To Code or Not to Code

PDPM AND CODING COMPLIANCE
JULY , 2019

Objectives

- Provide and overview of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- Explain the regulations associated with coding
- Review of basic coding compliance from the ICD-10 and PCS Official coding guidelines
- Correlate the relationship between coding and PDPM
- How to utilize CMS' coding tools

PDPM Overview

- Yes, it is true, PDPM will go into effective October 1, 2019.
- Do you seem to have more questions than answers?
- Preparation is the key

PDPM Overview

- Where do we begin?
  - One of the key objectives of PDPM is quality outcomes
    - Let's go back to the basics .....

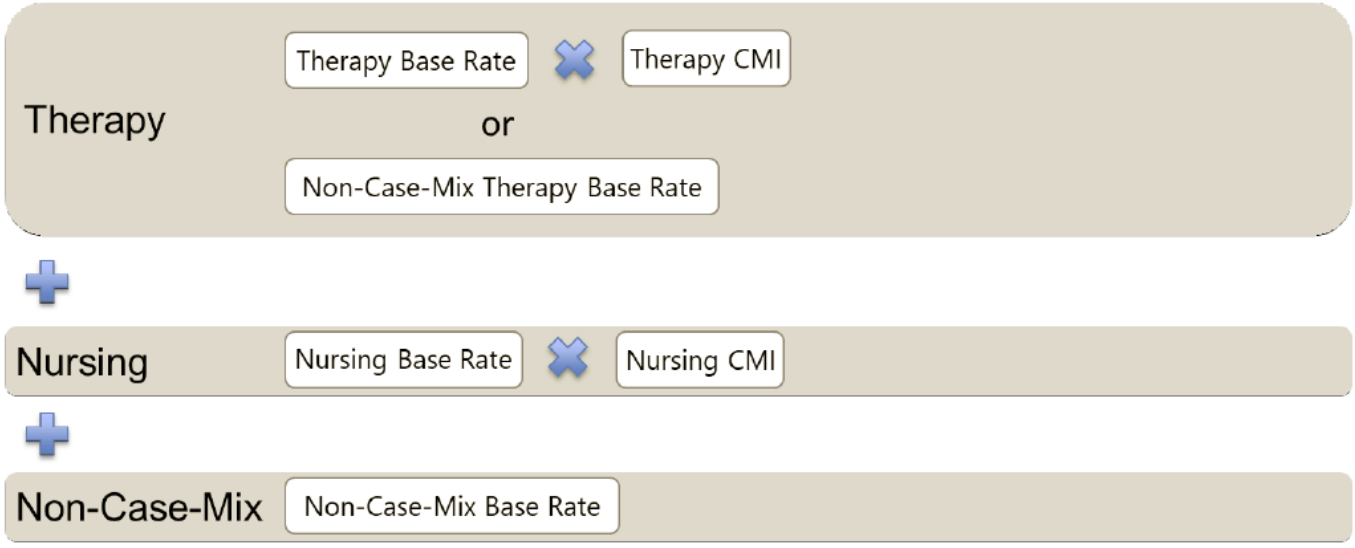
PDPM Overview

- How basic???
  - Nursing 101

PDPM Overview

RUG-IV Components

- RUG-IV consists of two case-mix adjusted components:
  - Therapy: Based on volume of services provided
  - Nursing: The nursing Case-Mix Index (CMI) does not currently reflect specific variations in non-therapy ancillary (NTA) utilization



