Frequently Asked Questions:

[On-demand webinar] PDPM: Getting to know you

On Thursday, Aug. 29, 2019, SimpleLTC and QRM (Quality Rehab Management) offered a free webinar with PDPM expert Susan Krall PT, RAC-CT, covering formerly hidden critical keys that drive both clinical and financial success under PDPM. This document contains answers to specific questions asked during the webinar answered by experts at AANAC and QRM.

1. **On 10/1/19, what primary diagnosis would you use when resident was admitted prior to 10/1/19 for an infection like pneumonia or UTI and the infection has since resolved, so the diagnosis is no longer active?**

   [AANAC] You will need to determine why the resident continues to receive skilled care if a former primary diagnosis has been resolved. If you are unsure, query the physician.

2. **What are the best coding resources with practice tests and examples?**

   [AANAC] One option for ICD-10 coding education is AANAC's ICD-10 virtual workshop certificate course. This four-part course walks the attendees through how to correctly select ICD-10 codes with opportunities to pause the training and complete coding scenarios.

3. **If a resident comes in post knee replacement but has underlying conditions (i.e. diabetes, dysphagia etc.), could their skilled dx be one of those instead of the knee replacement or does it have to be the knee replacement?**

   [AANAC] If you have a resident with multiple clinical conditions, which are all contributing to the reason he or she is receiving a skilled level of care, your team will need to determine which one is the primary reason for the SNF skilled stay. If unsure, query the physician for clarification. All diagnoses should still be coded in the medical record and on the MDS and claim as appropriate.

4. **Is it true that if Med advantage plans want to continue on RUGS IV PPS assessment/payment, the software vendor will have to enable the availability of those assessments (14, 30, 60, 90, cot, sot, etc.)?**

   [QRM] Each provider will need to confirm with their contracted Medicare Advantage plans how they are going to move forward following 10/1 then confirm with their software vendor that they will be able to continue to support that methodology and for how long.

5. **Can we code ICD-10-CM therapy diagnoses from the therapist notes? Can they diagnose within the scope of their practice? Does it make a difference if we are coding for inpatient or outpatient services, part A or part B? Or do we need to have the physicians document these diagnoses in their H&P progress notes, etc. for SNF patients so that they can be coded?**

   [AANAC] All diagnoses must be supported by physician documentation in the medical record.

6. **What if cognitive status is impaired and pt is unable to participate? ABI or unresponsive?**

   [QRM] If this is in regard to the PHQ9 or BIMs - All resident interviews are to be attempted according to the RAI manual. If the resident is rarely/never understood, skip to the staff assessments for the PHQ9. (deferring to the RAI manual)

7. **If historically a SNF has not used a restorative program, will it be a red flag if the SNF initiates a restorative program in the new payment system?**

   [QRM] Restorative programming is initiated to maintain functional abilities and prevent decline. The RAI manual outlines specifics regarding compliance in capturing restorative services delivered. The program must be administered according to the intent and instructions in the RAI manual.

8. **Does it have to be completed by day 8 or set by day 8? Do we still have 14 days to complete?**

   [QRM] The ARD must be any day day 1-8. The completion and submission timelines have not changed. For the Oct 1 PDPM transitional IPA the ARD can be no later than Oct 7th. Any date may be selected Oct 1-7 with a 7 day lookback (into Sept is acceptable).

9. **At one point in time, I had understood that ST would be doing the BIMS during their assessment. Is this a true understanding or not?**

   [QRM] Each nursing home has the ability to determine who on their team is most qualified to administer the BIMS including ST. That is a facility level decision.

10. **Your reference for the Admission Assessment can be the 5D. Can we separate the Admission from a 5 day if needed?**

    [AANAC] The 5-Day PPS Assessment and OBRA Admission Assessment can be combined or completed separately. The decision of whether or not to combine will be based on if the ARD selection works for both assessment ARD windows and completion timeframes.

11. **Can you explain again about Restorative Nursing? Did you say Restorative can come on board to work with resident at the same time therapy is working with resident?**

    [QRM] From the RAI Manual: "A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy"

12. **When there is an interrupted stay, do we need to do discharge and entry?**

    [AANAC] When referring to discharge assessments it is very important to refer to them as either OBRA discharge assessment or PPS discharge assessment. If a Medicare Part A resident physically discharges from the SNF and returns to resume the skilled stay during the interruption window, then the SNF PPS Discharge assessment is not completed (the Medicare stay did not end, it is being continued). However, OBRA rules did not change—since the resident physically discharged from the SNF, then the OBRA discharge is still required. You will continue to name OBRA discharges, planned or unplanned, and return anticipated or not, the way you currently name these assessments. The type of OBRA discharge has no impact on the interrupted stay.

