Frequently Asked Questions:

[On-demand webinar] Countdown to Oct 1: PDPM coding tips for MDS and ICD-10

On Tue., May 21, 2019, Mary Madison with Briggs Healthcare and SimpleLTC offered a free webinar covering PDPM coding tips for MDS and ICD-10 and how skilled nursing organizations can prepare for the upcoming changes. This document provides answers to specific questions asked during the webinar.

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1. **What do we do with skilled residents that are currently in building on 10/1/19?**

   You will be working with RUG-IV up until 11:59pm Sep. 30th. If they're still in a traditional part A stay on Oct. 1, then complete an IPA with an assessment reference date from Oct. 1st-7th. ARDs work as a single date, so you set the ARD anywhere from the 1st to the 7th and you complete that IPA. The reason for that is you're now receiving RUG-IV reimbursement through Sep. 30, but you need to get paid come Oct. 1 if they're still in that skilled stay. CMS' answer to the hard transition is the IPA with the ARD of Oct 1st-7th.

2. **Can you please differentiate between primary, principal, and admitting diagnoses, regarding long-term care residents that leave to the hospital and come back Medicare A?**

   In short, CMS is looking for the primary reason why they're in your building (review RAI manual). For example, if someone fell and broke their hip, their principal diagnosis might be that hip fracture with an open reduction internal fixation. Let's assume you don't do that surgery in your facility. You will need to collect a diagnosis, which is generally after care, if that's the primary reason why they're admitted to your facility. Ask yourself… why are they here? Why couldn't they go somewhere else? Capture that as the primary diagnosis for admission. It will never be the same code as what it was for admission to the hospital.

3. **Where can I get a copy of the October 2019 RAI manual?**

   The early release of the October 2019 RAI User's Manual was just posted and is found here. Scroll down that webpage to Related Links. You will also be able to purchase this manual from Briggs Healthcare.

4. **Is PDPM for Medicare Part A only? If so, how does this affect Medicaid and insurance patients?**

   It's for traditional Part A stays. PDPM = traditional Part A stay. If you're using managed care or private insurances, then contact your contractor to see what they're going to do. You'll need to contact them on what they want you to do to in terms of providing documentation for why they should pay you. Get a hold of those folks and don't wait until the middle of September. Do it early like mid-summer, if not now. Let them know if they don't have an answer for you, you'd like to hear back as soon as possible when they do have an answer.

5. **What would you recommend for putting a system in place for reviewing GG?**

   Look at the examples in the current and newest RAI manuals. Take those apart and use a buddy system. Go watch and see what happens and how that person codes it. And if you're knowledgeable about what should be coded, you can help the person coding a specific activity to determine whether or not they've coded it accurately. It's not a scientific approach when it comes to GG, but that's what a surveyor or outside auditor would do.

6. **If a resident goes to the hospital on 9/30 and they're not out of the facility in three days, do we do the 5-day when they return or IPA?**

   Good question for this hard transition. You'll do the re-entry when they come back, provided they were admitted or gone for over 24 hours. I think that you will do the five-day because when they return, they have re-entered the facility, for PDPM payment purposes. To be sure, I recommend that you contact your state RAI Coordinator. You can find the contact information for that individual here. Keep a copy of the RAI Coordinator's reply and follow his/her recommendation. Payment is at stake!

7. **What is your suggestion for coding aftercare effects of PNAs and UTIs for the medical record and claim?**

   Your question requires more information and is very specific – I would need more information to help you with that. Please review all available information within the resident's medical record and use a current ICD-10 coding reference to determine the appropriate code. Follow those coding guidelines.

8. **If the IPA is done after the 5-day MDS assessment and the ARD used for the IPA is Day 25 of the Medicare Part A Stay, Is the payment reset to x3 for the NTA component in the first 3 days from IPA ARD?**

   No, completion of the IPA doesn't reset the variable per diem adjustment schedule.

9. **What if an admission comes on 9/27? If we need to do a 5-day for 9/30 for RUGs IV, should we combine that 5-day with a SOT OMRA/Short Stay?**

   The current PPS assessment rules apply through 11:59pm on 9/30/2019 so if you have a short stay/SOT scenario that fits, yes. That does not impact the requirement to turn around and do the IPA with ARD of 10/1 – 10/7. The PPS rules change at midnight on October 1, 2019.

10. **Can you do a short stay if resident comes in late September and meets criteria?**

    Short stays are still in play through 9/30/2019 but NOT with October 1st and beyond. There is no such thing as a short stay assessment (MSSA) come 10/1.

