, 88	0

5 = **Score of 4**
5 = **Score of 4**
4 = **Score of 3**

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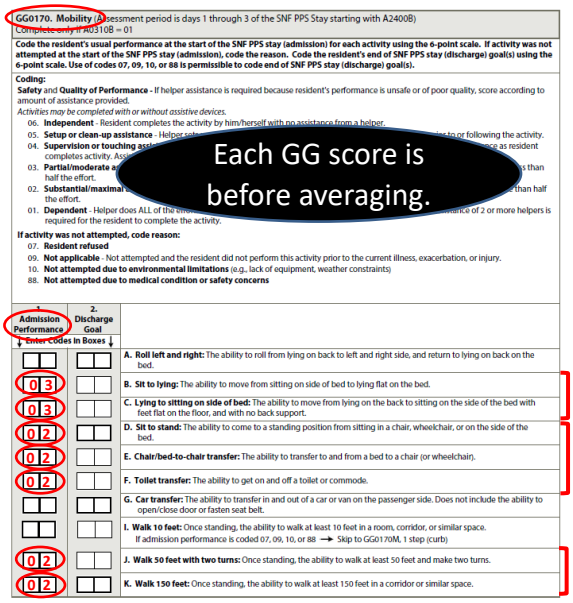
PT/OT Function Score, continued.



GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper
04. **Supervision or touching** completes activity. Assi
03. **Partial/moderate a** half the effort.
02. **Substantial/maximal** the effort.
01. **Dependent** - Helper does ALL of the
required for the resident to complete the activity.

Each GG score is before averaging.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	(Enter Codes in Boxes)	
		A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
03		B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
03		C.	**Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
02		D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
02		E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
02		F.	**Toilet transfer:** The ability to get on and off a toilet or commode.
		G.	**Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
02		J.	**Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
02		K.	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Column 1 Coding	Score
05,06	4
04	3
03	2
02	1
01, 07, 09, 10, 88	0

Average: 2+2 = 4/2 = 2 = **Score of 2**
Average: 1+1+1 = 3/3 = **Score of 1**
Average: 1+1 = 2/2 = **Score of 1**

PT/OT Function Score, continued.

Self Care

4 • GG0130A1 Eating
4 • GG0130B1 Oral Hygiene
3 • GG0130C1 Toileting Hygiene

Mobility

- Bed Mobility
  - GG0170B1 Sit to Lying
  - GG0170C1 Lying to Sitting on side of bed

2

- Transfer
  - GG0170D1 Sit to stand
  - GG0170E1 Chair to bed/bed to chair
  - GG0170F1 Toilet transfer

1

- Walking
  - GG0170J1 Walk 50 ft with 2 turns
  - GG0170K1 Walk 150 ft

1

Total Function Score
15

If total is not a whole number, will round to nearest integer.

PT/OT Case Mix Group

Acute Neurologic ➡ Function Score 15 = Classification = TO = CMI

PT COMPONENT

Clinical Category	Function Score	PT Case Mix Group	CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53
Major Joint Replacement or Spinal Surgery	6-9	TB	1.70
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92
Other Orthopedic	0-5	TE	1.42
Other Orthopedic	6-9	TF	1.61
Other Orthopedic	10-23	TG	1.67
Other Orthopedic	24	TH	1.16
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

OT COMPONENT

Clinical Category			
Major Joint Replacement or Spinal Surgery	10-23	TG	1.64
Major Joint Replacement or Spinal Surgery	24	TH	1.15
Major Joint Replacement or Spinal Surgery	0-5	TI	1.18
Major Joint Replacement or Spinal Surgery	6-9	TJ	1.45
Other Orthopedic	10-23	TK	1.54
Other Orthopedic	24	TL	1.11
Other Orthopedic	0-5	TM	1.30
Other Orthopedic	6-9	TN	1.50
Other Orthopedic	10-23	TO	1.55
Other Orthopedic	24	TP	1.09
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

16 CASE MIX GROUPS

Daily rate will vary according to Adjustment Factor

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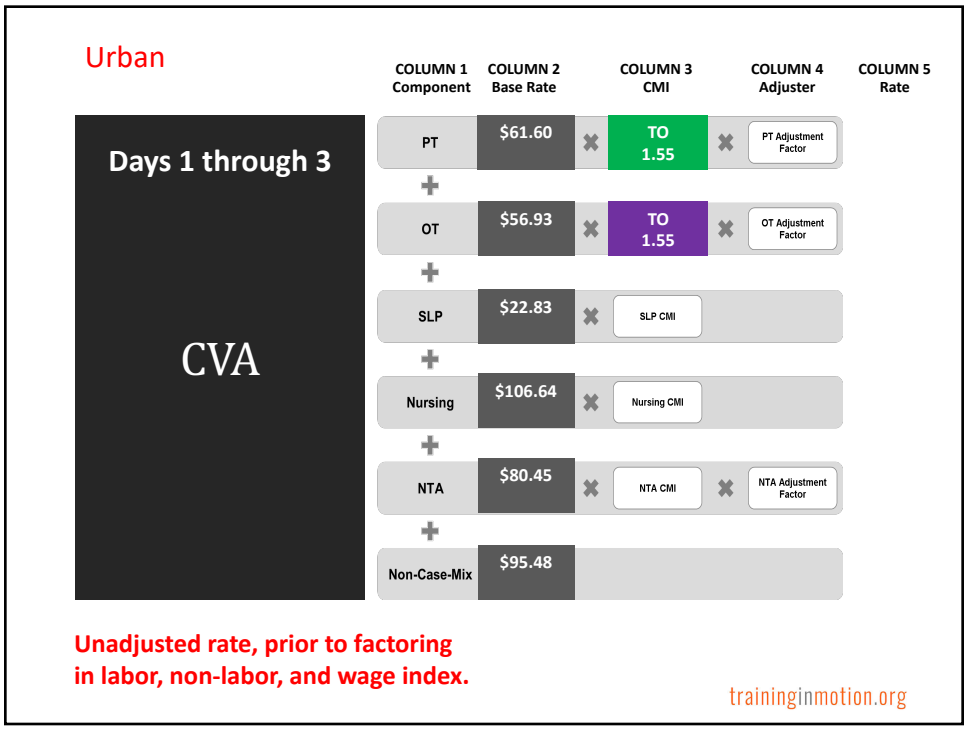
Urban
COLUMN 1 Component
COLUMN 2 Base Rate
COLUMN 3 CMI
COLUMN 4 Adjuster
COLUMN 5 Rate
Days 1 through 3
CVA
PT
$61.60
TO 1.55
PT Adjustment Factor
OT
$56.93
TO 1.55
OT Adjustment Factor
SLP
$22.83
SLP CMI
Nursing
$106.64
Nursing CMI
NTA
$80.45
NTA CMI
NTA Adjustment Factor
Non-Case-Mix
$95.48
Unadjusted rate, prior to factoring in labor, non-labor, and wage index.
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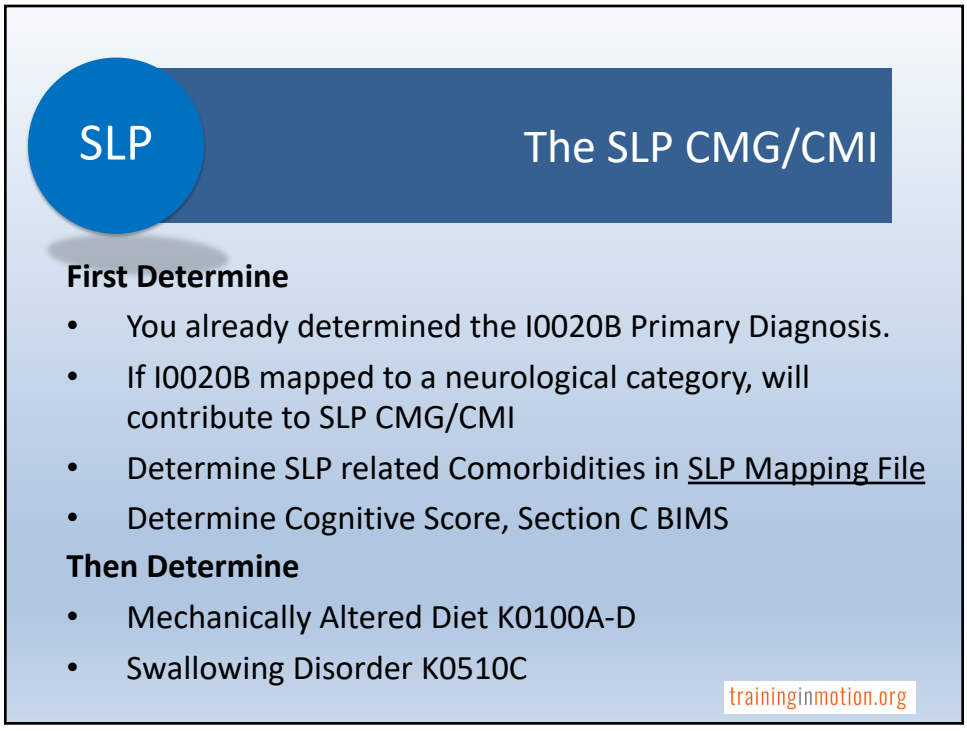
SLP
The SLP CMG/CMI
First Determine
• You already determined the I0020B Primary Diagnosis.
• If I0020B mapped to a neurological category, will contribute to SLP CMG/CMI
• Determine SLP related Comorbidities in SLP Mapping File
• Determine Cognitive Score, Section C BIMS
Then Determine
• Mechanically Altered Diet K0100A-D
• Swallowing Disorder K0510C
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Speech Language Pathology

SLP COMPONENT			
Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	**Mechanically Altered Diet or Swallowing Disorder**	**SLP Case Mix Group**	**CMI**
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.67
Any one	Neither	SD	1.46
Any one	Either	SE	2.34
Any one	Both	SF	2.98
Any two	Neither	SG	2.04
Any two	Either	SH	2.86
Any two	Both	SI	3.53
All three	Neither	SJ	2.99
All three	Either	SK	3.70
All three	Both	SL	4.21

Comorbidity	ICD-10	ICD-10-CM Code Description
ALS	G12.21	Amyotrophic lateral sclerosis
Apraxia	I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
Apraxia	I69.190	Apraxia following nontraumatic intracerebral hemorrhage
Apraxia	I69.290	Apraxia following other nontraumatic intracranial hemorrhage
Apraxia	I69.390	Apraxia following cerebral infarction
Apraxia	I69.890	Apraxia following other cerebrovascular disease
Apraxia	I69.990	Apraxia following unspecified cerebrovascular disease
Dysphagia	I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
Dysphagia	I69.191	Dysphagia following nontraumatic intracerebral hemorrhage
Dysphagia	I69.291	Dysphagia following other nontraumatic intracranial hemorrhage
Dysphagia	I69.391	Dysphagia following cerebral infarction
Dysphagia	I69.891	Dysphagia following other cerebrovascular disease
Dysphagia	I69.991	Dysphagia following unspecified cerebrovascular disease
Laryngeal Cancer	C32.0	Malignant neoplasm of glottis
Laryngeal Cancer	C32.1	Malignant neoplasm of supraglottis
Laryngeal Cancer	C32.2	Malignant neoplasm of subglottis
Laryngeal Cancer	C32.3	Malignant neoplasm of laryngeal cartilage
Laryngeal Cancer	C32.8	Malignant neoplasm of other specified sites of larynx
Laryngeal Cancer	C32.9	Malignant neoplasm of larynx, unspecified
Oral Cancers	C00.0	Malignant neoplasm of external upper lip
Oral Cancers	C00.1	Malignant neoplasm of external lower lip
Oral Cancers	C00.3	Malignant neoplasm of upper lip, inner aspect
Oral Cancers	C00.4	Malignant neoplasm of lower lip, inner aspect
Oral Cancers	C00.5	Malignant neoplasm of lip, unspecified, inner aspect
Oral Cancers	C00.6	Malignant neoplasm of commissure of lip, unspecified
Oral Cancers	C00.8	Malignant neoplasm of overlapping sites of lip
Oral Cancers	C00.2	Malignant neoplasm of external lip, unspecified
Oral Cancers	C00.9	Malignant neoplasm of lip, unspecified
Oral Cancers	C01	Malignant neoplasm of base of tongue
Oral Cancers	C02.0	Malignant neoplasm of dorsal surface of tongue
Oral Cancers	C02.1	Malignant neoplasm of border of tongue
Oral Cancers	C02.2	Malignant neoplasm of ventral surface of tongue
Oral Cancers	C02.3	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
Oral Cancers	C02.8	Malignant neoplasm of overlapping sites of tongue
Oral Cancers	C02.4	Malignant neoplasm of lingual tonsil

Note:
Only the listed ICD-10 codes will apply.

