Frequently asked questions

[On-demand webinar] 20/20 vision: What's in store for PDPM, RoPs, and the MDS

On Tues, Feb. 11, 2020, SimpleLTC and Briggs Healthcare offered a free webinar, "20/20 vision: What's in store for PDPM, RoPs, and the MDS". In the webinar, industry expert Mary Madison discussed strategies to enhance your PDPM expertise, when to expect Appendix PP for Phase 3 RoPs, and how to interpret the MDS item set changes. Based on questions asked during the webinar, Mary Madison prepared this follow-up FAQ document.

1. **How close should the diagnoses in the MDS and UB reflect each other?**

   Generally, the diagnoses recorded on the UB-04 and MDS are the same but they can be different.

   Chapter 6 of the Medicare Claims Processing manual states that only the top 8 secondary diagnoses will be reviewed on the claim. You'll want to rank the top 8 secondary diagnoses for inclusion on the UB for sure even though there is room for 17 total on the claim. (FL67 is the Primary with FL67 A->Q = Other Diagnoses.)

   It is very likely that you will have more diagnoses reflected on the MDS in Section I for any given resident. Remember that Section I asks for active diagnoses, not old or resolved dx.

2. **Does the primary diagnosis have to match the primary diagnosis that the SNF admitting doctor has listed as principal?**

   Typically, Primary and Principal diagnoses are the same but they can often be confused with each other and thus not the same. Section II (page 107) of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2020 says this about Principal Dx:

   "The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

   The Primary Dx used in I0020B is the reason for admission to your skilled facility. It may not be the same as the Principal Dx. Check with that physician for clarification if you have differing diagnoses.

3. **When you have two diagnosis, where do you find which diagnosis will pay you more if both could be the admit diagnosis?**

   Check with your Administrator and/or Billing person. They will have information regarding PDPM reimbursement rates.

   Remember also that while the I0020B dx sets the payment, there are numerous other factors that comprise the final numbers – all of the other components of PDPM classification and NTA. Check out this CMS slide deck for more info: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MLN_CalL_PDPM_Presentation_508.pdf.

4. **Can we use the MD certification form for diagnosis?**

   Without knowing what your physician certification/recertification form looks like, I really can't answer that question. Most forms I've worked with do not have room for diagnoses but perhaps yours does.

   Regulations require that the physician certify that the services provided must be for a condition for which the resident was treated during the qualifying hospital stay or arose while in the SNF for treatment of a condition for which the resident was previously treated in the hospital.

5. **Can you please repeat the timeliness of coding GG at the end of the stay?**

   Section GG – Self-Care and Mobility – is assessed the last 3 days of the skilled stay with the 3rd day being the last covered day of Medicare (if resident remains in the facility) or the date the resident was discharged. [Refer to Chapter 3, Page A-40 for the A2400C algorithm.] With that 3rd day established, you'll assess and code using the 2 days prior to day 3.

6. **Are Physician Certs/recerts needed for residents on Medicare Advantage or Managed Care?**

   You should touch base with your Managed Care and Medicare Advantage companies for the answer to this question. I believe most do require Certification and Recertification but contact each one to be sure.

7. **Regarding Physician orders required for Skilled Care: Is the list of admission orders enough or does there need to be a separate order that states "Admit to SNF"?**

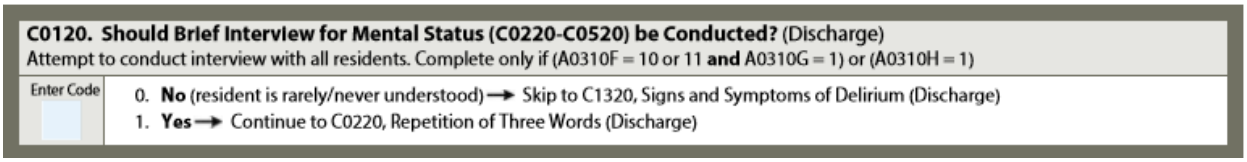
   Accepted standard of practice for admission orders for a resident include level of care as well as medications, treatments, diet, therapies, free from communicable disease, etc.