13. **Can we do first to third day for Therapist to do the evaluation? Like if Resident admitted Friday, can Therapist do evaluation on Monday?**

    [QRM] This decision should be based on patient need, physician orders and client satisfaction. If a patient admits for therapy, they may not be happy waiting until Monday to begin their rehab and we certainly don't want to run the risk of further decline. Perhaps alternative options like restorative initiation can help in situations where the evaluators are unavailable.

14. **So as of October 1st, will this be done for all current patients and those admitting?**

    [QRM] As of Oct 1st, all Medicare Part A (and HMOA programs following PDPM guidelines) patients will be admitted under PDPM instead of RUGs based PPS for reimbursement.

15. **How do we go about setting ARD's for the PDPM change over for October 1st? Speaker mentioned staggering ARDs and working on it before Oct. 1. If the payment is captured the first 3 days wouldn't day one need to be oct 1? with the ard being Oct 7?**

    [QRM] For any patient on Med A as of 10/1, an IPA MDS assessment must be completed to establish reimbursement for 10/1 through DC (unless an IPA is completed). The ARD can be any day 10/1 through 10/7 with a look back of 7 days. The intent of selecting appropriate ARDs and staggering is to ensure the capturing of active conditions the patient presented with and decreasing the burden of workload on the team.

16. **If they meet criteria, will we be permitted to do short-stay assessments for residents admitted on or after 9/24?**

    [QRM] Current PPS rules must be followed through the last day of Sept. If short stay qualifications are not met, then that would not be an option.

17. **Will you send the links to the trainings for GG?**

    [QRM] Section GG - Nursing and Rehab uniting to determine "Usual" performance
    - Comprehensive GG Training Video
    - Additional CMS GG specific training item sets:
    - Coding GG0110. Prior Device Use with Information From Multiple Sources (3:58)
    - Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility (11:56)
    - Coding GG0130B. Oral Hygiene (4:25)
    - Coding GG0170C. Lying to Sitting on Side of Bed (4:33)

18. **In completing GG, should we not use assessments if rehab has already starting treating the resident?**

    [QRM] Usual performance in the first 3 days begins upon admission through the 3rd midnight. If rehab has begun treating, the 'Usual performance is the level of help needed prior to the benefit of therapeutic intervention. Consider every time the person completes the task such as bed mobility and what is the usual performance – not best, not worst – do not include the progress made due to therapy.

19. **Are RD's or SLP's supposed to fill out section K "swallowing" K0100?**

    [QRM] The RAI manual allows each nursing home to decide the most qualified person to participate in completion of the MDS.

20. **If Rehab LCD and there is no nursing Skilled services to be provided like IV/wound, can we still continue the patient under part A services for NTA?**

    [QRM] Skilled determination is based on the documentation of the medical necessity of daily skilled intervention (7 out of 7 days in the look back period if nursing is skilling and 5 out of 7 days if rehab).

21. **On Slide 33, in the SLP Example/Trends--Where does the $22.68 come from? I understand where the multiplier (2.99) comes from but not the other number.**

    [QRM] CMS provides a base rate for urban and rural areas. That base rate is then adjusted based on geographic area. That $22.68 came from the base rate.

22. If you have a resident with a dx of functional quadriplegia, would you mark the dx of Quadriplegia under section I?

[AANAC] The RAI guidance on page I-14, addresses functional quadriplegia and directs us that I5100, Quadriplegia, should not be checked—see underlined section below:

> Item I5100 Quadriplegia:
> — Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
> — Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
> — Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, <u>their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.</u>

23. Is there training on how to use the crosswalk?

[AANAC] I believe you are talking about the crosswalk from the ten clinical category codes used on the ICD-10 Mapping file to the four clinical category codes used in the PT and OT case-mix methodology—there is not a training available for this crosswalk, however on page 6-16 and 6-21 of the RAI User's Manual, there is a very easy to use crosswalk identify how each default clinical category coverts to a PT or OT clinical category.

24. In section K0100 Swallowing Disorder - per RAI guidelines it ask does the resident have any of these problems in the last 7 days. If the resident is on a mechanical altered diet and are no longer having these issues do we still code that they do? that is why they require the altered diet?

[AANAC] No, only code swallowing problems that are still a problem. You will code the mechanically altered diet, as that is an active intervention.

The RAI User's manual provides a coding tip on page K-2:

> 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.

25. **How do we get the correct ICD coding if there is a 'missed' diagnosis? For example, new admit for hemiplegia, who is showing clinical signs of depression, but we do not have ICD10 code for that. Who adds that to the MDS?**

    [AANAC] All diagnoses require supporting physician documentation. If you suspect that a diagnosis is missing, such as hemiplegia, then you will need to query the physician to obtain the supporting documentation. The supporting documentation must be obtained within the look-back period (physician documentation last 60 day, active in the last 7 days) to be coded on the MDS.

