— WEBINAR QUESTIONS & ANSWERS —

PDPM Power Hour: Level up your reimbursement

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Question	Answer
If a pt is in hospital with severe sepsis or an AMI, but is treated and no longer in sepsis or is no longer having the AMI and was treated, why do WE use that as our Primary diagnosis? that is not what WE are treating them for?	What we must focus on is why the resident needs continued skilled services after a hospital stay. Using Sepsis as an example, although the resident may no longer be on ABTs, there are still lingering effects that need to be treated such as weakness by rehab and the nursing staff should be increasing their clinical assessments for any lingering effects of the infection.
Does anything need to be done if the Primary Dx changes during the course of the stay?	You should ensure that the new information is added to the documentation and EMR. Also include on the billing claim to support keeping the resident on skilled services.
Q: ADR reviewers usually deny due to an NTA not being considered an "active" diagnosis because there are no interventions for this diagnosis. Must all diagnoses used have a medical intervention? They are not accepting observations and follow-up as an intervention.	We must have supportive documentation from the physician that the DX is active - follow RAI guidance on what is considered active. The exception is "risk for malnutrition" which is included with malnutrition at I5600, there is no DX code for "risk for" but we still need supportive documentation.
I understand to validate a dx as active, you must have a source. She shared in exceptions you could use diagnostics results, medication, etc. Also I know to query the physycian when needed to secure support. If, however, none of the have been obatined, should you code for something you know to be accurate or ONLY code if validated?	You should only code if you have support and validation.
does CMS permit us to re-sequence the diagnoses once the resident is no longer here for the initial primary diagnosis? ex. hip fracture is healed, they are here for dementia.	As long as they are being skilled you should keep the principle DX the same unless there is a major significant change. If they change payers you can resequence the codes.
FROM YOUR LIST OF ACTIVE DX, CAN YOU CHOSE WHAT GIVES THE HIGHEST REIMBURSEMENT RATE? THUS MAKE IT THE PRIMARY DX	As long as the principle DX meets RAI guidance, is a billable code, and is being treated with skilled services from most recent hospital visit you can code as principle.

Is there a minimum amount of days a patient has to stay?	No there is no minimum amount of days they need to stay to receive skilled services. If the resident admits and leaves before midnight there are some billing exemptions that you could possibly still bill for that day.
If your facility has all private rooms can you still capture isolation?	Yes, as long as all of the criteria is met in the RAI.
When in doubt, query the physician with your diagnostics findings	Absolutely!
Does lung cancer count under I6200	If it is active, you can.
On isolation- what are some examples of when you would code isolation?? It reads as though even if someone had COVID-19, and they are in a room by themselves for isolation, they do have the ability to co-hort with another resident with COVID-19 if needed, so you could not code that.	You can't code isolation if they cohort. They have to be in a room by themselves and also do not share a bathroom.
what is a respiratory nurse?	You just need to ensure the nurses are educated on respiratory therapy, nebs, and you have proof of that. You can use a train the trainer method.
For SOB - do we only need one box checked to capture?	Yes, it only needs to be documented once in the lookback.
Resp certified or trained??	There is no specific federal requirement for a certification.
***The exception is "risk for malnutrition" which is included with malnutrition at I5600, there is no DX code for "risk for" but we still need supportive documentation. what are the criteria?	For "risk for malnutrition" there are multiple different criteria, some examples are low BMI, poor appetite, recent infection, new admit, depression, age.
Can you explain what exactly it means to be "respiratory certified"?	You just need to make sure the nurses are trained and you have proof of the training. There is no federal specific requirement for a certification.
Is a written order for isolation necessary?	Yes
What does it mean to be "respiratory certified" for Nurse giving respiratory Treatment?	They must be trained and have proof of the training. There is no specific federal requirement for a certification.
Please define respiratory certified.	There is no federal specific certification requirement, you do need proof all nurses are trained.
As an RN, I have a lot of experience in ICU and trauma, I have never heard of a "respiratory nurse" listed in the RAI. How does this get counted in a SNF?	You just need to ensure all nurses are trained and have proof of the training.