Speech Language Pathology

Oral Cancers	C02.8	Malignant neoplasm of overlapping sites of tongue
Oral Cancers	C02.9	Malignant neoplasm of tongue, unspecified
Oral Cancers	C03.0	Malignant neoplasm of upper gum
Oral Cancers	C03.1	Malignant neoplasm of lower gum
Oral Cancers	C03.9	Malignant neoplasm of gum, unspecified
Oral Cancers	C03.9	Malignant neoplasm of gum, unspecified
Oral Cancers	C04.0	Malignant neoplasm of anterior floor of mouth
Oral Cancers	C04.1	Malignant neoplasm of lateral floor of mouth
Oral Cancers	C04.8	Malignant neoplasm of overlapping sites of floor of mouth
Oral Cancers	C04.9	Malignant neoplasm of floor of mouth, unspecified
Oral Cancers	C09.9	Malignant neoplasm of tonsil, unspecified
Oral Cancers	C09.8	Malignant neoplasm of overlapping sites of tonsil
Oral Cancers	C09.0	Malignant neoplasm of tonsillar fossa
Oral Cancers	C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
Oral Cancers	C10.0	Malignant neoplasm of vallecula
Oral Cancers	C10.1	Malignant neoplasm of anterior surface of epiglottis
Oral Cancers	C10.8	Malignant neoplasm of overlapping sites of oropharynx
Oral Cancers	C10.2	Malignant neoplasm of lateral wall of oropharynx
Oral Cancers	C10.3	Malignant neoplasm of posterior wall of oropharynx
Oral Cancers	C10.4	Malignant neoplasm of branchial cleft
Oral Cancers	C10.8	Malignant neoplasm of overlapping sites of oropharynx
Oral Cancers	C10.9	Malignant neoplasm of oropharynx, unspecified
Oral Cancers	C14.0	Malignant neoplasm of pharynx, unspecified
Oral Cancers	C14.2	Malignant neoplasm of waldeyer's ring
Oral Cancers	C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
Oral Cancers	C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
Oral Cancers	C06.0	Malignant neoplasm of cheek mucosa
Oral Cancers	C06.1	Malignant neoplasm of vestibule of mouth
Oral Cancers	C05.0	Malignant neoplasm of hard palate
Oral Cancers	C05.1	Malignant neoplasm of soft palate
Oral Cancers	C05.2	Malignant neoplasm of uvula
Oral Cancers	C05.9	Malignant neoplasm of palate, unspecified
Oral Cancers	C05.8	Malignant neoplasm of overlapping sites of palate
Oral Cancers	C06.2	Malignant neoplasm of retromolar area
Oral Cancers	C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
Oral Cancers	C06.80	Malignant neoplasm of overlapping sites of unspecified parts of mouth
Oral Cancers	C06.9	Malignant neoplasm of mouth, unspecified

Speech/Language Deficits	I69.020	Aphasia following nontraumatic subarachnoid hemorrhage
Speech/Language Deficits	I69.021	Dysphasia following nontraumatic subarachnoid hemorrhage
Speech/Language Deficits	I69.022	Dysarthria following nontraumatic subarachnoid hemorrhage
Speech/Language Deficits	I69.023	Fluency disorder following nontraumatic subarachnoid hemorrhage
Speech/Language Deficits	I69.028	Other speech/language deficits following nontraumatic subarachnoid hemorrhage
Speech/Language Deficits	I69.120	Aphasia following nontraumatic intracerebral hemorrhage
Speech/Language Deficits	I69.121	Dysphasia following nontraumatic intracerebral hemorrhage
Speech/Language Deficits	I69.122	Dysarthria following nontraumatic intracerebral hemorrhage
Speech/Language Deficits	I69.123	Fluency disorder following nontraumatic intracerebral hemorrhage
Speech/Language Deficits	I69.128	Other speech/language deficits following nontraumatic intracerebral hemorrhage
Speech/Language Deficits	I69.220	Aphasia following other nontraumatic intracranial hemorrhage
Speech/Language Deficits	I69.221	Dysphasia following other nontraumatic intracranial hemorrhage
Speech/Language Deficits	I69.222	Dysarthria following other nontraumatic intracranial hemorrhage
Speech/Language Deficits	I69.223	Fluency disorder following other nontraumatic intracranial hemorrhage
Speech/Language Deficits	I69.228	Other speech/language deficits following other nontraumatic intracranial hem
Speech/Language Deficits	I69.320	Aphasia following cerebral infarction
Speech/Language Deficits	I69.321	Dysphasia following cerebral infarction
Speech/Language Deficits	I69.322	Dysarthria following cerebral infarction
Speech/Language Deficits	I69.323	Fluency disorder following cerebral infarction
Speech/Language Deficits	I69.328	Other speech and language deficits following cerebral infarction
Speech/Language Deficits	I69.820	Aphasia following other cerebrovascular disease
Speech/Language Deficits	I69.821	Dysphasia following other cerebrovascular disease
Speech/Language Deficits	I69.822	Dysarthria following other cerebrovascular disease
Speech/Language Deficits	I69.823	Fluency disorder following other cerebrovascular disease
Speech/Language Deficits	I69.828	Other speech and language deficits following other cerebrovascular disease
Speech/Language Deficits	I69.920	Aphasia following unspecified cerebrovascular disease
Speech/Language Deficits	I69.921	Dysphasia following unspecified cerebrovascular disease
Speech/Language Deficits	I69.922	Dysarthria following unspecified cerebrovascular disease
Speech/Language Deficits	I69.923	Fluency disorder following unspecified cerebrovascular disease
Speech/Language Deficits	I69.928	Other speech/language deficits following unspecified cerebrovascular disease

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Clinical Category

MDS I0020B will map to one of the Primary Diagnosis Clinical Categories.

Section I | **Active Diagnoses**

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code: 01

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code: I69.851

Hemiparesis following CVA, affecting right dominant side.

SLP Co-Morbidities

Section I | **Active Diagnoses**

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Heart/Circulation
- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal
- ☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary
- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections
- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic
- ✓ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)

Musculoskeletal
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I4000. Other Fracture**

Neurological
- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ✓ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ✓ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional
- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Section I | **Active Diagnoses**

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Psychiatric/Mood Disorder
- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary
- ✓ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.	Dysphagia following cerebral vascular disease	I69.991
B.	Dysphagia oropharyngeal phase	R13.12
C.	Proliferative DM retinopathy	E08.311
D.		
E.		
F.		
G.		
H.		
I.		
J.		

Cognitive Function

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code: 2

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: "*Please tell me what year it is right now.*"

Enter Code: 1

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: "*What month are we in right now?*"

Enter Code: 0

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: "*What day of the week is today?*"

Enter Code: 0

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?*"
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code: 0

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code: 0

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code: 0

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score: 03

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Cognitive Level	BIMS
Cognitively Intact	13-15
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

If assessed as mildly, moderately, or severely impaired then classifies as cognitively impaired.

3 = Moderately Impaired

K0100 Swallowing Problems

RAI Instructions:

- Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.
- If any one of the conditions is present in K0100A through K0100D, the resident has a swallowing disorder.
- **Do not ignore SLP documentation for swallowing problems!**

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K0100 Swallowing Disorder

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☑	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☑	C. Coughing or choking during meals or when swallowing medications
☑	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

- *Did staff **or** SLP identify a swallowing problem with any of these symptoms during the look-back period that resulted in SLP services?*
- *Does the SLP progress notes indicate a swallowing problem that describes any of the symptoms A through D during the look-back period?*
- *If a staff interview or observation reveals any of these symptoms during the look-back period, document the interview or observation and code it.*

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K0510 Mechanically Altered Diet

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last **7 days**		
1. **While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply	
A. **Parenteral/IV feeding**	☐	☑
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☑
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

K0510C2 Mechanically altered diet **while a resident** (Column 2).

A diet specifically prepared to alter texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet is not automatically be considered a therapeutic diet.

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SLP Determine Group

Primary Diagnosis listed in I0020B is I69.851 Hemiparesis following CVA, affecting right dominant side (Acute Neurological)	I69.991 Dysphagia following CV disease (SLP Related Comorbidity)	BIMS = 3, Moderately impaired (Cognitive Impairment)	K0510C Checked (Mechanically Altered Diet) K0100 A,C,D checked (Swallowing Problem)

SLP COMPONENT

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.67
Any one	Neither	SD	1.46
Any one	Either	SE	2.34
Any one	Both	SF	2.98
Any two	Neither	SG	2.04
Any two	Either	SH	2.86
Any two	Both	SI	3.53
All three	Neither	SJ	2.99
All three	Either	SK	3.70
All three	Both	SL	4.21

No Adjustment Factor **12 CASE MIX GROUPS**

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Urban

Days 1 through 3

CVA

COLUMN 1 Component	COLUMN 2 Base Rate		COLUMN 3 CMI		COLUMN 4 Adjuster	COLUMN 5 Rate
PT	$61.60	✖	TO 1.55	✖	PT Adjustment Factor	
+						
OT	$56.93	✖	TO 1.55	✖	OT Adjustment Factor	
+						
SLP	$22.83	✖	SL 4.21			
+						
Nursing	$106.64	✖	Nursing CMI			
+						
NTA	$80.45	✖	NTA CMI	✖	NTA Adjustment Factor	
+						
Non-Case-Mix	$95.48					

Unadjusted rate, prior to factoring in labor, non-labor, and wage index.

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NSG

The Nursing CMG/CMI

First Determine

- Clinical Qualifiers
- Depression Score
- Restorative Nursing Services

Then Determine

- Nursing Function Score
- Determine if B20 should be coded on claim

Nursing

NURSING COMPONENT

Nursing Category	Conditions/Services	Additional Conditions/Services	Nursing GG-Based Function Score	PDPM CMG	CMI
Extensive Services	Trach and Ventilator/Respirator while a resident	N/A	0-14	ES3	4.06
	Trach or Ventilator/Respirator, while a resident	N/A	0-14	ES2	3.07
	Infection with Isolation, while a resident	N/A	0-14	ES1	2.93
Special Care High	• B0100, Section GG items: Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1,GG0170F1 all = 01,09, or 88) • I2100: Septicemia • I2900, N0350A,B: Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B) • I5100 Quadriplegia + Nursing Function Score <= 11 • I6200 + J1100C: COPD and shortness of breath when lying flat • J1550A Fever and one of the following; I2000 Pneumonia, J1550B Vomiting, K0300 Weight loss (1 or 2), K0510B1 or K0510B2 Feeding tube* • K0510A1 or K0510A2: Parenteral/IV feedings • O0400D2: Respiratory therapy all 7 days **Tube feeding classification requirements: K0710A3 is 51% or more of total calories OR K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake last 7 days.*	Depression ≥ 10	0-5	HDE2	2.40
		No Depression	0-5	HDE1	1.99
		Depression ≥ 10	6-14	HBC2	2.24
		No Depression	6-14	HBC1	1.86
Special Care Low	• I4400, Nursing Function Score: Cerebral palsy, with Nursing Function Score <=11 • I5200, Nursing Function Score: Multiple sclerosis, with Nursing Function Score <=11 • I5300, Nursing Function Score: Parkinson's disease, with Nursing Function Score <=11 • I6300, O0100C2: Respiratory failure & oxygen therapy while a resident • K0510B1 or K0510B2: Feeding tube* • M0300B1: Two or more stage 2 pressure ulcers with two or more selected skin treatments** • M0300C1,D1,F1: Any stage 3 or 4 pressure ulcer with 2 or more selected skin txs** • M1030: Two or more venous/arterial ulcers with two or more selected skin treatments** • M0300B1, M1030: 1 stage 2 pressure ulcer & 1 venous/arterial ulcer with 2 + selected skin txs** • M1040A,B,C; M1200I: Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet • O0100B2: Radiation treatment while a resident • O0100J2: Dialysis treatment while a resident *Tube feeding classification requirements: K0710A3 is 51% or more of total calories OR K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake last 7 days.* ***Selected skin treatments:* *M1200A,B#: Pressure relieving chair and/or bed M1200C Turning/repositioning, counts as one treatment even if both provided.* *M1200D: Nutrition or hydration intervention M1200E Pressure ulcer care* *M1200G: Application of dressings (not to feet) M1200H Application of ointments (not to feet)*	Depression ≥ 10	0-5	LDE2	2.08
		No Depression	6-14	LDE1	1.73
		Depression ≥ 10	6-14	LBC2	1.72
		No Depression	0-5	LBC1	1.43
Clinically Complex	• I2000: Pneumonia • I4900, Nursing Function Score: Hemiplegia/hemiparesis + nursing function <= 11 • M1040D,E: Open lesions other than ulcers, rashes, cuts) with any selected skin treatments or surgical wounds • M1040F: Burns	Depression ≥ 10	0-5	CDE2	1.87
		No Depression	0-5	CDE1	1.62
		Depression	6-14	CBC2	1.55