8. **Could you explain what effect a readmission to the hospital within 30 days has on reimbursement?**

   At the present time, readmission to a hospital within 30 days of a discharge earns the hospital a penalty. CMS is keeping track of such readmissions. Such penalties will no doubt case a negative view of the SNF discharging the resident and subsequently the resident presents for readmission to the hospital and thus could negatively impact future referrals to your facility from that hospital. This is a claims-based measure at this time. At some point in the future, CMS may well turn its attention to the discharging facility.

9. **Will they require a BIMS to be completed on Unplanned Discharges?**

   The short answer is no – not for unplanned discharges. Here's what that currently looks like on the DRAFT v1.18 looks like:



C0120. Should Brief Interview for Mental Status (C0220-C0520) be Conducted? (Discharge)
Attempt to conduct interview with all residents. Complete only if (A0310F = 10 or 11 **and** A0310G = 1) or (A0310H = 1)

Enter Code

0. **No** (resident is rarely/never understood) → Skip to C1320, Signs and Symptoms of Delirium (Discharge)
1. **Yes** → Continue to C0220, Repetition of Three Words (Discharge)

   We'll know more when we see the RAI Manual for this version later this summer/early fall.

10. **When are these MDS revisions effective?**

    The DRAFT MDS Items I showed during the webinar/on the presentation slides are version 1.18 which will be used beginning October 1, 2020.

11. **What's behind all these additional changes? What initiated it?**

    The IMPACT Act of 2014 is responsible for many of the additions to v1.18. They are planned changes because of this legislation. For more information, check out: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/-IMPACT-Act-Standardized-Patient-Assessment-Data-Elements.

    Note also the hyperlinks in the left margin of this webpage – there's additional materials beneath those links.

12. **Will the observations we have that we complete quarterly and annually (Bradens, Falls, Pain, etc.) be changing as well to coincide with MDS assessments?**

    The RAI Manual for version 1.18 will tell us for sure but I believe that we will continue with the assessments you identify that complement the data recorded on any given MDS Item Set. I don't know that they will be changing as they are already "tied" to the MDS in certain sections – Sections J and M in particular.

    The current Appendix PP speaks to skin assessments being done more frequently than with an MDS:

    "Many clinicians utilize a standardized pressure ulcer/injury risk assessment tool to assess a resident's PU/PI risks upon admission, weekly for the first four weeks after admission, then monthly or whenever there is a change in the resident's condition."

    The above quote is located on page 283 of the current Appendix PP – 2nd paragraph on that page which is part of the Interpretive Guidance for F686 – Skin Integrity. Note the weekly x 1st 4 weeks after admission then monthly or with a condition change. Clinicians utilize either the Braden or Norton as a rule; some states require a specific risk assessment.

13. **Can you please clarify if the primary dx, reason for SNF admission, doesn't HAVE to come from the physician? Can we collaborate and come up with it if the dx is in the H&P or we get a clarifying order for admitting dx?**

    The diagnosis that is used in I0020B as well as any diagnoses coded in Section I of the MDS must be found in physician documentation. That documentation could be the H&P you receive from the transferring facility. It could also be recorded on radiology or lab reports as well as physician progress notes, physician telephone orders or any clarifying order.

    The key is that any diagnosis that is coded on the MDS as well as on a claim for reimbursement must be found in physician documentation.

14. **How do we code GG if we have equal number of varying levels?**

    Great question. CMS guidance re: GG coding is this:

    "If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance."

    Clinicians charged with this assessment should review the data gathered during the 3-day observation period and decide what the usual is for that resident. It shouldn't be decided by arm wrestling or a coin toss – decide which data point best represents the usual for that resident and use that code.

15. Can we use hospital diagnosis marked as resolved on the DC summary on our active diagnosis list?

Use caution with hospital-resolved diagnosis. I'm not saying they're incorrectly identifying dx as resolved but do some research to make sure they are or are not active once the resident enters your facility. You certainly can include them as resolved on your list if that's the case. Inclusion informs the next care provider to their presence in the resident's past history.

16. For GG, if the therapist do not see the patient for a specific task during the last 3 days, but they worked with the PT 5 days ago and the resident was independent at that time, can/should they code the task at discharge with the code they saw 5 days ago?

5 days is 2 days beyond the designated assessment period and thus should not be used to encode Section GG. A lot can happen in those 2 extra days!

Use only the designated 3 days for Section GG and nothing else. P.T. is not the only entity that can assess functional status.

17. For Section A0300 under B. Assessment type, I see #4 is Change of Therapy. Does that mean we are going to start doing COTs again?