the nurse has to be respiratory certified to administer neb and be able to count the minutes provided? hope that makes sense.	There is no federal specific certification requirement, they do have to have training and have documentation that the training occurred.
If there is a documentation of SOB while lying flat and patient does have diagnosis of ASTHMA, does this fall into Special Care High category? Thanks	Yes it does.
If a resident is on a 1,000mL fluid restriction, is the resident considered dehyrated when coding the MDS?	That alone would not mean the resident to should be considered dehydrated.
I see that the Active diagnosis codes slides discussed are all information listed in the RAI. Thank you for talking about the chart scrubbing aspects of it , it's so commonly missed with our busy day.	Answered live during webinar (see recording)
Is incentive spirometry included in respiratory therapy?	Yes as long as there is documentation with minutes to support.
Can hydration be coded if a resident is NPO prior to a surgery and receives fluids?	You have to have proof that the fluids were not just given for the surgical procedure.
Is a wound on the ankle considered a wound on the foot?	You should query the physician if you are unsure - I would say no.
does cellulitis of a lower extremity count as cellulitis of foot if it is not specifically on the foot.	No, and if it's open and being treated I would also consider coding wound infection as this is a wound that is infected.
cellullities to bilateral or single lower extremity - this can not be doced as infection of the foot unless it is specifically on the foor correct? so if just on legs it does not get coded?	If it's not on the foot it shouldn't be coded as such.
For using hospital records to capture IV fluids on new admissions. Every hospital nurse piggybacks antibiotics to the lines don't run dry. This won't be documented or on hospital MAR. Would this be something we just can't capture?	As long as you can support that it was for hydration you can code based on order showing IVPB.
Would peg sites, suprapubic catheters, and colostomies fall under surgical wound care?	No
Where would we code a blister? ie., blood-filled blister or any type of blister	Look at RAI in section M, there are specific examples for blisters.
Why do you think SOB is missed frequently on MDS	I believe nurses need more education on how to assess for SOB while lying flat.
Was this no depression or no billed depression ?	Answered live during webinar (see recording)

What do you mean end split?	Answered live during webinar (see recording)
Is it worth to do an IPA - if there are 2 or more days of insulin order changes?	For an IPA you must look at each PDPM component, drill down the $ amount and total amount. Then look at what CMGs would change too for each component to see if it makes sense.
A fungal foot infection can be coded as foot infeciton in M1040A, right?	Yes
IF a resident is dicharged return anticipated and does not return for 10 days and is not a bed hold can hospital PDPM treatments in Section O still be coded if 5day ARD is selected for day or 4?	If they have gone over 3 midnights, it is a new stay which means a new 5 day.
The ankle is not considered part of the foot. (per RAI)	Answered live during webinar (see recording)
I missed the part on respiratory do you have to be a respiratory therapist to capture resp txs?	No, you just need to ensure that all of the nurses are trained and you have proof of that training.
Resident hoyer lift and was prior. Bed mobilities 9?	Answered live during webinar (see recording)
Just clarifying - a trauma wound can be classified as an "Other Lesion"?	Answered live during webinar (see recording)
When do I do an IPA rather than a quarterly.	Answered live during webinar (see recording)
For RNA and respiratory therapy can we still code if they do not document in minutes?	No unfortunately you can't.
We have CLA PPS PDPM RATES why is there a different rate from CLA and PCC	Answered live during webinar (see recording)
How much documentation is needed to code trach care after a canula has been removed?	You can put this on the TAR and code.
What would we need to ensure that the respiratory nurse is trained. Does this need to be an RN, LPN? What qualifies them as a respiratory nurse?	Answered live during webinar (see recording)
Can you repeat the average percentage of patients scored with depression nationally?	Answered live during webinar (see recording)
About that respiratory question from the first question, I think Joleen said RT or nurses that are "certified".	Answered live during webinar (see recording)