Note: *Qualifiers are subject to change.*

Nursing

	• O100A2: Chemotherapy while a resident • O0100C2: Oxygen therapy while a resident • O0100I2: Medications while a resident • O0100I2: Transfusions while a resident	Depression	15-16	CA2	1.09
		No Depression	6-14	CBC1	1.34
		No Depression	15-16	CA1	0.94
Behavioral Symptoms and Cognitive Performance	If Nursing Function Score is 11+, determine whether the resident presents with any one of the three cognitive conditions: • B0100 = 1, comatose and GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D, GG0170E1, and GG0170F1 are coded as completely dependent or activity did not occur on the 5-day PPS assessment; or • C1000 = 3, cognitive skills for daily decision making are severely impaired; or • Two or more of the following: B0700 > 0, usually, sometimes or rarely/never understood, C0700 = 1, short term memory problem, C1000 > 0, cognitive skills for daily decision making are impaired; and • One or more of the following severe impairment indicators are present: B0700 > or = 2, sometimes or rarely/never makes self understood; or C1000 > or = 2, cognitive skills for daily decision making are moderately or severely impaired If Nursing Function Score is 11+, determine whether the resident presents with any **one** of the following behavioral symptoms. • E0100A Hallucinations • E0100B Delusions • E0200A Physical behavioral symptoms directed toward others (coded 2 or 3) • E0200B Verbal behavioral symptoms directed toward others (coded 2 or 3) • E0200C Other behavioral symptoms not directed toward others (coded 2 or 3) • E0800 Rejection of care (coded 2 or 3) • E0900 Wandering (coded 2 or 3) If the resident presents with one of these symptoms, he/she classifies as Behavioral Symptoms and Cognitive Performance. If the resident's nursing function score is less than 11 or if does not present with one of the symptoms, skip to Reduced Physical Function. To determine the Case Mix Group, determine the restorative services count (only count services delivered for 15 minutes a day for 6 + days during the 7-day look-back period). • H0200C, H0500 Urinary toileting program and/or bowel toileting program (count as 1 service if both provided) • O0500A,B Passive and/or active range of motion (count as 1 service if both provided) • O0500C Splint or brace assistance • O0500D,F Bed mobility and/or walking training (count as 1 service if both provided) • O0500E Transfer training • O0500G Dressing and/or grooming training • O0500H Eating and/or swallowing training • O0500I Amputation/prostheses care • O0500J Communication training	Count = 2 or more services	11-16	BAB2	1.04
		Count = 0-1 services	0-5	BAB1	0.99
Reduced Physical Function	Determine the restorative services count (only count services delivered for 15 minutes a day for 6 + days during the 7-day look-back period). • H0200C, H0500 Urinary toileting program and/or bowel toileting program (count as 1 service if both provided) • O0500A,B Passive and/or active range of motion (count as 1 service if both provided) • O0500C Splint or brace assistance • O0500D,F Bed mobility and/or walking training (count as 1 service if both provided) • O0500E Transfer training • O0500G Dressing and/or grooming training • O0500H Eating and/or swallowing training • O0500I Amputation/prostheses care • O0500J Communication training	2 or More	0-5	PDE2	1.57
		0-1	0-5	PDE1	1.47
		2 or More	6-14	PBC2	1.22
		2 or More	15-16	PA2	0.71
		0-1	6-14	PBC1	1.13
		0-1	15-16	PA1	0.66

Nursing Classification Model

Titles of **6 nursing categories** are same as RUG IV nursing groups, but only comprise **25 case mix groups** (*not 43*).

- Tracheostomy, ventilator, infection with isolation is a factor for:
  - **Extensive Services**
- Depression severity score from D0300 (≥ 10 but not 99) or D0600 (≥ 10) is a factor for:
  - **Special Care High**
  - **Special Care Low**
  - **Clinically Complex**
- Restorative services is a factor for:
  - **Behavioral Symptoms and Cognitive Performance**
  - **Reduced Physical Functioning**

Nursing SPECIAL CARE HIGH

If at least **one** of these services or treatments is coded and has **Nursing Function Score of 14 or less, classifies as Special Care High**. **If Nursing Function Score is 15 or 16, is Clinically Complex.** **Qualifiers subject to change by CMS.**

B0100 Comatose and GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, GG0170F1 all coded 01, 09, or 88.
I2100: Septicemia
I2900, N0350A,B Diabetes with both insulin injections all 7 days and insulin order changes on 2 or more days
I5100 Quadriplegia with Nursing Function Score ≤ 11
J1550A and others - Fever **and** one of the following: • I2000 pneumonia • J1550B vomiting • K0300 weight loss (1 or 2) • K0510B1 or K0510B2 feeding tube
K0510A1 or K0510A2 parenteral feeding
O0400D2 respiratory therapy all 7 days

Nursing Component: While a resident or while not a resident.
NTA Component: While a resident.

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Nursing SPECIAL CARE HIGH

Depression Score MDS Section D - PHQ9

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	2
B. *Feeling down, depressed, or hopeless*	☐	3
C. *Trouble falling or staying asleep, or sleeping too much*	☐	1
D. *Feeling tired or having little energy*	☐	2
E. *Poor appetite or overeating*	☐	1
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	0
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	1
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	0
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	0

D0300. Total Severity Score

Enter Score: 1 0

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Depression score = 10

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Function Score

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	Enter Codes in Boxes
05		A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
		B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
04		C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
		G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
		H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Column 1 Coding	Score
05,06	4
04	3
03	2
02	1
01, 07, 09, 10, 88	0

5 = Score of 4

4 = Score of 3

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Function Score

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

Calculate each GG score first.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	Enter Codes in Boxes
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
03		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
03		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
02		D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
02		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
02		F. **Toilet transfer:** The ability to get on and off a toilet or commode.
		G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
		K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Column 1 Coding	Score
05,06	4
04	3
03	2
02	1
01, 07, 09, 10, 88	0

Average: 2+2 = 4/2 = 2 = **Score of 2**

Average: 1+1+1 = 3/3 = **Score of 1**

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Function Score

Self Care

4 • GG0130A1 Eating

3 • GG0130C1 Toileting Hygiene

Mobility

2 • Bed Mobility
  – GG0170B1 Sit to Lying
  – GG0170C1 Lying to Sitting on side of bed

1 • Transfer
  – GG0170D1 Sit to stand
  – GG0170E1 Chair to bed/bed to chair
  – GG0170F1 Toilet transfer

Total **Nursing** Function Score
10

If total is not a whole number, will round to nearest integer.

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Nursing SPECIAL CARE HIGH

NURSING COMPONENT

Nursing Category	Conditions/Services	Additional Conditions/Services	Nursing GG-Based Function Score	PDPM CMG	CMI
Extensive Services	Trach and Ventilator/Respirator while a resident	N/A	0-14	ES3	4.06
	Trach or Ventilator/Respirator, while a resident	N/A	0-14	ES2	3.07
	Infection with Isolation, while a resident	N/A	0-14	ES1	2.93
Special Care High	• B0100, Section GG items: Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1,GG0170F1 all = 01,09, or 88) • I2100: Septicemia • I2900, N0350A,B: Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B) • I5100 Quadriplegia + Nursing Function Score <= 11 • I6200 + J1100C: COPD and shortness of breath when lying flat • J1550A Fever and one of the following; I2000 Pneumonia, J1550B Vomiting, K0300 Weight loss (1 or 2), K0510B1 or K0510B2 Feeding tube* • K0510A1 or K0510A2: Parenteral/IV feedings • O0400D2: Respiratory therapy all 7 days **Tube feeding classification requirements: K0710A3 is 51% or more of total calories OR K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake last 7 days.*	Depression ≥ 10	0-5	HDE2	2.40
		No Depression	0-5	HDE1	1.99
		Depression ≥ 10	6-14	HBC2	2.24
		No Depression	6-14	HBC1	1.86

CASE STUDY

- K0510A1 or K0510A2 parenteral feeding classifies into Special Care High.
- Function Score = 10
- Depression Score = 10
- Further classify into HBC2 (CMI 2.24)

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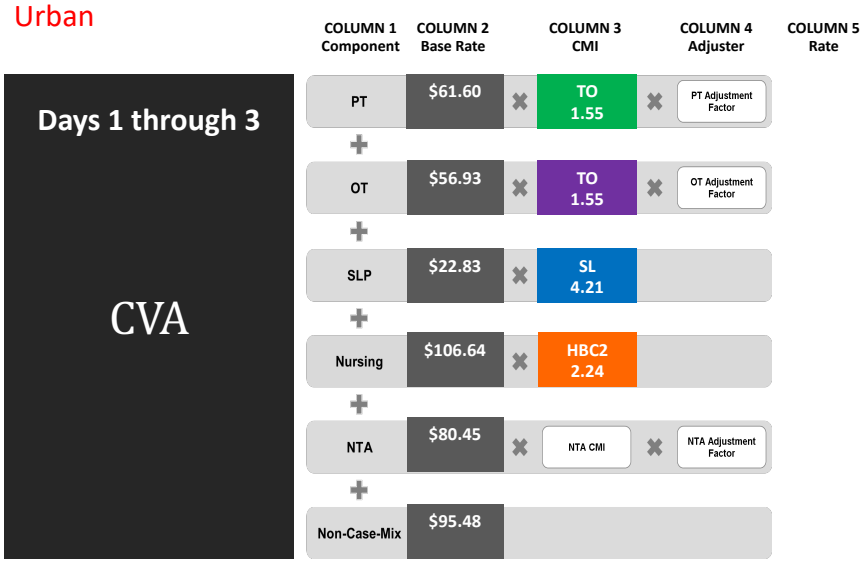
Urban



Unadjusted rate, prior to factoring in labor, non-labor, and wage index.

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O0100M "Single Room Isolation"

Avoid contraindications in documentation!

Examples:

- Coded as single room isolation, but MDS is coded in section G as having locomotion off unit or walked in corridor during lookback.
- **No therapy documentation that therapy was delivered in room.**
- No documentation that meals were delivered in room.
- Care plan does not indicate single room isolation, delivery of therapy, activities, or meals in room.

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NTA

The NTA CMG/CMI

Determine the following

- Health Conditions using NTA mapping file for MDS section I8000 ICD10 codes
- Additional NTA conditions coded/checked in MDS section I, O, M, H)
- MDS coding for Parenteral/IV feeding in section K
- If B20 should be coded on claim
- Total points earned for all qualifying conditions

Non-Therapy Ancillaries

NTA COMPONENT		
NTA Comorbidity Score	**NTA Case Mix Group**	**CMI**
12+	NA	3.24
9-11	NB	2.53
6-8	NC	1.84
3-5	ND	1.33
1-2	NE	0.96
0	NF	0.72

Comorbidities Included in NTA Comorbidity Score and Assigned Points – *MDS coding will map to one of these NTA categories.*

Condition/Service	MDS Item	Points
HIV/AIDS	SNF Claim ICD-10 B20	8
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit	O0100H2	5
Special Treatments/Programs: Ventilator Post-admit	O0100F2	4
Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2
Multiple Sclerosis	I5200	2
Opportunistic Infections	I8000	2
Asthma, COPD, Chronic Lung Disease	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection	I2300	2
Diabetes Mellitus (DM) includes diabetic retinopathy, nephropathy, neuropathy)	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer	M1040B	1

Non-Therapy Ancillaries

Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Post-admit	O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO)	I1700	1
Special Treatments/Programs: Isolation Post-admit	O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit	O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot, Except Diabetic Foot Ulcer	M1040A M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit	O0100D2	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Malnutrition (protein or calorie) or at risk for malnutrition	I5600	1
Disorders of Immunity – Except RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

Importance of Using NTA Mapping File

- Coding Diabetic Retinopathy
  - I8000 = E10319, Earn 1 NTA point
  - I2900 = ✓, Earn 2 NTA points
- General categories, need to validate ICD code to determine if falls into a category that can be coded in I8000 to earn points
  - i.e., K72.10 Chronic hepatic failure without coma
  - “End Stage Liver Disease” (1 pt) in I8000

Check NTA I8000 Codes with Mapping File

- Check I8000 codes with NTA mapping file to determine if the code falls within a listed category.
- Only specific ICD-10 codes will map to certain categories
- i.e. I8000 diabetic retinopathy conditions, only certain codes apply for points

Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E08351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E08359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E09359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E10359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E11359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	E13359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	H4310	Vitreous hemorrhage, unspecified eye
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	H4311	Vitreous hemorrhage, right eye
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	H4312	Vitreous hemorrhage, left eye
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	H4313	Vitreous hemorrhage, bilateral

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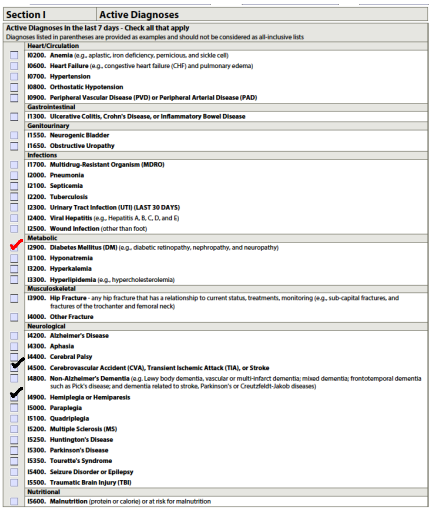
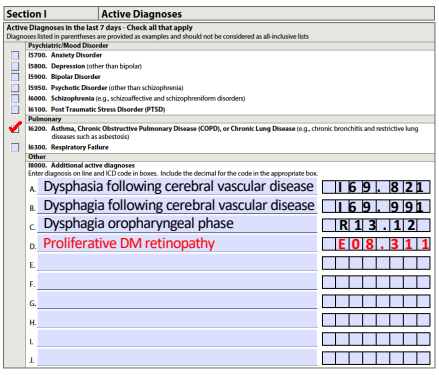
NTA Co-Morbidities





I6200 COPD = 2
I2900 Diabetes & Retinopathy = 2
I8000 Diabetic Retinopathy = 1

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K0510A Parenteral/IV Feeding

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last **7 days**	1. While NOT a Resident	2. While a Resident
1. **While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☑
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☑
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

K0510A2 Parenteral/IV feeding **while a resident** (Column 2).
Then proceed to K0710, A & B for calories and cc's.