No – COTs for Skilled Medicare residents are not starting up again. A0300 is an item for the OSA (Optional State Assessment) which is used by some of the case-mix states for Medicaid reimbursement. Each case-mix state decides whether to use PDPM elements or the OSA Item Set to reimburse facilities for Medicaid care.

18. If a Med A is discharged overnight > 24 hours but returns less than 72 hours: Per OMRA, a discharge assessment is required, but do we mark that it is a PPS d/c assessment? When setting up the MDS, it gives a notification that it is a PPS dc assessment.

You'll open the discharge assessment then wait until the resident returns to determine which discharge assessment is required. In your question, you note the resident returned in less than 72 hours so this will be an interrupted stay and only the elements for the OBRA discharge need to be completed. Your description leads me to assume that the resident's skilled stay has not ended – he/she is returning for continued skilled care. A0310G1 will = 1 with A0310H = 0; A2400C will be dashed and you'll enter the re-entry date in A1700.

If the resident does not return to the skilled stay, this would become an NPE or End of PPS Part A Stay Discharge and you'll encode the Section A elements accordingly.

19. If there is a dx that has an NTA or speech, does it have to be in I8000 or is the check box enough? And if check box is not enough, do you mark in both places?

You can mark a given check box in Section I as well as record a more specific diagnosis in one of the ten I8000 fields. The check boxes are pretty generic whereas I8000 provides for the specific diagnosis. Please reference my slides on NTA and SLP – slides 7 and 11 in particular.

20. Can SNF attending MD documentation after admission be used to support admitting diagnosis or does this have to be supported by hospital MD documentation prior to admission? For example, hospital only states suspected pneumonia but does not clearly document acute pneumonia. Can our attending physician documentation support the admitting primary diagnosis?

Let's address the example you give as it is specific. The documentation you receive from the transferring hospital should reflect pneumonia as well as whether it's due to bacteria, virus or fungi. You may need to look closely at all related documentation, i.e. blood cultures, bronchoscopy results, pleural fluid cultures, etc. to get the specifics. Those records should spell out more details and if they don't, you should contact the transferring facility and/or the referring physician. The SNF attending MD that you reference can also be very helpful in getting the more specific information to support not only reimbursement but the care you plan for and provide while the resident is in your facility.

21. In PCC, not all my dysphagia dx show up as SLP comorbidity. Am I using the wrong code?

Without knowing how you're currently coding dysphagia, consider this from the PDPM Fact Sheet: "The SLP component uses the patient's PDPM clinical category, cognitive function, the presence of an SLP related comorbidity, and the presence of a swallowing disorder or a mechanically altered diet to assign a resident to an SLP component group.

With regard to the presence of an SLP-related comorbidity, CMS identified twelve comorbidities that were directly correlated with increased SLP costs. Rather than separately accounting for each of these twelve conditions, the presence of any one of these conditions is sufficient to qualify the patient under this aspect of the SLP component classification criteria. The twelve SLP-related comorbidities that will be used under the SLP component may be found in the table below.

SLP-Related Comorbidities

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

The presence of a swallowing disorder or mechanically altered diet are captured on the MDS in items K0100 and K0510C2, respectively."

22. If you have a more specific dx code in I8000, should it also be marked in the boxes above? Or is it one or the other?

Definitely include more specific diagnosis codes in I8000. Remember that the check boxes in I proper are general in nature.

It is possible and appropriate, for example diabetes, to select the check box then code diabetic neuropathy, retinopathy, etc. in I8000. Remember there's only 10 spaces in I8000 so use them wisely.

23. For swing bed, my Cert/Recert says Skilled Nursing facility. Will this be sufficient?

The physician should specify the order for Skilled Care in your Swing Bed as well as the other needed documentation for Certification and Recertifications.

24. Does the Acute Neuro diagnosis need to be in I0020B or can it be in I8000 to impact SLP reimbursement?

The best answer is this quote from the PDPM Fact Sheet: "The SLP component uses the patient's PDPM clinical category, cognitive function, the presence of an SLP related comorbidity, and the presence of a swallowing disorder or a mechanically altered diet to assign a resident to an SLP component group.