11. **Can you please explain the HIPPS codes, their importance, and what causes them to not trigger?**

    That's a great question with lots of detail! The short answer comes from the October 2019 RAI User's Manual (pg. 592): "The HIPPS code is a Skilled Nursing Facility (SNF) Part A five-position billing code; the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator. You can get more information here.

    HIPPS (definition): Health Insurance Prospective Payment System code is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed."

12. **If a long-term care resident was admitted to the hospital and returns under MCR, would the dx still be what kept the resident in the facility?**

    The primary diagnosis would be the reason why you're providing skilled care/services to this resident upon return to the facility. In some cases, that diagnosis could change upon return which in turn could possibly invoke the need to consider/do an IPA because of the condition change.

13. **What do you need to complete if a Med A resident is admitted on 9/30/2019? Would you need a 5-day on 9/30 and IPA set between 10/1-10/7?**

    You will complete an Entry Tracking Record then a 5-day assessment with ARD of *no later* than 9/30/2019. That 5-day will provide payment for the single skilled day of 9/30. You will then open and complete an IPA with an ARD of between 10/1 and 10/7. That IPA provides payment for any skilled days starting with October 1st.

14. **It appears that the RAI collides with ICD-10 Official Coding guidelines as it guides MDS Coordinators to code the primary SNF diagnosis (I0020B) with examples to code a stroke as an acute care code (I63.) instead of as a sequela (I69.) or to code cancer as current even if the cancer was excised prior to SNF admission. (Examples are on RAI pages I-3 and J-44). Can you please provide guidance with this apparent issue?**

    That's quite the question! My best advice is to send this question to the mds@cms.hhs.gov or SNF_LTCODF-L@cms.hhs.gov mailbox. CMS may need to clarify the manual directions – bring it to their attention.

15. **When we do the IPA for skilled residents already in the building, would the GG answers be based on when they first began skilled care or in the last 3 days prior to the ARD date?**

    The instructions for encoding Section GG on the IPA specify "assessment period is the last three days." Those days are the ARD and the two days prior to the ARD so you will encode the functional activities for those 3 days.

16. **On the 5-day, do we have to code to specificity in I0020B if we check mark anything above it?**

    Yes. I0020 is non-specific…it's the category with I0020B being the specific diagnosis. On page 347 of the October 2019 RAI User's Manual: "Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal."

    There are five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each resident is to be classified into **one** group for each of the five case-mix adjusted components. The first step in classifying each component is to determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B; mapping by condition is a later step in classification.

17. **When will those 10/1-10/7 IPA need to be completed? 14 days from 10/1 or from ARD?**

    Completion dates for MDS have and will not be changed. Must be completed (item Z0500B) within 14 days after the **ARD** (ARD + 14 days).

18. **Can the primary and admitting diagnoses be the same code?**

    Yes, that's possible if the diagnosis for admission and care in your skilled facility is also the resident's primary diagnosis.

19. **Can we assume that Medicare Advantage Plans (Part C) are adopting all the same guidelines and deadlines?**

    I would definitely ***not*** assume that! Be safe – contact your Part C contractor to have that conversation. Document that conversation and share what that plan wants you to do with all interested parties, i.e. Administration, Billers, MDS Coordinators.

20. **If a patient was hospitalized due to COPD exacerbation and admitted to our facility for deconditioning, what is the primary dx to use?**

    Reference your ICD-10-CM coding manual/resource and follow the coding guidelines that speak to COPD exacerbation and deconditioning. Make sure that the diagnosis code you select is the primary reason for admission for skilled care/services.

21. **Is the state optional assessment going to be used for Managed skilled that now require use of 5-day, 14-day etc.?**

    The OSA is the set of items that may be required by a State Medicaid agency to calculate the RUG III or RUG IV HIPPS code – for state case-mix reimbursement. This is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. It is not to be used for managed care. (Remember that the OSA is a standalone assessment whenever it's used.) My best advice is to contact your state LTC Medicaid Coordinator to see what the plan is for your state and if it involves the OSA as of 10/1/2019.

22. **For a long-term resident that gets readmitted for UTI, what would be a primary diagnosis?**

    If the physician orders/certifies and the resident receives skilled care/services for a UTI, that would be the primary diagnosis or the reason for admission to your facility. If the certification for skilled care is for a different diagnosis, use that one.

23. **How will the primary vs. admitting diagnosis be affected on the UB04 billing?**

    I have no reason to believe that it will be at this point in time, but we'll have to watch and see. I know that the current UB-04 is up for renewal (with OMB) on 8/31/19 so we'll see if that is extended or there are changes to that billing form. Other resources to watch are Chapter 23 – Medicare Claims Processing Manual and MLN notifications.