K0710 Intake by Artificial Route

K0710. **Percent Intake by Artificial Route** - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B 1. **While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days*** 3. **During Entire 7 Days** Performed during the entire ***last 7 days***	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓		
A. **Proportion of total calories the resident received through parenteral or tube feeding** 1. 25% or less 2. 26-50% 3. 51% or more	☐	2	☐
B. **Average fluid intake per day by IV or tube feeding** 1. 500 cc/day or less 2. 501 cc/day or more	☐	2	☐

If K0710A2 = 3, meets criteria for High Intensity
If K0710A2 = 2 and K0710B2 = 2, meets criteria for Low Intensity

K0710A2 = 2 + K0710B2 = 2 **Low Intensity = 3 NTA Points**

Determine NTA Score

Calculate total NTA score from the Condition/Service table.

K0510, K0710 Parenteral, Low = 3
I6200 COPD = 2
I2900 Diabetes & Retinopathy = 2
I8000 Diabetic Retinopathy = 1
Total NTA Score = 8

Determine Group

NTA COMPONENT		
NTA Comorbidity Score	NTA Case Mix Group	CMI
12+	NA	3.24
9-11	NB	2.53
6-8	NC	1.84
3-5	ND	1.33
1-2	NE	0.96
0	NF	0.72

Score = 8
Case Mix Group = NC

6 CASE MIX GROUPS

Daily rate will vary according to Adjustment Factor

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Urban

Days 1 through 3

CVA

COLUMN 1 Component	COLUMN 2 Base Rate		COLUMN 3 CMI		COLUMN 4 Adjuster	COLUMN 5 Rate
PT	$61.60	✖	TO 1.55	✖	PT Adjustment Factor	
+						
OT	$56.93	✖	TO 1.55	✖	OT Adjustment Factor	
+						
SLP	$22.83	✖	SL 4.21			
+						
Nursing	$106.64	✖	HBC2 2.24			
+						
NTA	$80.45	✖	NC 1.84	✖	NTA Adjustment Factor	
+						
Non-Case-Mix	$95.48					

Unadjusted rate, prior to factoring in labor, non-labor, and wage index.

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NCM

Non-Case Mix Component

- Base rate only
- Rate is not based on patient characteristics
- Urban and rural
- Costs not likely to change
- i.e., Room and board, capital related expenses

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Per Diem Adjustment

Days 1 through 3

CVA

COLUMN 1 Component	COLUMN 2 Base Rate		COLUMN 3 CMI		COLUMN 4 Adjuster	COLUMN 5 Rate
PT	$61.60	✖	TO 1.55	✖	1	
+						
OT	$56.93	✖	TO 1.55	✖	1	
+						
SLP	$22.83	✖	SL 4.21			
+						
Nursing	$106.64	✖	HBC2 2.24			
+						
NTA	$80.45	✖	NC 1.84	✖	3.0	
+						
Non-Case-Mix	$95.48					

Unadjusted rate, prior to factoring in labor, non-labor, and wage index.

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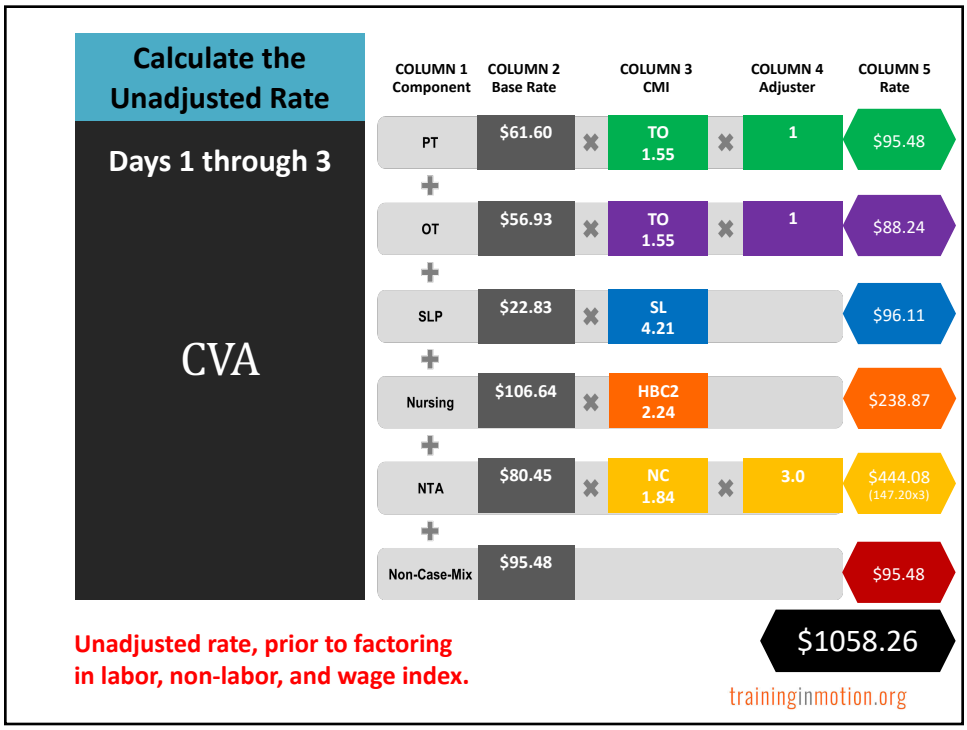
Calculate the Unadjusted Rate
Days 1 through 3
CVA
COLUMN 1 Component
COLUMN 2 Base Rate
COLUMN 3 CMI
COLUMN 4 Adjuster
COLUMN 5 Rate
PT
$61.60
TO 1.55
1
$95.48
OT
$56.93
TO 1.55
1
$88.24
SLP
$22.83
SL 4.21
$96.11
Nursing
$106.64
HBC2 2.24
$238.87
NTA
$80.45
NC 1.84
3.0
$444.08
(147.20x3)
Non-Case-Mix
$95.48
$95.48
$1058.26
Unadjusted rate, prior to factoring in labor, non-labor, and wage index.
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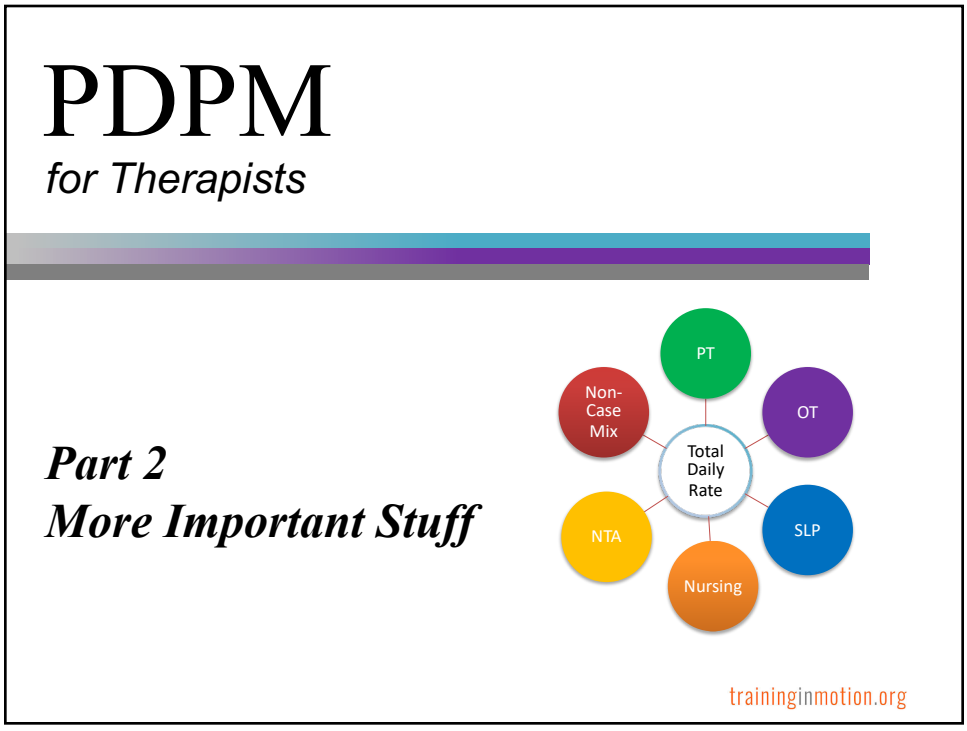
PDPM
for Therapists
Part 2
More Important Stuff
PT
OT
SLP
Nursing
NTA
Non-Case Mix
Total Daily Rate
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The HIPPS Billing Code

PDPM

What about the HIPPS code on the claim?

HIPPS CODES

PT and OT	
Case Mix Group	HIPPS Code
TA	A
TB	B
TC	C
TD	D
TE	E
TF	F
TG	G
TH	H
TI	I
TJ	J
TK	K
TL	L
TM	M
TN	N
TO	O
TP	P

SLP	
Case Mix Group	HIPPS Code
SA	A
SB	B
SC	C
SD	D
SE	E
SF	F
SG	G
SH	H
SI	I
SJ	J
SK	K
SL	L

NURSING	
Case Mix Group	HIPPS Code
ES3	A
ES2	B
ES1	C
HDE2	D
HDE1	E
HBC2	F
HBC1	G
LDE2	H
LDE1	I
LBC2	J
LBC1	K
CDE2	L
CDE1	M
CBC2	N
CA2	O
CBC1	P
CA1	Q
BAB2	R
BAB1	S
PDE2	T
PDE1	U
PBC2	V
PA2	W
PBC1	X
PA1	Y

NTA	
Case Mix Group	HIPPS Code
NA	A
NB	B
NC	C
ND	D
NE	E
NF	F

New HIPPS for ARD on or after October 1, 2019
No HIPPS code, no payment
5th Character Assessment Indicators
0 = Interim Payment Assessment
1 = 5-Day PPS assessment
6 = OBRA assessment

Was initially going to be PT,OT,SLP,NTA,NSG

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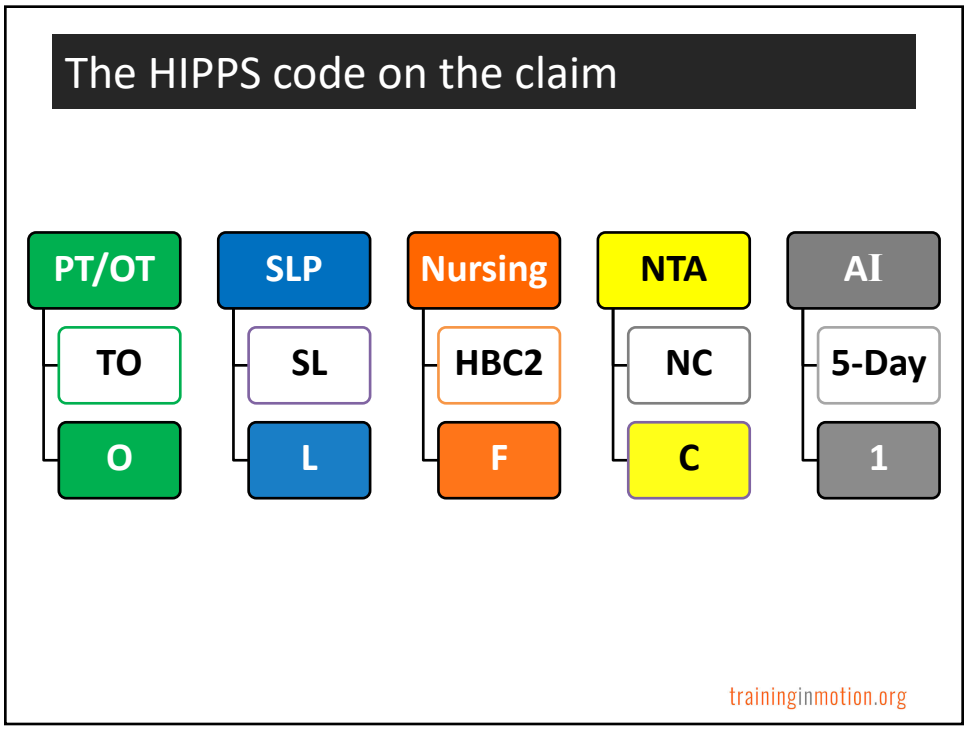
The HIPPS code on the claim
PT/OT
TO
O
SLP
SL
L
Nursing
HBC2
F
NTA
NC
C
AI
5-Day
1
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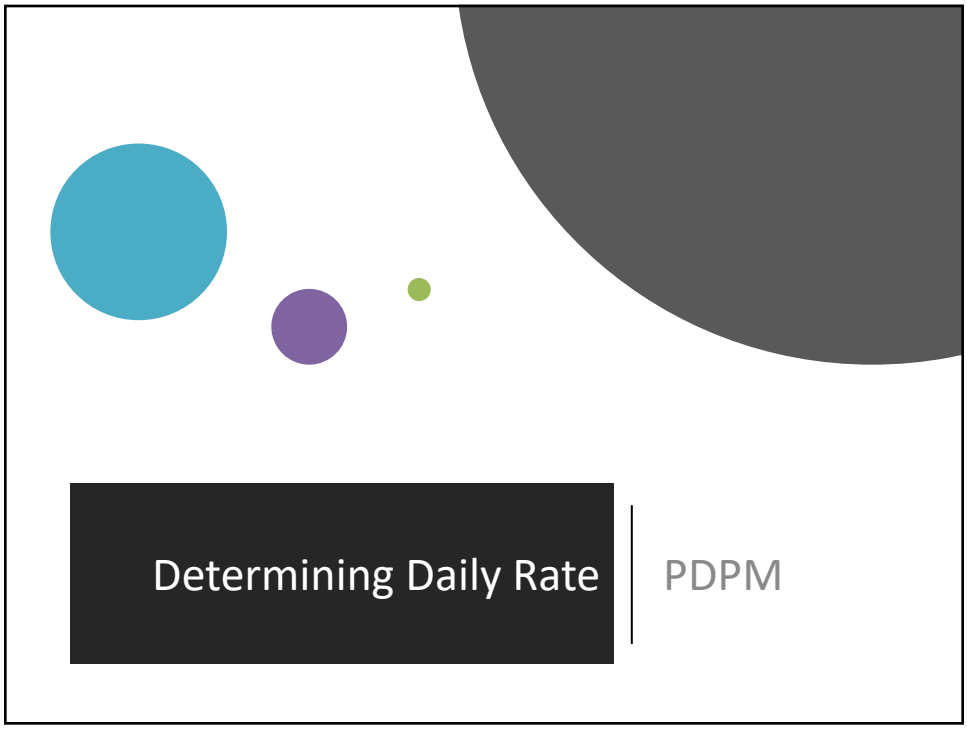
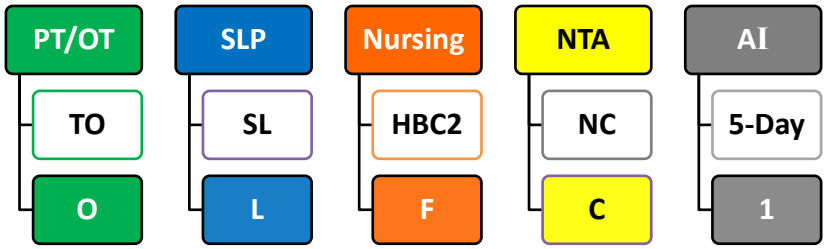