With regard to the presence of an acute neurologic condition, this criteria solely depends on if the patient is classified into the Acute Neurologic clinical category. If the patient is not classified into this clinical category, then they would not qualify for this aspect of the SLP component classification criteria. For the presence of a cognitive impairment, any level of cognitive impairment (mild or above) is sufficient to qualify the patient for this aspect of the SLP component classification criteria.

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25. **I am a coder providing I-10 codes for our SNF accounts. We are having difficulty with physician documentation (particularly, a problem when the documentation changes by the time the PT discharges). Example: PT comes in with Pdx of CHF and secondary dx of HTN. Combo code for the hypertensive CHF is assigned as Pdx. Subsequent documentation of CRF stage 3 is noted a couple days into the stay. Now the combo code would need to be updated to HTN/CHF/CRF. The late info regarding the CRF is causing a problem with the Pdx code needing to be changed at the time of discharge.**

    I hear and feel your pain! I have heard this from other providers and coders as well. Chances are good that you can correctly identify the combo ICD code on the 5-day/Initial Medicare Assessment before it is marked as complete and transmitted to CMS. Working with the team will keep everyone informed so when additional physician documentation "arrives", it can be conveyed to you as quickly as possible for inclusion in the MDS.

    I'm sure you're already doing this so continue to work with physicians for more thorough/complete documentation as early on in the skilled stay as possible. Convey the need to have accurate diagnoses as soon as humanly possible to ensure accuracy of coding and provide for best possible reimbursement for the care you provide.

26. **If on admit, the documentation only states femur fracture and then on discharge it is specified as intertrochanteric fracture, does the initial MDS code need to be changed to intertrochanteric fracture?**

    You need to make every effort to accurately encode the 5-day/Initial Medicare Assessment in terms of the specific dx, which in your question is a femoral fracture. Take a look at the operative reports, radiology reports, etc. for specificity. Those reports as well as others should show specifically the nature and type of fracture so that you can encode it on that initial PPS assessment. If you find it later, modify the accepted record to include the specific diagnosis.

27. **Can we start Medicare stay within the 30 day of last billing? Specifically, when the status of resident becomes skilled again (i.e., IV meds due to infection), is this an IPA?**

    From what I'm understanding from your question, the resident's 1st skilled stay has ended and within 30 days of the end of that skilled stay, the resident requires skilled care/services again. If the "break" in skilled care is greater than 72 hours (< 72 hours would be an interrupted stay which, upon return to the skilled stay *might* trigger an IPA), you would restart the assessment schedule for the new skilled stay – a 5-day/Initial Medicare assessment.

28. Can you please explain supportive documentation for speech component?

Beyond documentation of any dysphagia screening (see next question for a resource), nursing will likely be assessing and documenting their observations of signs and symptoms of a possible swallowing disorder. Review the October 2019 RAI User's Manual for guidance on assessing and encoding K0100 – Swallowing Disorder.

29. Is this documentation from speech only regarding difficulty swallowing or pain with swallowing?

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_Payment-Overview_v5.zip is a great resource to review for documentation, especially pages 3 through 5 as they pertain to SLP classification. In addition, you'll want to reference the coding guidance for K0100A->D. A, B & C address swallowing issues while D goes a bit further to include pain with swallowing. Such supporting documentation will likely come initially from nursing and then your SLP therapist once a referral/evaluation is ordered and completed followed by any treatment(s) indicated.

30. Is a speech bedside swallow enough supportive documentation?

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550&section=Assessment is a great resource/place to start for information on bedside swallow testing as well as your SLP therapist. The documentation of results from this screening will support whether or not further assessment and treatment is indicated.

31. What additional documentation is needed if any if it's a bedside swallow?

I'm not certain of what specifics you're asking about, but I do believe the SLP that conducts the bedside swallow testing/screening will provide the needed documentation for additional assessments and potentially treatment.

32. Is nursing documentation needed to support the speech?

In answering this question, I'll point you back to accurate assessment and coding of K0100 as well as follow-up charting and inclusion on the resident's plan of care and periodic progress notes.

33. With the upcoming changes in MDS regarding discharge data, does that mean we have to do another MDS on discharge?

No. You will still complete the NPE or Part A PPS Discharge when the skilled stay ends, and the resident leaves your facility or stays on at a lower level of care.

For general discharges from your facility, you will complete either a planned or unplanned discharge. The OBRA and PPS Discharge Item sets will include all elements required for completion which, effective October 1, 2020, will include the BIMS, PHQ, Pain, etc.