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ICD - 10 Coding Under PDPM

The Patient-Driven Payment Model (PDPM), taking effect on October 1, 2019 represents change for skilled nursing providers (SNFs) in that patient condition, rather than therapy minutes, will drive reimbursement.

Under the PDPM, ICD-10 codes will form the basis of payment; we are going to be utilizing the primary patient diagnosis as the key determinant of payment making it crucial for SNFs to have accurate coding. The level of detail and accuracy required for ICD-10 coding under PDPM is new for SNFs. Under PDPM, the MDS will have 188 items associated with assigning someone to one of the five service-related components: physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), non-therapy ancillary (NTA) and nursing.

The PDPM system is case-mix index combining which means it combines dollar amounts for each component per day. One MDS is required for the entire stay until the Discharge MDS, with one exception - the Interim Payment Assessment (IPA). Rate per day will change due to variable/tapering rates for PT, OT, and Non-Therapy Ancillary (NTA). Every resident is assigned a Case Mix Group (CMG) for each Payment Component, (except Non-Case Mix Payment is fixed).

Of the five components, ICD-10 diagnosis information is needed for Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP) and it also impacts Non-Therapy Ancillaries (NTAs); for a person that would have comorbidities that would impact the NTA payment.

Selection of Primary SNF Diagnosis
It will be imperative to enter the correct ICD-10-CM code into I0020B since it drives the clinical category for Physical Therapy (PT), Occupational Therapy (OT), as well as Speech-Language Pathology (SLP) under Patient-Driven Payment Model (PDPM) effective October 1, 2019. The following documentation from the medical record at a minimum should be reviewed to determine the appropriate primary SNF Diagnosis:

- History and Physical
- Transfer Documents
- Discharge Summary
- Progress Notes
- Operative Reports (if applies)

There are 13 Primary Condition Categories Associated with SNF Admissions which include:

- Stroke
- Non-traumatic Brain Dysfunction
- Traumatic Brain Dysfunction
- Non-traumatic Spinal Cord Dysfunction
- Traumatic Spinal Cord Dysfunction
- Progressive Neurological Conditions
- Other Neurological Conditions
- Amputation
- Hip and Knee Replacement
- Fractures and Other Multiple Trauma
- Other Orthopedic Conditions
- Debility, Cardiorespiratory Conditions
- Medically Complex Conditions

If a resident has two different diagnoses that meet the definition of principal diagnosis, the CMS mapping tool; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html can help determine which diagnosis to use in I0020B of the MDS, primary skilled diagnosis. It will be imperative to capture the correct primary diagnosis in I0020B to drive clinical category, as well as include all pertinent diagnoses in I8000 in order to qualify for all NTA as well as SLP comorbidities under PDPM.

CMS Provides List of Candidates for SFF

Every month, the Centers for Medicare & Medicaid Services (CMS) identifies nursing homes with a persistent record of poor resident care for inclusion in the Special Focus Facility (SFF) program. This program is a federally mandated initiative to address persistent problems through enhanced oversight. Over an 18 to 24-month period, CMS expects SFFs to significantly improve quality of care and implement practices to ensure that poor performance does not reoccur. Facilities that succeed graduate from the program. Facilities that do not face termination from participating in Medicare and Medicaid. Termination from Medicare and Medicaid typically results in a facility's closure. In 2008, CMS began posting an icon for identifying SFFs on the Nursing Home Compare website, and revised the methodology for identifying SFF candidates to be harmonized with the methodology used in the Five Star Quality Rating System.

There are nearly 15,000 nursing homes in the country, and almost 3,000 of these have a one-star rating on their health inspections. By contrast, there are only 88 Special Focus Facility (SFF) program slots, and only about 400 candidates for the program. CMS regularly helps states narrow down the list of poor performers to identify nursing homes that are candidates for the program.

A bipartisan pair of U.S. senators recently released an "undisclosed list", of the more than 400 nursing home candidates. The list, furnished by CMS, consists of candidates for the Special Focus Facilities (SFF) program, a designation for providers that have extended patterns of serious health and safety violations. Though the government makes public information about skilled nursing facilities on the SFF list, CMS has not previously disclosed the names of facilities that it is targeting for potential candidates on the SFF list.

CMS officials announced in a "Statement on Quality in America's Nursing Home Facilities", they will soon be posting a list of candidates for the SFF program.