Determining Daily Rate
PDPM

The HIPPS code on the claim



PDPM Wage Index Adjustment Calculation

HIPPS Code	Unadjusted Daily Rate	Labor Portion		Wage Index		Adjusted Rate		Non-Labor Portion		Total Adjusted Rate
OLFC	$1057.58	———	X	0.8291	=	———	+	———	=	

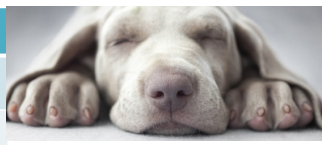
Urban Wage Index Benton County, AR 0.8291

The HIPPS Default Code | PDPM

What about the PDPM Default HIPPS Code?

- Z Z Z Z Z *(RUG-IV = AAA00)*
- Lowest possible per diem rate
- Equivalent payment is lowest per diem per component

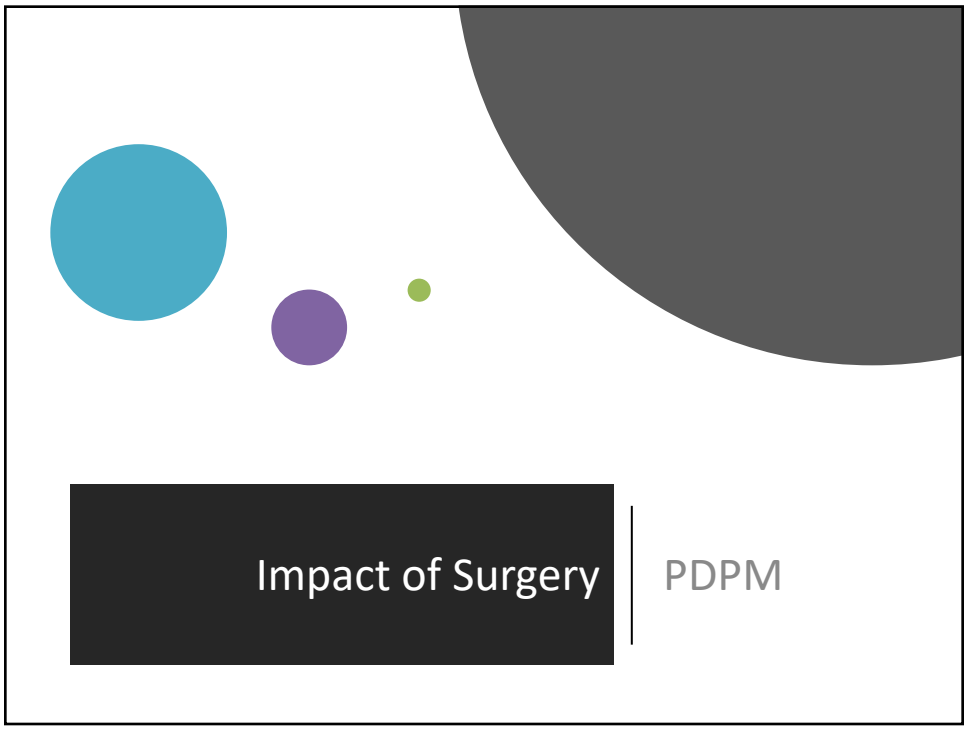
Discipline	CMG	CMI
PT	TP	1.08
OT	TP	1.09
SLP	SA	0.68
NSG	PA1	0.66
NTA	NF	0.72



Late Assessments & Adjustment Factor

Non-compliance with late assessments example:

- 5 day is 2 days late
- Day 1 and 2 calculated using ZZZZZ
- Adjustment factor will pick up beginning at day 3 of the schedule
- Lose day 1 and 2 of adjustment factor payment



Why would an ICD-10 code map to more than one category? Yes, it can.

Care needs will differ depending on whether or not received surgical intervention while in the hospital immediately preceding SNF stay.

Patients who had surgery in the immediately preceding hospital stay may require extensive post-surgical nursing or rehabilitation care in the SNF.

If did not receive a surgical procedure in the immediately preceding hospital stay, then resulting clinical category will be a non-surgical.

Example: *Certain wedge compression fractures treated with an invasive surgical procedure, such as a fusion, during the prior inpatient stay would be categorized as* ***Major Joint Replacement or Spinal Surgery****, but if not treated with a surgical procedure then they are categorized as* ***Non-Surgical Orthopedic/Musculoskeletal****.*

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Importance of Section J2300-J5000 in PDPM *Surgical Procedures*

- J2300-J5000 checkboxes when J2100 = 2 (yes)
- Captures specific surgeries (check boxes) that occurred during **qualifying** hospital stay
- Used in conjunction with item I0020B to classify into PDPM clinical category
- Check all that qualify
- If 2 surgeries qualify, software will choose most reimbursement. **Example:**
  - ***I0020B*** *= S02.101D fracture base of right skull maps to* ***Acute Neurologic****. Also had surgery…*
  - ***J2600*** *= Neurosurgery of brain and surrounding tissues or blood vessels (check boxes only,* ***no PCS codes****). Classification will change to* ***Non-Orthopedic Surgery.***

Criteria for Coding Surgery that occurred during the qualifying hospital stay

- If J2100 is coded 0 (no prior surgery) then results in non-surgical clinical category. If J2100 is coded 1 (yes) then J2300-J5000 is completed.
- **Criteria for J2000 (Prior major surgery):** 1 day as in-patient in acute care hospital, within 100 days of SNF care, surgery carried some degree of risk to life or potential for severe disability. **J2000 is not a factor in PDPM**.
- **Criteria for J2100 (Recent surgery requiring SNF care): 1 day as in-patient in acute care hospital, within 30 days of SNF care, surgery carried some degree of risk to life or potential for severe disability.**
- **J2100 is a factor in PDPM to reclassify clinical category.**

I0020B Fracture coding when purpose of admission is for rehabilitation

Therapy for Joint Replacement: HIP replacement surgery was related to fracture:

You are treating the aftercare of fracture

- **Code first** S72.141D displaced intertrochanteric fracture of right femur, subsequent encounter/routine healing

Primary and Principal

- **Non-Surgical Orthopedic PDPM category, but mapping states may be eligible for Orthopedic Surgical category**, check medical record and **check surgery section J2100-J5000**

Z code in I8000 and second on Claim

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Joint Replacement related to Fracture

JI0020B = Fracture Code
J2310 = Hip Replacement

DEFAULTS TO SURGERY CATEGORY

J2000. Prior Surgery - Complete only if A0310B = 01 — 5-Day PPS (1 day in hosp, 100 days prior, degree of risk.

Enter Code: 1
Did the resident have major surgery during the **100 days prior to admission**?
0. No
1. Yes
8. Unknown

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08 — 5-Day PPS, IPA

Enter Code: 1
Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
0. No
1. Yes
8. Unknown

Surgical Procedures - Complete only if J2100 = 1 — 5-Day PPS

Check all that apply

	Major Joint Replacement
	J2300. **Knee Replacement** - partial or total
✓	J2310. **Hip Replacement** - partial or total
	J2320. **Ankle Replacement** - partial or total
	J2330. **Shoulder Replacement** - partial or total
	Spinal Surgery
	J2400. **Involving the spinal cord or major spinal nerves**
	J2410. **Involving fusion of spinal bones**
	J2420. **Involving lamina, discs, or facets**
	J2499. **Other major spinal surgery**
	Other Orthopedic Surgery
	J2500. **Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
	J2510. **Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
	J2520. **Repair but not replace joints**
	J2530. **Repair other bones** (such as hand, foot, jaw)
	J2599. **Other major orthopedic surgery**
	Neurological Surgery
	J2600. **Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
	J2610. **Involving the peripheral or autonomic nervous system** - open or percutaneous
	J2620. **Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
	J2699. **Other major neurological surgery**
	Cardiopulmonary Surgery
	J2700. **Involving the heart or major blood vessels** - open or percutaneous procedures
	J2710. **Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
	J2799. **Other major cardiopulmonary surgery**
	Genitourinary Surgery
	J2800. **Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
	J2810. **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
	J2899. **Other major genitourinary surgery**
	Other Major Surgery
	J2900. **Involving tendons, ligaments, or muscles**
	J2910. **Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
	J2920. **Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
	J2930. **Involving the breast**
	J2940. **Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
	J5000. **Other major surgery not listed above**

Description

ICD code in I0020B maps to one of these categories but CMG will change when surgery is checked in J2000:

10 PRIMARY DIAGNOSIS CATEGORIES	4 COLLAPSED PT/OT CATEGORIES
Major joint replacement or spinal surgery	**Major joint replacement surgery or spinal surgery (Higher PT/OT CMI than Other Orthopedic)**
Non-orthopedic surgery	Non-orthopedic surgery and acute neurologic
Acute neurologic	
Non-surgical: orthopedic/musculoskeletal	**Other orthopedic** (hip replacement related to fracture, but had joint replacement. Category will change to Major Joint Replacement when checked in section J)
Other orthopedic surgery (except major joint replacement or spinal surgery)	
Medical management	Medical Management
Acute infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulation	

I0020B Fracture coding when purpose of admission is for rehabilitation

Therapy for Joint Replacement: KNEE replacement surgery related to severe degenerative osteoarthritis of the right knee:

- The condition is no longer present since had a right knee replacement, and you are treating for aftercare of the knee replacement
  - Primary and Principal — **Code first** Z47.1 aftercare following joint replacement surgery (**Major Joint Replacement PDPM category**)
  - I8000 and Second on Claim — **Code second**, the location of the joint replacement
    - Example: Z96.651 Presence of right artificial knee joint (**Return to Provider, cannot use for I0020B**)

Description

ICD code in I0020B maps to one of these categories:

10 PRIMARY DIAGNOSIS CATEGORIES	4 COLLAPSED PT/OT CATEGORIES
Major joint replacement or spinal surgery	Major joint replacement surgery or spinal surgery
Non-orthopedic surgery	Non-orthopedic surgery and acute neurologic
Acute neurologic	
Non-surgical: orthopedic/musculoskeletal	Other orthopedic
Orthopedic surgery (except major joint replacement or spinal surgery)	
Medical management	Medical Management
Acute infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulation	

Surgery and Reimbursement for PT/OT

Function Score OT/PT	CMI for PT/OT Major Joint Replacement	CMI for PT/OT Other Orthopedic *(non-surgical)*
0-5	1.53/1.49	1.42/1.41
6-9	1.70/1.63	1.61/1.60
10-23	1.88/1.69	1.67/1.64
24	1.92/1.53	1.16/1.15

Another example of Surgery requiring active SNF Care and its relationship to the primary diagnosis in I0020B