Can you code IV medications, such as Vancomycin, that is given at dialysis (after) but not part of the treatment in section O as while a resident?	Answered live during webinar (see recording)
The 15 minutes for respiratory therapy is face to face…for the entire treatment. Correct?	Answered live during webinar (see recording)
Do you have inputs in coding the diagnosis of Bronchiectasis as I have notice in our EHR system it has 3 NTA points.	Answered live during webinar (see recording)
For example on our TAR it does not specify that breathing treatment was done for 15 min. The RT just signs that it was done	Answered live during webinar (see recording)
PT CAME IN AND IS ABLE TO DC BUT JUST HAS A BLOOD TRANSFUSION. DO I DO AN IPA BEFORE THE DC?	Answered live during webinar (see recording)
If a resident was hospitalized in the while on Medicare A, example: transferred and readmitted to the hospital on DAY 20, then came back to SNF with a new Dx. what would be the Primary Dx on this 2nd hospitalization? would it still be from the First Stay/Admission?	The primary diagnosis may be either the original diagnosis or a new one from the recent stay. In I0020, it states to indicate the resident's primary medical condition that best describes the primary reason for the Medicare Part A stay.
Regarding the bed mobility items in GG with use of hoyer lift: the argument has been made that the lift is doing the sit to lying and lying to sitting portion. Should those items be coded as 9 N/A or 1 dependent	This is not specifically addressed in the RAI manual. The instruction for mechanical lift being used is for chair/bed to chair transfer, coding would be activity not attempted code.
the diaysis outside facility and isolation you can capture or yoiu cant?	Answered live during webinar (see recording)
Does an LVN or an RN qualify with regard to respiratory treatment with documentation.	Depends on state guidelines. In most cases respiratory therapy is included in nursing program, however some states have more stringent guidelines under their particular nurse practice act.
Hi, some of the diagnosis like ESBL has NTA points but they are non billable, can we include them in our diagnoses sequencing and will it increase our NTA total points?	Answered live during webinar (see recording)

When you say there has to be 2 treatments for wounds, do you mean 2 seperate treatments or 2 different type treatments in one order at the same time?	Answered live during webinar (see recording)
Is the GG function score affecting nursing component found only the GG score in the nursing component section on PCC? I noticed a different GG score in PT/OT.	Answered live during webinar (see recording)
Does the respiratory nurse need to be a RN that provided the treatments?	Answered live during webinar (see recording)
LN school training includes RT in WA schools... no special training or cert in WA either.	Answered live during webinar (see recording)
Or can it be a LPN that received the respiratory training	Depends on state guidelines. In most cases respiratory therapy is included in nursing program, however some states have more stringent guidelines under their particular nurse practice act.
I am attached to the hospital and RT is privided through them same with PT wound care can I claim? We are owed by the hospital	Yes, but the documentation needs to be present, and minutes need to be present for respiratory therapy.
Is reimbursement higher for SOB lying flat rather than with exertion?	Yes. Shortness of breath while lying flat + a chronic lung condition such as COPD, falls into the special care high category. Shortness of breath with excertion does not have a reimbursement impact.
can you repeat what you said about "while a resident" when in the ER. we can code with that they were given in the ER?	Yes, as long as the resident is not admitted to the hospital, they remain our resident, so while a resident is in place.
can you go in to depth about malnutrition vs risk for malnutrition	Malnutrition has a diagnosis which would come from a physician or extender. At risk for malnutrition does not have a diagnosis code, but is evidenced by resident's condition and comorbid conditions. Since at risk for malnutrition is coded in section I, we still must have physician or extender such as a NP to document the risk for coding in section I.
If a pateint has an MDRO, a draining wound , in a private room, not being treated with antibiotics but on topical antimicrobial wound treatement can we code for isolation ?	No, the RAI specifically states we cannot code isolation for wound infections. We treat it appropriately clinically, but we cannot code on MDS.