    Once the supporting documentation is obtained, it can be added to the resident diagnosis list based on your facility policy/procedure.

26. **What are your thoughts about OT completing PHQ-9?**

    [QRM] Each nursing home is able to decide who on their team is most qualified to complete.

27. **Is there a place to download competency check off for BIMS assessment?**

    [QRM] Begin with the RAI manual instructions and training video's – sign off as reviewed and retain.

28. **Residents may have diagnosis of depression and take medications but are not having active symptoms and are denying issues because they are treated. That is my experience why most PHQ are low. Thoughts?**

    [QRM] That could certainly impact the test outcomes. We must make certain the PHQ9 is being administered according to the RAI instructions and guidance for accuracy.

29. **Can we still use the RTP diagnosis as long as it is not use as a Primary Diagnosis?**

    [AANAC] The return to provider (RTP) code only applies to the primary diagnosis used at I0020B. There are separate lists to identify ICD-10 codes that qualify for the NTA and SLP-related comorbidities.

30. **If patient have dx of depression and taking antidepressant medication, but the behavior monitoring every shift is 0 (no s/s of depression), can we still mark depression?**

    [QRM] Depression captured in Nursing category classification is based solely on the PHQ9 score as documented on the MDS.

31. **When they were talking about section K, did they say to monitor for the first 3 days or first 7 days for the best day?**

    [QRM] Section K completion should follow instructions in the RAI manual and observed during the entire look back period for accuracy.

32. **Is there a possibility to use MOCA rather than BIM?**

    [QRM] Only the BIMs / CPS as completed in the MDS will drive the SLP and Nursing category for cognitive impairment

33. **With the significant increase we are seeing in managed care, when will the decision be made regarding how to proceed?**

    [QRM] Each managed care entity can decide how to proceed and when the decision will be made.

34. **It was suggested in another webinar that we complete all initial Medicare assessments by day 7, not day 8, so that the hospital stay falls in the 7-day lookback. Do you have thoughts on that?**

    [QRM] Each ARD selection should be individualized to ensure all active conditions impacting care delivery are captured. Identify which items are potential for capturing prior to admission to include in pre-admission IDT discussions.

35. **We've always wanted to go in-house, is it too late or can we transition now?**

    [QRM] It's never too late.

36. **If a code is not on a H&P and/or DC summary or NP/MD progress note, can we add the DX that Therapy enters as a treatment?**

    [AANAC] No. Therapists cannot provide diagnoses; all diagnosis (medical and treatment) must be confirmed by the physician being used on the MDS or claim.
    Note the direction in the ICD-10 Coding Guidelines:

> **Documentation by Clinicians Other than the Patient's Provider**
> Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

37. **I have encountered that the diagnosis is fracture in the C2 (S12.100D) without surgery intervention and in the mapping of the PDPM the category belongs to " Major Joint Replacement or Spinal Injury" based on the ICD code from TSI. Is that correct even if there's no surgery done?**

    [AANAC] Using the ICD-10 Mapping file, posted on 8-30-19 for FY2020, the specific ICD-10 code you listed maps directly to Major Joint Replacement or Spinal Surgery. Keep in mind that not all diagnoses require a surgical procedure to be coded in J2100-J5000 to map to a surgical procedure code.

38. **When someone's BIMS is 15, and they answer the PHQ9 as a 0 - 3, but staff observe symptoms of depression, how is this dealt with when reporting on the MDS?**

    [QRM] Must follow RAI instructions when administering and scoring the PHQ9 – it is based on patient responses to questions as scripted.

39. **So all skilled patients in facility during the Oct 1st change need a IPA no matter what payer or just Medicare payer?**

    [QRM] Only Skilled patients -Med A and Skilled Managed Care following PDPM will need an IPA

40. **Do you do the transition assessment only on SNF patients? Or on all patients including LTC?**

    [QRM] See above

41. **How does this play into HMOs, Managed Care Plan PPS Assessments etc.?**

    [QRM] Up to the HMOs and Managed Care Plans - must have those discussions now to gain answers

42. **During the transition phase, is it the 5 day or the ID assessment?**

    [QRM] For the Oct. 1 transition, there will be an IPA (Interim payment assessment) completed.

43. **Can RNP provide the same component that skilled therapy is providing?**

    [QRM] Restorative and Therapy would not be the same exact service. Restorative may be practicing a skill (walk to dine) while Therapy is training and advancing the skill (gait training for equal stride and balance improvement while in single leg stance phase).