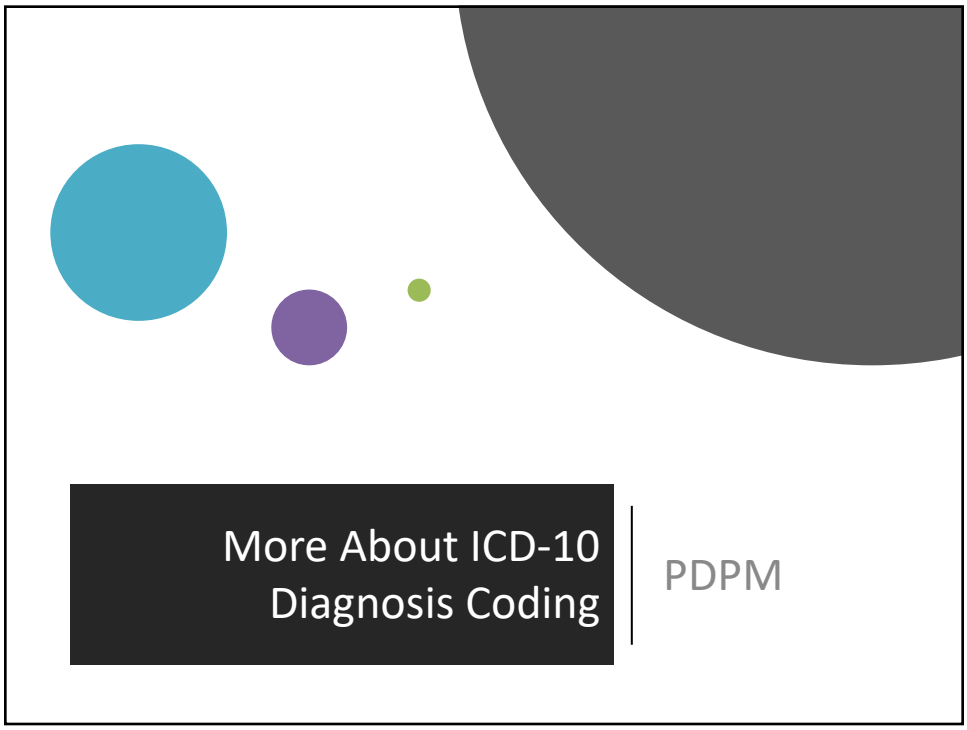
Removal of malignant neoplasm of left kidney

ICD10 = C64.2

- I0020 = 13, medically complex
- I0020B = C64.2 (maps to cancer in clinical mapping file, which maps to medical management of the final 4)
- J2810 = checked for genitourinary surgery will change mapping to non-orthopedic surgery of the final 4)

Surgery and Reimbursement for PT/OT

Function Score OT/PT	CMI for PT/OT Cancer (Medical Management)	CMI for PT/OT Non-Orthopedic Surgery
0-5	1.13/1.18	1.27/1.30
6-9	1.42/1.45	1.48/1.50
10-23	1.52/1.54	1.55/1.55
24	1.09/1.11	1.08/1.09



ICD-10 Coding Guidelines and PDPM

Example: Sepsis, severe sepsis, septic shock (R65.2-)

- Majority of time, I0020B will match claim, **but not always**
- **ICD-10 Coding Guidelines** = cannot code R65.2- as principal diagnosis on claim
- **ICD-10 PDPM Mapping File** = cannot code R65.2- as primary diagnosis in I0020B
  - Required at least 2 codes, **code underlying infection first**, then code R65.2-
- Cannot assign severe sepsis R65.2- unless associated with documented acute organ dysfunction
- **Example for underlying infection:**
  - Clinical Mapping File for A41.02 (sepsis due to e-coli), Infections PDPM Category
  - Valid for I0020B
  - If type of infection is not specified, use A41.9 (sepsis unspecified) which is Infections Category

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ICD-10 Coding Do's

- Check with the CMS PDPM mapping to **ensure the code is not a "return to provider"** code, examples of **invalid I0020B codes**:
  - M62.81 muscle weakness, general weakness
  - M79.604 pain in right leg
  - R49.0 dysphonia
  - R13.10 dysphagia unspecified
  - R13.12 dysphagia, oropharyngeal phase
- **Know which codes reap higher reimbursement**, for example:
  - R47.02 dysphasia = medical management
  - R47.01 aphasia = acute neurologic
  - I69.091 dysphagia following nontraumatic subarachnoid hemorrhage = acute neurologic

ICD-10 Coding Don'ts

- Don't - Code incomplete codes, use 7th character when instructed
- Don't - Code symptoms when an underlying diagnosis is available
- Don't - Use 2 separate codes when a combination code is available
- Don't - Use unspecified codes when a more detailed code is available
- Don't - Use treatment diagnoses as primary diagnosis **unless approved in mapping file**

Importance of Accurate ICD-10 Coding
Traumatic Fracture of Left Femur

I0020B = S72.002D

Non-displaced traumatic fracture of left femoral neck, subsequent encounter, routine healing.

Traumatic fractures are from the ”S” tabular list in the ICD-10 code set.

Appropriate 7th character must be added to each code from the S72 ICD-10 category.

Importance of Accurate ICD-10 Coding
Pathological Fracture of Right Shoulder

I0020B = M80.011D

Age related osteoporosis with current pathological fracture of right shoulder, subsequent encounter, routine healing. This is a combination code.

Pathological fractures are from the ”M” tabular list in the ICD-10 code set.

Appropriate 7th character must be added to each code from the M80 ICD-10 category.

Importance of Accurate ICD-10 Coding
Non-Traumatic Intracranial Hemorrhage

I62.9 Hospital diagnosis *for non-traumatic intracranial hemorrhage. But SNF is treating* ***sequela*** *of the condition, not the acute condition.*

I0020B = I69.251 Hemiplegia following non-traumatic intracranial hemorrhage affecting right dominant side.

I8000 = I69.191 Dysphagia following non-traumatic intracranial hemorrhage.

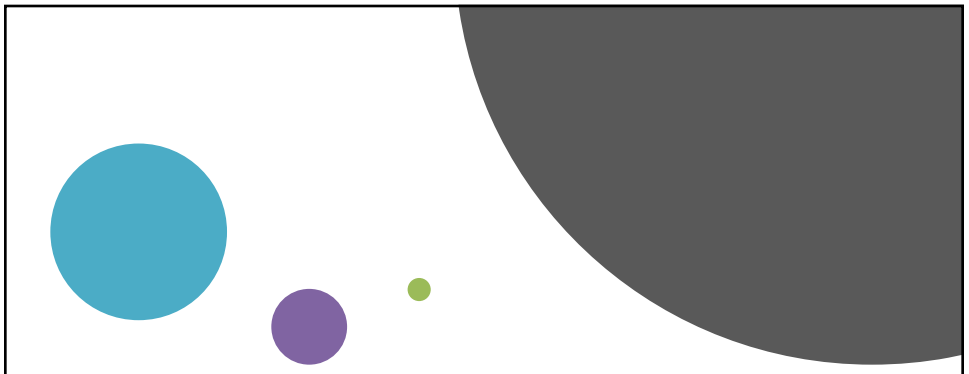
I8000 = R13.12 Dysphagia oropharyngeal phase (do not list in I0020B, "return to provider" code.

Considerations

- Diagnosis had less significance for higher payment in RUG-IV, but takes center stage in PDPM, so must be accurately and strategically coded!
  - *Example: Has both hip replacement and acute neurological diagnosis. I0020B should reflect the code for the higher reimbursement.*
- Provider behavior for therapy services should not change since resident characteristics will not change, and CMS will be data mining trends.
- SLP – Swallowing - Currently the MDS is not coded for swallowing problems if the problem is corrected by interventions
- SLP – Mechanically Altered Diet - Important to code in K0510C2

CMS PDPM Payment Projections

- Must know facility RUG billing habits, look at RUG-IV utilization regularly, be familiar with your PEPPER.
- **Revenue decreases for high therapy cases, increases for clinically complex:**
  - SNFs that bill 0 -10% utilization days as RU would increase estimated 27.6 % increase in payments.
  - SNFs that bill 90-100% utilization days as RU would see estimated 9.8% decrease in payments.
- Other facility types that may see higher relative payments under PDPM are small facilities, non-profits, government-owned, hospital-based and swing-bed facilities.



Assessment Schedule

PDPM

PDPM Assessment Schedule

	Assessment	ARD	Payment Days
Required to set classification for the stay.	PPS 5-Day (NP) *Can combine with OBRA*	1-8 Standard assessment window. Eliminates "grace days" language. Completion date is **no later than 14 days from ARD.**	• All days until Part A discharge • Unless IPA completed
Required for all Part A discharges. Unless interrupted stay.	PPS Discharge (NPE)	End date of most recent Part A stay (A2400C). Completion date is **no later than 14 days from ARD.**	• N/A
Reclassifies payment if criteria are met.	Interim Payment Assessment (IPA)optional *Cannot combine*	ARD is day SNF chooses to complete the IPA (after 5-day ARD) Must "set" ARD in 1st week. Completion date is **no later than 14 days from ARD.**	• ARD through Part A discharge, unless another IPA is completed

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PPS Discharge Assessment

- Therapy will continue to track therapy minutes, *including co,conc,indiv.*
- Completed whenever any Part A resident ends Part A stay
  - Remains in facility
  - Physically discharged from facility
- Therapy services will be captured on discharge assessment
- Total amount of therapy minutes received during entire stay (**look back period is the entire stay**)
- **New PDPM items for each discipline** in O0425A1 to O0425C5
- Will also capture: O0425C1 Individual, O0425C2 Concurrent, and O0425C3 Group
- *5-day therapy items will likely remain for a short time after PDPM implementation*
- Does not affect payment
- Used to track utilization before and after PDPM implementation
- **PPS Discharge not required for "interrupted stay"**

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Interim Payment Assessment (IPA)

New **optional** PDPM assessment can re-classify.

- Determined by provider when patient has undergone a clinical change that would require a new PPS assessment *(i.e., change in case mix group, change in function that changes summary score, addition of new diagnosis that changes I0020B)*
- No late penalties since optional
- Similar item set as 5-day assessment (payment items and demographics to obtain new billing HIPPS)
- **GG column on IPA** will capture interim performance
- Lookback for new column is three day window preceding and up to the ARD of the IPA

Interim Payment Assessment (IPA)

- Optional if change in 5-day classification for any component
- "Change" is such that resident would not be expected to return to his/her original status within a 14-day period
- **Cannot be combined** with any other assessment
- Variable per diem schedule continues, is <u>not</u> restarted
- New PDPM GG column for PDPM IPA captures interim performance (3 day window, ARD + 2 days)
  - So functional performance will be re-captured during that 3-day window
- **ARD must be set beyond ARD of the 5-day**

IPA Example: Initial primary diagnosis is cholecystectomy then develops sepsis. Complete the IPA?

5-Day

- I0020B = Z48.815 (surgical aftercare for digestive system)
- J2910 = checked for cholecystectomy *(OFB43ZZ excision of gallbladder, percutaneous approach)*
- Z48.815 maps to Medical Management
- J2910 maps to Non-Orthopedic Surgical

IPA

- I0020B = A4102 (sepsis due to MRSA)
- Maps to **Medical Management** category due to acute infection.

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Interrupted Stay Policy

- **Sets criteria** for determining when Medicare will treat multiple SNF stays occurring in a single Part A benefit period as a single "interrupted" stay rather than separate stays.
- **When "interrupted", both assessment schedule and variable per diem continue from point just prior to discharge.**
- **When "not interrupted", both assessment schedule and variable per diem rate reset to Day 1 (considered a new stay, not an interrupted stay).**
- **"Interrupted window"** = 3 days or less.
  - Maximum period of tie that may elapse between discharge and readmission
  - Begins with day of discharge
  - Ends with midnight the 3rd night (returns to same SNF by 12:00 a.m. at end of third day then is continuation of previous stay

PDPM Interrupted Stay Policy

- **Source of readmission is not relevant.**
- **Applies for both these circumstances:**
  - Physically leaves facility.
  - Remains in facility but is discharge from Medicare Part A covered stay.
- **Only relevant factors are:**
  - Number of days between discharge from a SNF and readmission to a SNF.
  - Readmission to same SNF or another SNF.
- **Triggering event:**
  - Any time a Medicare Part A stay ends (i.e., admitted to hospital or not in building at midnight)

Stay Policy

Interrupted

Discharges and returns to **same SNF within 3 days or less** (the interruption window) after discharge.

- *Assessment schedule continues.*
- *Previous CMI and day count continues.*
- *Variable per diem continues.*

Note: *When dropping to non-skilled level of care or leaves Part A SNF care, is considered discharged for purposes of interrupted stay policy even if remains in facility*

May choose to "open" the MDS in anticipation of an interrupted stay during the interruption window of time.

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Stay Policy

Not Interrupted (new stay)

Discharges and returns to same SNF or different SNF **more than 3 consecutive calendar days.**

- *Considered new stay,* ***not interrupted stay****, with new 5-day assessment and re-set of per diem.*
- *Count starts over on day 1 of the return.*

May choose to "open" the MDS in anticipation of an interrupted stay during the interruption window of time.

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Stay Example A

Not Interrupted (new stay)

Discharged from SNF on **Day 3** of the stay.
Readmitted to **same SNF 4 days after** SNF discharge.