for RNA program - in order to code it, it has to be 15 mins lable on the RNA form right? otherwise can't code it?	Answered live during webinar (see recording)
If a patient is admitted with a hip replacement from a fracture, should you code the fracture as the primary dx or hip replacement?	The RAI gives guidance on this. You would code the fracture; the appropriate S code.
do you ever check CVA or TIA without active sequelae even if it is a new CVA TIA	If the CVA/TIA meets the criteria for an active diagnosis per RAI guidance, yes it should be coded. Active diagnosis is a 2 step process. 1. Active written by a physician within 60 days, and 2. In the last 7 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death.
Is the Diagnosis Cellulitis except foot area can be coded in the Section I wound infection eventhough there is no Open wound?	If the cellulitis is open and being treated it is a wound infection.
can you rephrase the phq9 or does it have to be asked exactly how it is written?	The RAI manual says the interview sections are scripted, therefore we must use the exact language provided in the MDS/RAI.
does lying flat only apply to copd	It is a chronic lung condition + SOB while lying flat. Chronic lung condition can be COPD, but there are other lung conditions that are chronic. If chronic, code at I6200.
how about if there's no open wound, just inflammation and antibiotic for Cellulitis.	I would query the physician. If documented as a wound infection, then yes.
If you have someone with a new PEG tube - could you code surgical care for the treatment of a new PEG tube site?	For a new surgical wound, yes you can code. As soon as it is healed, I would not code. I would document carefully that it is a new surgical wound.
Can we code TINEA UNGUIUM IN SEC M1040 A?	I would only code if it is a true infection.
Just to clarify - when looking at services provided while a resident - any treatment that occurs in the hospital the day the resident admits to the SNF, but prior to actual admission are not counted, correct?	In section O, coding is only "while a resident", in section K-coding is both "while a resident" and "while not a resident". It depends on the section of the MDS.

Is active C-Diff a covered reason for isolation	The CDC says contact and standard precautions. In most cases we may not isolate, however depending on the resident's condition, such as incontinent with cognitive disorder, potentially. This would be a resident specific assessment.
In sequencing ICD-10 on the UB04, do you have to have at least one PT, one OT and one SLP (if indicated) code idenified for Medicare A?	There is no mandate on having to have a PT, OT, or SLP code on the UB04, however if the resident is being skilled by therapy, it is encouraged to have supporting ICD 10 codes on the UB04. This helps to protect your claim and would need to be reviewed during your triple check meeting.
I understand not coding what is given at dialysis. But we capture the IVF and IV meds while they are at the hospital when it is in the look back - that's ok to code correct?	IV fluids in section K0520A2, can be coded while not a resident in the 7-day look-back period. If IV fluids were given for hydration/nutrition even while not a resident, yes we can code. IV medications can only be coded "while a resident." If IV medications were given while the resident is inpatient at the hospital, we cannot code in section O.
If a resident goes to the ED for 2 hours and gets IVM and comes back we can code that	Yes, we can code IV medications for status of "while a resident". If the resident is not admitted to the hospital and remains our resident, yes you can code.
And it has to be documented 7 consecutive days?	For reimbursement purposes, respiratory therapy is at least 15 each day for all 7 days in the look-back period.
for the respiratory treatments and incentive spirometer. it has to be 15mins on a day right?	For reimbursement purposes, respiratory therapy is at least 15 each day for all 7 days in the look-back period.
wouldn't the hospital bill fluids too? Dont understand the argument between while resident in er vs at dialysis	The RAI Manual guides us in coding the MDS. IV medications can be coded in the scenario of "while a resident" A resident going to the ER, if not admitted to the hospital, they remain our resident, so coding can occur. As far as dialysis the RAI manual instructs in section O, do not code IV medications of any kind that were administered during dialysis.
in texas referring to MCD Patients, when do or why should you do a OSA?	Texas Medicaid
If a resident is deemed safe to be appropriate to self adm can we still code for 15 min respiratory therapy?	The time that a resident self-administers a nebulizer treatment without supervision is not included in the minutes recorded on MDS.
Do inactive DX not coded on the MDS need to be removed from the EMR?	If the diagnosis code is no longer active and does not meet the criteria for an active code per RAI Manual, then yes, the diagnosis should be resolved from EMR.