For the complete list of SFF candidates: http://polaris-group.com/news_releases.asp

CMS Will Publicly Report SNF QRP Potentially Preventable 30-Day Post-Discharge Readmissions Measure
Beginning fall 2019, CMS will publicly display measure results on Nursing Home Compare for the Potentially Preventable 30-Day Post-Discharge Readmissions Measure adopted for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). CMS postponed publishing this measure in late 2018 to allow more testing to ensure it provides a reliable, accurate picture of provider performance on quality, in line with CMS's Meaningful Measures Initiative to address high-priority areas for quality measurement with measures that will help improve patient outcomes while minimizing provider burden. CMS has since completed this additional testing and have refined the method for assigning providers to performance categories, in which their performance level is compared to the national rate.

For the Complete CMS FAQs: http://polaris-group.com/news_releases.asp

SNF QRP: Updates to SNF Provider Preview Reports
There will be enhancements to the upcoming SNF Provider Preview Reports scheduled for August 1, 2019. The updates will include:

- **Pressure Ulcer Measure Transition**
– The current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), will last appear on the May 2019 SNF Provider Preview Report
– Starting August 1, 2019, this measure will be removed. The new pressure injury measure, Changes in Skin Integrity Post-Acute Care, will first display on the August 2020 Provider Preview Report.

- **Ending suppression of the PPR claims-based Measure**
– Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient

- **Rehabilitation Facility Quality Reporting Program**
– Displaying measure short names in place of their long names and many aesthetic changes to field labels and headings.

- **Update of the Discharge to Community Measure**
– The refined measure results for the Discharge to Community Measure will be reflected for the first time in the fall 2019 Quarterly Refresh for the Nursing Home Compare website and the related August 2019 Provider Preview Reports.

CMS Section GG Training Videos

The Centers for Medicare & Medicaid Services is releasing a series of short videos to assist providers with coding select Section GG items on the OASIS, IRF-PAI, LTCH CARE Data Set, and the MDS. These videos, ranging from 4-12 minutes, are designed to provide targeted guidance using simulated patient scenarios. To access the videos, click on the links below:

• Coding GG0110. Prior Device Use with Information from Multiple Sources (3:58) This 4-minute video demonstrates how a caregiver can utilize information collected from multiple scenarios to accurately code GG0110. Prior Device Use.

• Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility (11:56). This 12-minute video demonstrates how to apply the six-point coding scale to GG0130. Self-Care and GG0170. Mobility using GG0170D. Sit to stand as an example.

• Coding GG0130B. Oral Hygiene (4:25). This 4-minute video demonstrates how to distinguish between Code 05, Set-up or clean-up assistance and Code 04, Supervision or touching assistance when coding GG0130B. Oral Hygiene.

• Coding GG0170C. Lying to Sitting on side of bed (4:33). This 4-minute video demonstrates how to distinguish between Code 02, Substantial/maximal assistance and Code 03, Partial/moderate assistance when coding GG0170C. Lying to sitting on side of bed.

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
We have a resident on hospice. The hospice provider changed names but did not change anything else. Do I need to do a significant change in status?

Answer:
No. The reason for doing a significant change in status is to coordinate the care with the nursing home and the hospice provider. Since it was just a name change and not a change in providers then no significant change in status is required. I would put a note in the chart identifying this was just a hospice name change not a hospice provider change explaining why no significant change in status was completed. Here is what the RAI says on page 2-23: A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home.

Question:
We have a resident that discharged from our facility on 4/10/19. She went back to the hospital on 6/8/19 under observation and admitted inpatient on 6/9/19. We believe she is at 59 days and thus she will not receive another 100-day episode. Do you agree?

Answer:
The day of discharge from the SNF is day one of the 60-day wellness period so if the resident was discharged on 4/10 19 then 6/9/19 would be day 61 because the observation day is not considered a day of inpatient stay. An inpatient stay at a SNF or hospital is what interrupts the 60-day well period. The regulation that identifies the beginning of the 60 day well period is in the Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Section 10.4.1 Ending a Benefit Period which says "To determine the 60 consecutive day period, begin counting with the day the individual was discharged".

Question:
Is hospice an exclusion for the pressure ulcer QM?

Answer:
No.

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Oct 22-24 Las Vegas, NV