- ***Considered a new stay, not an interrupted stay.***
- *Readmission is same benefit period.*
- *New 5-day assessment at start of the second admission and reclassifies accordingly.*
- *Payment schedule for the second admission resets to Day 1 payment rates for the beneficiary's new case-mix classification.*
- *Variable per diem is re-set.*

Stay Example B

Not Interrupted (new stay)

Discharged from SNF stay on Day 7 and readmitted to **different** SNF **within the 3-day interruption window.**

- *Different SNF **would** conduct a new 5-day assessment at the start of this second admission .*
- *Re-classifies beneficiary accordingly.*
- *Payment schedule for second admission would reset to Day 1 payment rates for beneficiary's new case-mix classification.*
- *Variable per diem is re-set.*

Stay Example C

Interrupted

Beneficiary is discharged from SNF stay on Day 7 and readmitted to **same SNF within the 3-day interruption window.**

- *SNF **would not** conduct new 5-day assessment.*
- *Classification and payment is a continuation of the previous stay.*
- *Payment schedule continues where it left off.*
- *In this case, the first day of the second stay would be paid at the Day 8 per diem rates under that schedule.*
- *Variable per diem continues, not re-set.*

Stay Example D

Interrupted

Beneficiary is discharged from Part A services on **day 20,** but **remains in facility**. **Back on Part A services on day 22, within 3 days after Part A discharge**.

- *SNF **would not** conduct new 5-day assessment.*
- *IPA is optional.*
- *Classification and payment is a continuation of the previous stay.*
- *Payment schedule continues where it left off.*
- *Variable per diem continues, not re-set.*

Interrupted Stay & Therapy Evaluations

A new 5-day PPS assessment is **not required after the interruption in the case of an interrupted stay** that meets the criteria defined by the Interrupted Stay Policy. Such a stay is considered a continuation of the previous stay.

In this case, providers are **not required to complete an evaluation for the purposes of PPS payment upon the patient's readmission after an interruption in a stay**.

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Interrupted Stay and SNF Physician Certs

- No changes to policy *except for "new admission"*.
- Certs/Recerts are tied to beneficiary SNF admission.
- "Interrupted Stay" does is not considered a new admission for purposes of new SNF certification.
  - Discharged from Part A, remains in facility
  - Returns to Part A within 3 days
  - Considered "interrupted stay"
- Not interrupted stays (considered new admit) will need new SNF cert.
- ***SNF Certs:*** *Admit, Day 14, every 30 days thereafter.*

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Interrupted Stay and PPS Discharge

- **No PPS Discharge assessment is required**
- OBRA will still be required
- ***Note:*** *If qualifies for a new stay (not interrupted) must complete a PPS discharge assessment.*

Interrupted Stay and Therapy Section O

- For interrupted stays (discharged and readmitted to same SNF before midnight of 3rd day), **therapies that occurred since admission are included in section O of MDS for each discharge assessment (since the beginning of the Part A stay, includes all parts of an interrupted stay)**

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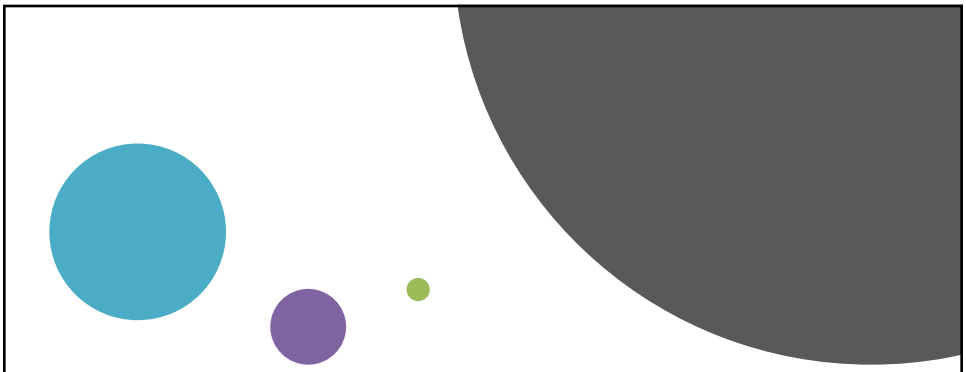

PDPM vs. RUGIV Payment

PDPM

Classification Example: Patient A vs. B

Patient Characteristics	Patient A	Patient B
Rehabilitation Received	Yes	Yes
Therapy Minutes	730 RUB *Same RUG, Same $*	730 RUB
Extensive Services	No	No
G: ADL Score	9	9
Clinical Category	Acute Neurologic	Major Joint Replacement
GG: PT & OT Function Score	10	10
GG: Nursing Function Score	7	7
Cognitive Impairment 10+	Yes	No
Swallowing Disorder	No	No
Mechanically Altered Diet	Yes	No
SLP Comorbidity	No	No
Comorbidities	IV Medication and Diabetes	Chronic Pancreatitis
Other Conditions	Dialysis	Septicemia
Depression	No	Yes
NTA Comorbidity Score	IV meds/DM = 7	Chronic Pancreatitis = 1
DAILY RUG-IV RATE Benton County, AR CBSA .8138	548.36	548.36

Unadjusted rate.

Patient A
Acute Neurologic

Days 1-3 = $982.37
Then…
NTA 100% Days 4-100
PT/OT down 2% every 7 days

RUG-IV = $548.36

(amount is approximate)

COLUMN 1 Component	COLUMN 2 Base Rate		COLUMN 3 CMI		COLUMN 4 Adjuster	COLUMN 5 Rate
PT	$61.60	✖	TC 1.88	✖	1	$115.80
OT	$56.93	✖	TC 1.88	✖	1	$107.03
SLP	$22.83	✖	SH 2.85			$65.06
Nursing	$106.64	✖	LBC1 1.43			$152.50
NTA	$80.45	✖	NNC 1.85	✖	3.0	$446.50
Non-Case-Mix	$95.48					$95.48

Base rates used in this calculation are for educational purposes only and may or may not match the current published base rates.

$982.37

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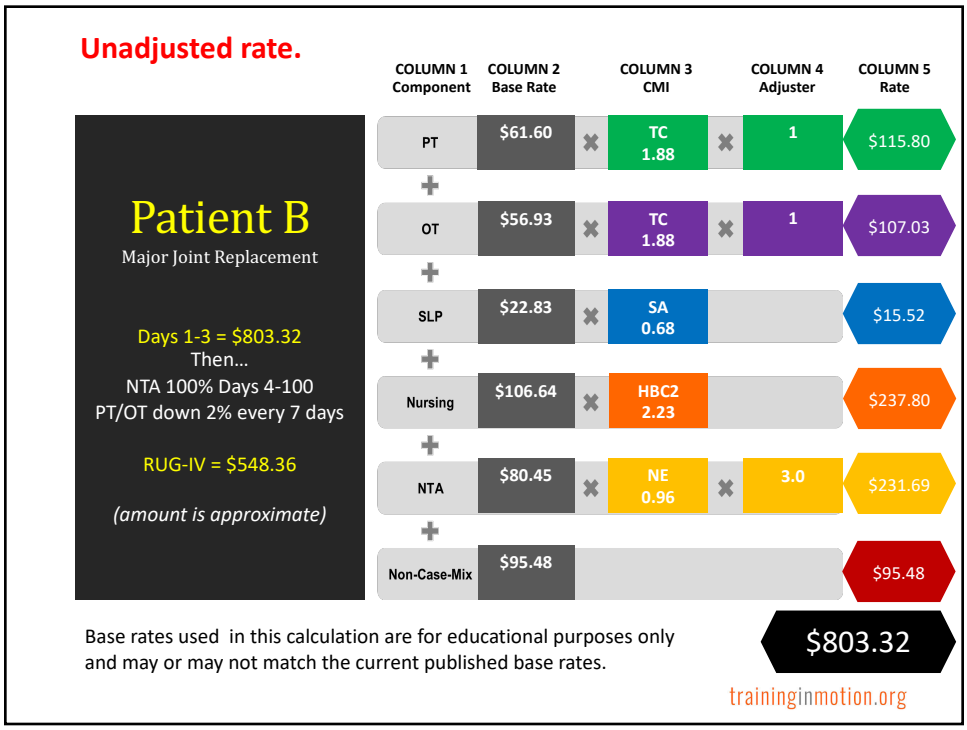
Unadjusted rate.
COLUMN 1 Component
COLUMN 2 Base Rate
COLUMN 3 CMI
COLUMN 4 Adjuster
COLUMN 5 Rate
Patient B
Major Joint Replacement
Days 1-3 = $803.32
Then…
NTA 100% Days 4-100
PT/OT down 2% every 7 days
RUG-IV = $548.36
(amount is approximate)
PT $61.60 TC 1.88 1 $115.80
OT $56.93 TC 1.88 1 $107.03
SLP $22.83 SA 0.68 $15.52
Nursing $106.64 HBC2 2.23 $237.80
NTA $80.45 NE 0.96 3.0 $231.69
Non-Case-Mix $95.48 $95.48
Base rates used in this calculation are for educational purposes only and may or may not match the current published base rates.
$803.32
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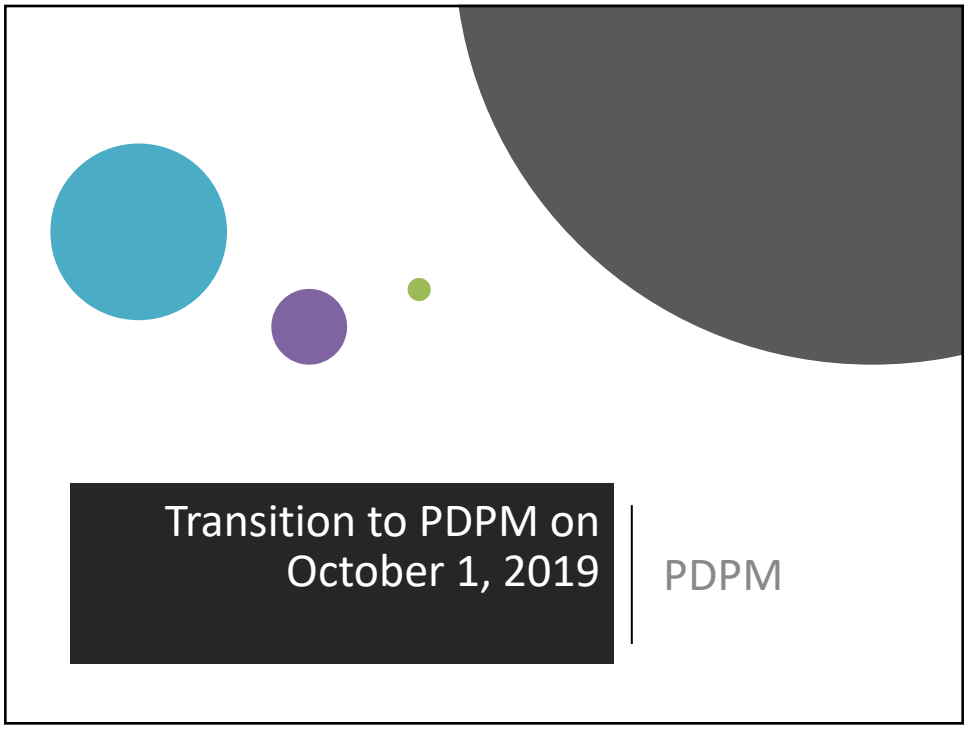
Transition to PDPM on October 1, 2019
PDPM

Transitioning from RUG-IV to PDPM

"Hard" Transition

- Two systems will not run concurrently at any point.
- RUG-IV billing will end on September 30, 2019 and PDPM billing will begin on October 1, 2019.

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Transitioning from RUG-IV to PDPM

- "To obtain a PDPM HIPPS code for billing beginning October 1, 2019, all providers will be required to complete a **transitional IPA** with an **ARD no later than October 7, 2019** for all SNF Part A patients whose Part A stay began before October 1, 2019".
- In other words, The IPA ARD will be October 1st -7th.
- Transitional IPA's with ARD after October 7, 2019 results in application of late assessment penalty.
- **Cannot use same RUG-IV ARD on transitional IPA.**

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Transitioning from RUG-IV to PDPM

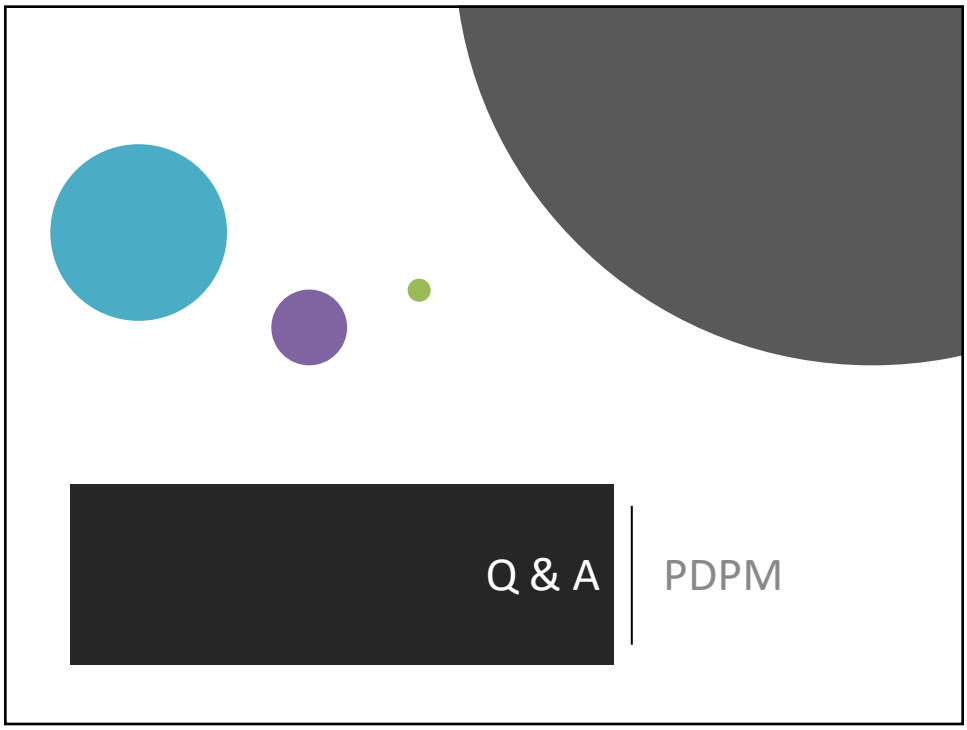
- October 1, 2019 will be considered Day 1 of the variable per diem schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
- This does not qualify for an additional presumption of coverage.
- October 1, 2019 is 1st day of variable per diem even if started stay prior to October 1, 2019
- **Transition Exception:** If discharged prior to October 1, 2019 and returns after October 1, 2019, must do 5-Day again. All PDPM rules will apply.