If a resident goes to the ED for 2 hours and gets IVM and comes back we can code that? So why couldn't we code if given after dialysis if it is given for say pneumonia and after dialysis is complete?	The RAI manual has different coding guidelines in different sections. In section O, there is specific guidance that says do not code IV medications of any kind that were administered during.
so would it be ggod practice to add supplemental doccumentation for how long breathing treatment took?	Yes, since there are multiple areas that count towards the time such as resident/assessment, treatment administration, setup and removal of treatment equipment. Having a supplemental document for recording is a good idea.
Can you code cough & deep breathing or incentive spirometer interventions provided by "respiratory trained nurse" in section O?	Yes, as long as all of the criteria is met in the RAI.
I code antibiotic in the N section when given in diaylsis but don't code IV in O section. But we are monitoring the antibiotic therapy adverse effects. Is this not correct?	Yes, that is correct. The two sections have different coding guidance. You will count in section N and not in section O.
for d/c gg section, can i use pt/ot score for 3days before discharge	We can certainly use therapy documentation. The RAI manual steps for assessment says assess based on direct observation, incorporating resident self-reports, reports from qualified clinicians, care staff documented in the resident's medical record.
I don't think I asked that correctly. If they have the ability to cohort, but are in a single room r/t COVID, flu ect. The way it reads, we can't code isolation because if needed we could cohort. I am reading that wrong?	The RAI manual states, we could for isolation if the resident meets the 4 level criteria. 1. the resident has an active infection highly transmissible pathogens. 2. Precautions are over and above standard precautions. 3. The resident is along in room because of the active infection. We cannot code if the resident has a roommate even if the roommate has a similar active infection. 4. The resident must remain in their room, and services brought to room.
what do we do with insurances that done accept the hospital documentation such as Humana-	Most insurance companies have a process where we can request a reviewer to reconsider reimbursement related to acuity. We can state our case based on this acuity. At times, this gives us more reimbursement to take care of the patient.
can remove pt/ot code upon discharge assessment?	If the diagnosis code is no longer active and does not meet the criteria for an active code per RAI Manual, then yes, the diagnosis should be resolved from EMR.

Is hospital documentation charted as "NPO after midnight" acceptable backup for IVF to code on MDS for potential surgical procedure the next day?	The RAI manual says we can code IV fluids if given to prevent dehydration if fluid is needed for nutrition or hydration. Prrevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record. A review/query of physician can assist with determining hydration need.
Our coders will not ever code cardiac arrest. I have had admits that admitted after cardiac arrest with rib fx. They said cardiac arrest diagnosis is one they never code for us. Does this sound right?	Cardiac arrest has some excludes and includes notes. You would code an underlying cardiac or underlying condition first. Cardiac arrest has an excludes2 note for cardiogenic shock.
When a Podiatry comes in and notes pateint has Onychomycosis, and performed debribement.. can that be coded in M1040A? thank you!	Since it is classified as a fungal infection, I would say yes. There is nothing in the RAI that excludes fungal infections.
when do you remove history of COVID from the diagnsis list	There is no specific timeframe for when a personal history code is assigned. If the provider documents that the patient no longer has COVID 19, assign the appropriate personal history code.
Does Shingles meet the criteria for isolation?	CDC says standard precautions in a patient with an intact immune system. For an immunocompromised patient, airborne, contact and standard precautions.
I struggle with capturing IV fluids in the hospital because proving they were administered for Hydration or nutritional purpose is difficult based on the documentation. Its rare for the Physician to state right out the patient has dx of dehydration. Any insight?	Based on the information in the medical records from the hospital, such as labs, patient condition, etc., if it can be clinically led to hydration/nutrition, this can be presented to the physician/NP as a query.
Please clarify how many days the ARD can be moved back to capture IV fluids, while a resident, given at the hospital	IV fluids in section K0520A2 while not a resident is a 7-day look-back. Depending on the last day IV fluids were given for hydration or nutrition, the ARD would be set for coding. Technically, we have from day 1-8 to set the 5-day ARD.