44. **If a patient is re-admitted to the hospital for the less than 3 days that we can use an IPA and they have a procedure during this time, since they have not been discharged from the facility, will the facility be responsible for paying for the services in the hospital?**

    [QRM] No

45. **Could we get a few examples of case studies using Restorative?**

    [QRM] The RAI manual has many specific examples/case studies.

46. **Also, should new admissions after Oct 1st be set to day 8 or should they be set earlier?**

    [QRM] Reminder - the transitional IPA assessment is no later than Oct 7. All other admission assessments following 10/1 can select any day day 1-8 as an ARD - selecting the date to most accurately capture active conditions in the look back period (including pre admission on those eligible items)

47. **Is the primary dx the only thing that can't be return to provider or should we avoid RTP dx on most all dx?**

    [AANAC] The return to provider (RTP) code only applies to the primary diagnosis used at I0020B. There are separate lists to identify ICD-10 codes that qualify for the NTA and SLP-related comorbidities.

48. **Is it recommended to have a coder on staff for this new PDPM process?**

    [AANAC] I would recommend having someone who is competent in ICD-10 coding through some form of formalized training.

49. **What conditions require an IPA?**

    [QRM] IPA's are 'Optional' (except the transition on 10/1).

50. **Do all Medicare/Insurance require an assessment to be done to get the RUG before Oct 1?**

    [QRM] All current PPS / RUG requirements remain in place until the last day of Sept in order to receive payment.

51. **If a patient says they have swallowing issues but don't have a diagnosis, we still code swallowing issues correct?**

    [QRM] Swallowing disorder capturing for the SLP category comes from the answers provided in Section K (swallowing disorder) alone – not a diagnosis.

52. **It was my understanding that if a person left one SNF and went to the hospital but then was admitted to another SNF 2 days later, that it is not an interrupted stay because it's a different facility? Is that incorrect?**

    [QRM] An interrupted stay is when a patient leaves for any reason to anywhere and comes back to the same SNF within 3 midnights. If they admit to another facility at any time or to the same SNF after 3 midnights have passed, a new admission assessment is required and is not an interrupted stay.

53. **For residents who are already Medicare in September, do we do another PDPM assessment?**

    [QRM} An IPA PDPM assessment must be completed on anyone in a Med A bed 10/1 to determine payment going forward.

54. **All the guidance I have seen for Interrupted Stay Policy states " the same skilled facility..." can you clarify that this for sure covers another facility?**

    [QRM] If they admit to another SNF, a new Admission Assessment must be completed. This is not an interrupted stay.

55. **In response to, "sit around the table, the morning of day #4," ... aren't these assessments due by day #3?**

    [QRM] The GG Huddle or sitting around the table the morning of day 4 to discuss what was captured in the first 3 days, is a recommendation to ensure an accurate IDT assessment, determination and documentation of usual performance. This is then entered into the MDS by the completion due date.

56. **How would you code arthroplasty?**

    [AANAC] You will need more specific information to code arthroplasty. For example, which joint had repairs/reconstruction? Was it a complete replacement of the joint?

57. **What do we do with the Med A patients that are on skilled therapy starting Oct. 1? Do they need a whole new evaluation?**

    [QRM] A new therapy evaluation, no. GG assessment, yes (by nursing and therapy if involved)– since this will be an IPA, the GG assessment window is the ARD date and the 2 days prior.

58. **In another webinar, we were told that any Medicare ongoing PPS scheduled MDS assessments that were initiated before Oct. 1, we continue the RUG schedule and any new admissions with Medicare after October 1, we will use the new PDPM requirements. Is this true?**

    [QRM} The PPS RUG schedule stops for all skilled patients eff 10/1.

59. **If a resident transfers facilities within the first 3 days, do the new receiving facility complete another admission assessment or do we have to follow the previous facilities admission assessment?**

    [QRM} Whenever a resident admits to a new facility a completely new MDS admission assessment is complete

60. **Since DM is above as a check off in section I, do we have to code at the bottom?**

    [AANAC] It is very important to understand the source for items used for PDPM case-mix group classification. For Diabetes Mellitus, the source of information for the NTA component and nursing component is the check box I2900. Since this is the source, the ICD-10 code at I8000 is not needed for case-mix methodology.

61. **Any suggestions for SLPs re: screening each admit for swallow and cognitive skills and still being able to maintain productivity standards?**

    [QRM] Each nursing home will need to determine expectations surrounding completion of the screening and assessments by therapists and take into consideration when assessing productivity.

62. **Doesn't the MD have to chart the diagnosis in the medical record?**

    [AANAC] All diagnoses must be supported by physician documentation in the medical record.