What if look-back goes back to September ?

- May use look-back period information and documentation even if goes back to September.

What if admitted on September 28th?

- Obviously, RUG-IV rehab RUG will not be attained.
- May result in a nursing RUG.



"Need for Daily Skilled Care" Requirement

Nothing has changed:

"Daily Basis" of Skilled Care:

- Therapy services – 5 days per week
- Restorative Nursing services – 6 days per week
- Nursing skilled services – 7 days per week

If only skilled service is therapy, must be delivered 5 days per week to qualify for Part A benefits.

- Will still receive CMI for all other components.

Technical Corrections to SNF Level of Care

Defines SNF level of care to more closely correspond to statutory requirements.

Defines SNF level of care in terms of skilled services furnished on a daily basis which can only be provided on an inpatient basis in a SNF.

SNF-level care must be for either:

- **Ongoing condition that was one of the conditions that the beneficiary had during the qualifying hospital stay; *or***
- **A new condition that arose while the beneficiary was in the SNF for treatment of that ongoing condition**

Note: Previously, the second point had been omitted, now more accurately tracks language in statute.

Replaced AIDS Add-On

- Replace with case-mix adjustments for increased costs of care (Nursing and NTA costs are high).
- Done through PDPM Non-Therapy Ancillary and Nursing components.
- Previous RUG-IV "add-on" of 128% was intended to be temporary.
- **Nursing:** Adjustment is **18%** payment increase as part of nursing case-mix component, multiplied by 1.18 **if B20 is on the claim**
  - *Processed through PRICER software used by CMS to set the appropriate rate*
- **NTA: 8 points** added, highest NTA point value.
- **Alert!**
  - *Not coded on MDS if your State prohibits!*
  - *How will this be communicated to Billing?*

Presumption of Coverage

- PDPM has "Administrative Presumption" mechanism similar to RUG-IV.
- Means automatically "presumed" as meeting the level of skilled care.
- Would correspond to being correctly assigned to a designated classifier in initial 5-day assessment.
- **Presumption of Coverage: PT, OT, Nursing, NTA**

Presumption of Coverage, continued...

Remains presumed "**up to an including**" the ARD on the 5-day Medicare assessment.

Categories that apply to presumption of coverage, must meet **any one** of these classifications:

- **Nursing:** extensive services, special care high, special care low, clinically complex
- **PT/OT:** TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, TO
- **NTA:** 12+ score

Will there be a CMI for a therapy discipline when no therapy is delivered?

- Yes, since will always fall into one group from each component regardless of services.
- May result in lowest CMI for that component
  - i.e., SLP will be lowest CMI if no acute neurologic diagnosis, no SLP comorbidities, no swallowing problems, no mechanically altered diet, no cognitive impairment
- PT/OT CMI will continue to classify according to I0020B and function score

Medicare Advantage Plans

- They will continue to make their own decisions as to which assessments are necessary.
- Not obligated to participate in PDPM.

Short Stay Assessment for RUG-IV prior to 10/01, for example admitted 09/28

- Option does not exist for this scenario with these dates.
- If they meet the criteria per current RUG-IV, then they qualify.
- And remember, cannot do short stay without an accompanying discharge assessment.

NPE Discharge Assessment Coding Total Therapy Minutes of Multiple Stays

- **Multiple stays that link together with "interrupted" stays** will be coded with the total number of minutes for each discipline.
  - O0425C1 Individual, O0425C2 Concurrent, and O0425C3 Group
  - Total amount of therapy minutes received during entire stay **(look back period is the entire stay)**

Proposed Rule 2020: 2-6 patients to match IRF PPS.

Therapy Aides and Therapy Minutes

- Per RAI, Therapy Aides cannot provide skilled services.
- **Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS** (e.g., set up the treatment area for wound therapy
- Therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

Therapy Students and Therapy Minutes

- **Therapy students** are not required to be in line-of-sight of the professional supervising therapist (Final Rule FY12).
- Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.
- All time that the student spends with patients should be documented.

Missing therapy services when there is no more End of Therapy (EOT) assessment

- PDPM eliminates the EOT assessment.
- However, if a patient misses more than 3 days of therapy, the provider must assess whether or not the patient still needs therapy or will resume.

Therapy Treatment after the 5-Day

- PDPM is based on characteristics, not therapy minutes
- It's possible there will be no therapy provided prior to the 5-day being completed
- Will still classify for therapy disciplines
- No need to do an IPA when therapy begins since it will not affect payment
- *But remember to modify plans of care.*

PDPM Impact on Benefit Days

- Remains the same.

PDPM Impact on Co-Pay Days

- Remains the same.

NOMNC, ABNS, SNFABN

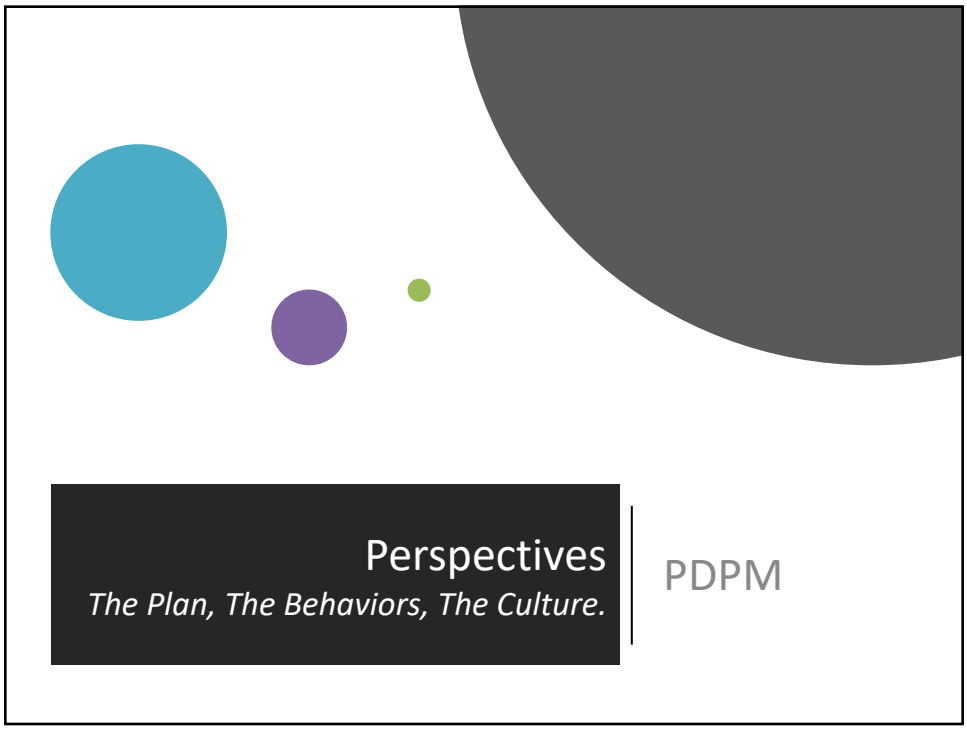
- Remains the same.

What CMS will be monitoring

- **Increases in use of mechanically altered diet** among that may suggest beneficiaries are being prescribed such a diet based on facility financial considerations, rather than clinical need.
- Facilities whose beneficiaries experience **inappropriate early discharge** or provision of fewer services (i.e., **due to the variable per-diem adjustment**).
- Use of the interrupted-stay policy to identify SNFs whose residents experience frequent readmission, particularly facilities where the **readmissions occur just outside the 3-day window** used as part of the interrupted-stay policy. *Ex: September 30th = RU, October 1st = significantly less.*

What CMS will be monitoring

- Changes in payment that result from changes in coding or classification of SNF patients vs. actual changes in case mix.
- Changes in volume and intensity of therapy services provided to SNF residents under PDPM compared to RUG-IV.
- Compliance with group and concurrent therapy limit.
- Potential consequences (i.e., overutilization) of using cognitive impairment as payment classifier in the SLP component.



Evolution of the Therapy Practice in a SNF

Success will be measured in evidence based therapy you provide (patient outcomes achieved).

- Patients and families first – PT, OT, SLP necessary components of achieving best outcomes.
- Team work makes the dream work – Must have a powerful interdisciplinary team approach.
- Support nursing colleagues – Collaboratively coordinate care and drive IDT initiatives.
- Work with nursing to drive IDT initiatives.
- Role is far beyond traditional therapy services, focus on outcomes and successful transitions.
- No longer making therapy decisions based on a "cost center, but making decisions based on patient need for skilled services.
- PDPM will close the IDT gaps.

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Skilled Nursing News

"Unreasonable to think therapy patterns will not change under PDPM", by Maggie Flynn, April 9, 2019

- Still all eyes on therapy, but related to changes in provision of services vs. changes in patient population.
- Minutes will no longer be clustered around payment thresholds, but clustered around patient needs.
- Therapy is still vital since the post acute market is still based on therapy needs.
- Capturing all comorbidities and patient characteristics is essential.

Skilled Nursing News

"Providers can't fall for therapy myths when preparing for PDPM", by Maggie Flynn, March 5, 2019

- Do not expect mass therapy service reductions if you have been historically providing it based on needs.
- PPS Discharge assessment will reflect all minutes during the stay, so continue to keep documentation.
- Contemplate utilization of therapy clinical pathways.
- Utilize group and concurrent only if clinically appropriate.
- Focus on outcomes (i.e., QRP and VBP hospitalizations)

Assess Current Processes

- Assess current communication system between therapy and nursing and billing
- Assess process for GG data collection *(collaborative, across all shifts)*
- Modify triple check process tool **to include** validation of payment source, primary diagnoses, additional active diagnoses, completion of GG function, etc.
- Medicare team members collaborate on primary ICD-10 diagnosis code for I0020B
- Medicare team members collaborate on additional active conditions and ICD-10 codes

Therapy and Nursing

- Must work together, collaborate on I0020B and additional pertinent diagnosis.
- Medical diagnoses on MDS should match Therapy Eval/PoC and the Claim.
- All medical diagnoses used must be “active”.
- **Generate a new diagnosis sheet in software each time the resident is re-admitted to ensure diagnoses are current and active.**

Assess Current Processes, continued

- Primary diagnosis code is cross-checked with clinical mapping file
- Modify tools to ensure compliance (billing worksheets, admission worksheets, etc.)
- Revitalize Restorative Nursing Program and analyze process for program referrals and documentation
- Consider use of clinical pathways for common post-acute conditions
- Create a process to communicate the B20 diagnosis code to billing

Be Sure…

- All documentation is supportive
  - Supports skilled services (therapy and nursing)
  - Supports coding of diagnosis as active
  - Supports treatment and procedures
  - Supports medical necessity to be in SNF
- Process for staff to report changes in condition that may contribute to the need for an IPA are in place and working (i.e., Interact Stop and Watch)
  - *i.e., If your hospitalization rate is high, then your current process may not be working*

Recommended soon after Admission

- Create new diagnosis sheet in software for each readmission
- Therapy complete evaluation and review medical record to identify current and any new conditions (i.e., dysphagia,)
- Nursing complete assessments and review medical record to identify current and any new conditions (i.e., pressure ulcers assessed, swallowing problems observed)

Recommended soon after Admission

- Initiate first PDPM meeting with nursing and therapy
- Collaboratively determine which diagnosis and conditions apply
- Obtain necessary documentation when needed via physician query, then assign the ICD-10 code

Recommended soon after Admission

- Use the 2-step process to determine which diagnoses are “active”
- Collaboratively determine which diagnosis will be I0020B
- Collaboratively determine which diagnoses will be checked on the MDS or listed in I8000
- Obtain SNF cert and therapy cert signatures timely

Training Resources

PDPM Mapping Files and Tools

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PDPM Payment Model Research files

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

Final Rule, Vol. 83, No. 153, August 8, 2018

https://federalregister.gov/d/2018-16570

Proposed Rule, Vol. 84, No. 80, April 25, 2019

https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08108.pdf