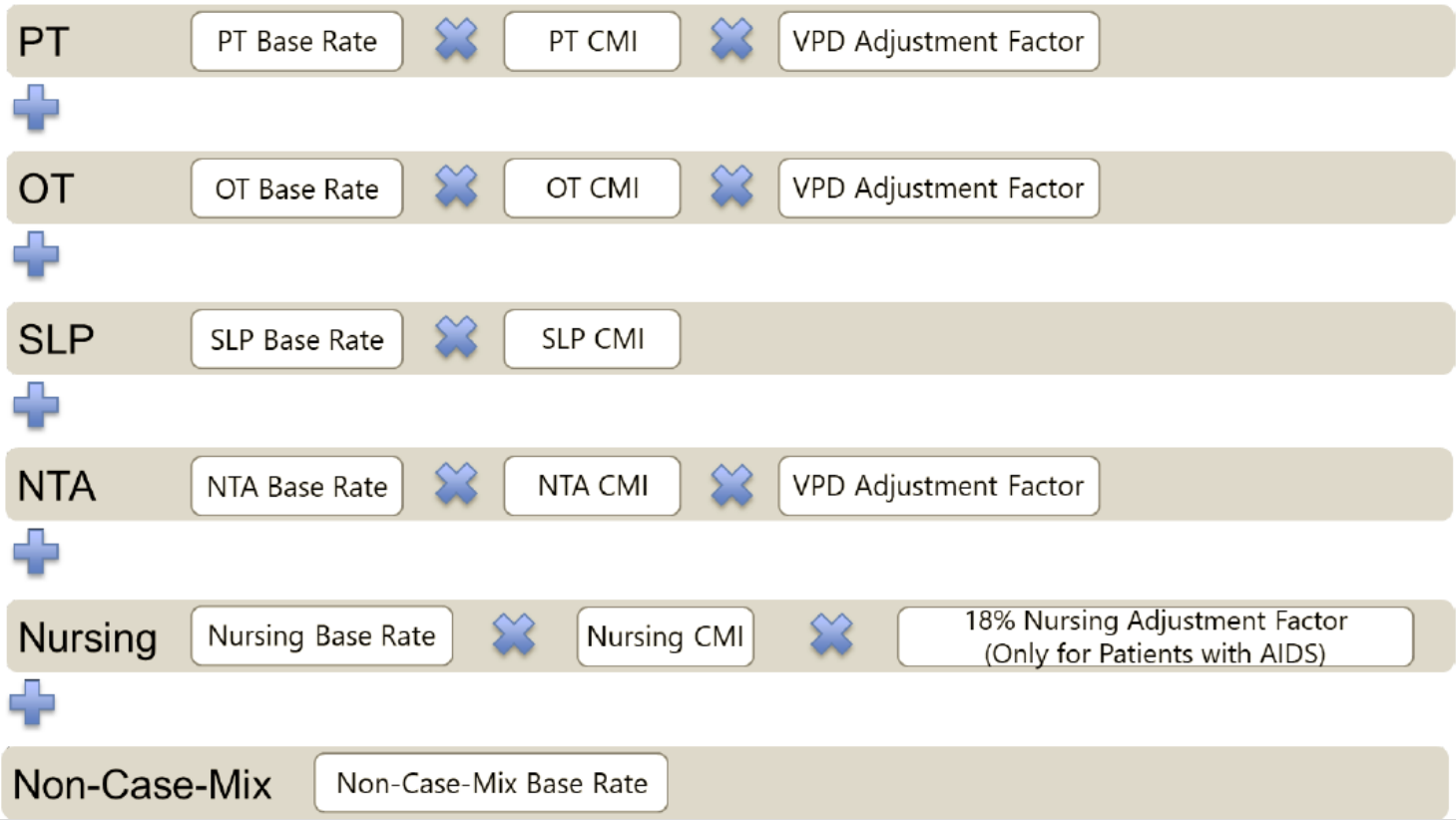
PDPM Overview

PDPM Components

- **PDPM** consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Nursing
  - NTA
- PDPM also includes a “Variable Per Diem (VPD) adjustment” that adjusts the per diem rate over the course of the stay

PDPM Overview

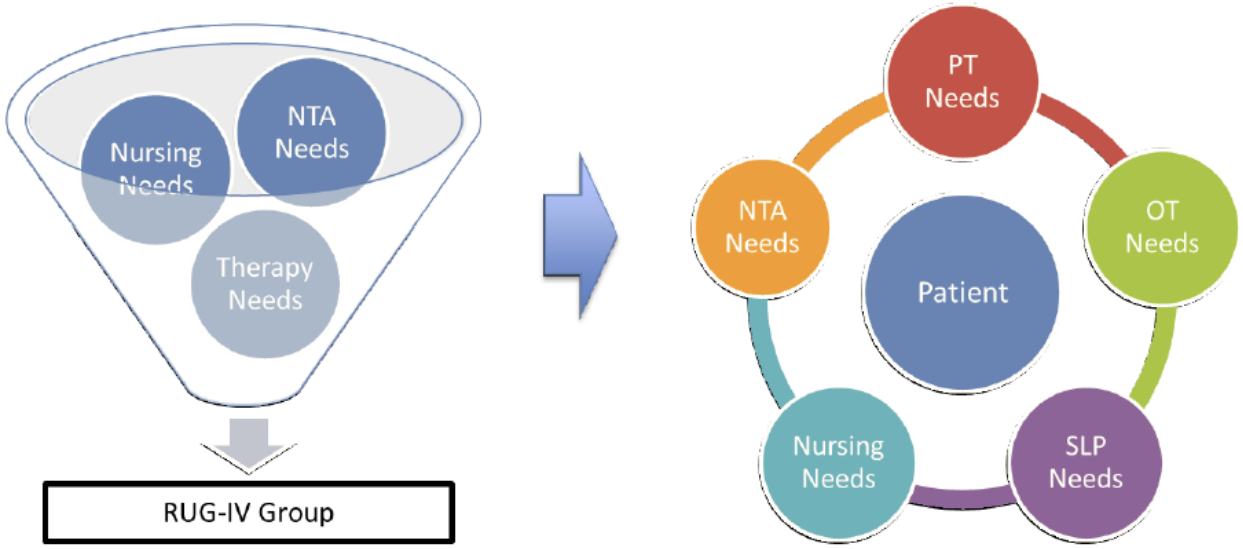
PDPM Snapshot



PDPM Overview

RUG-IV vs. PDPM

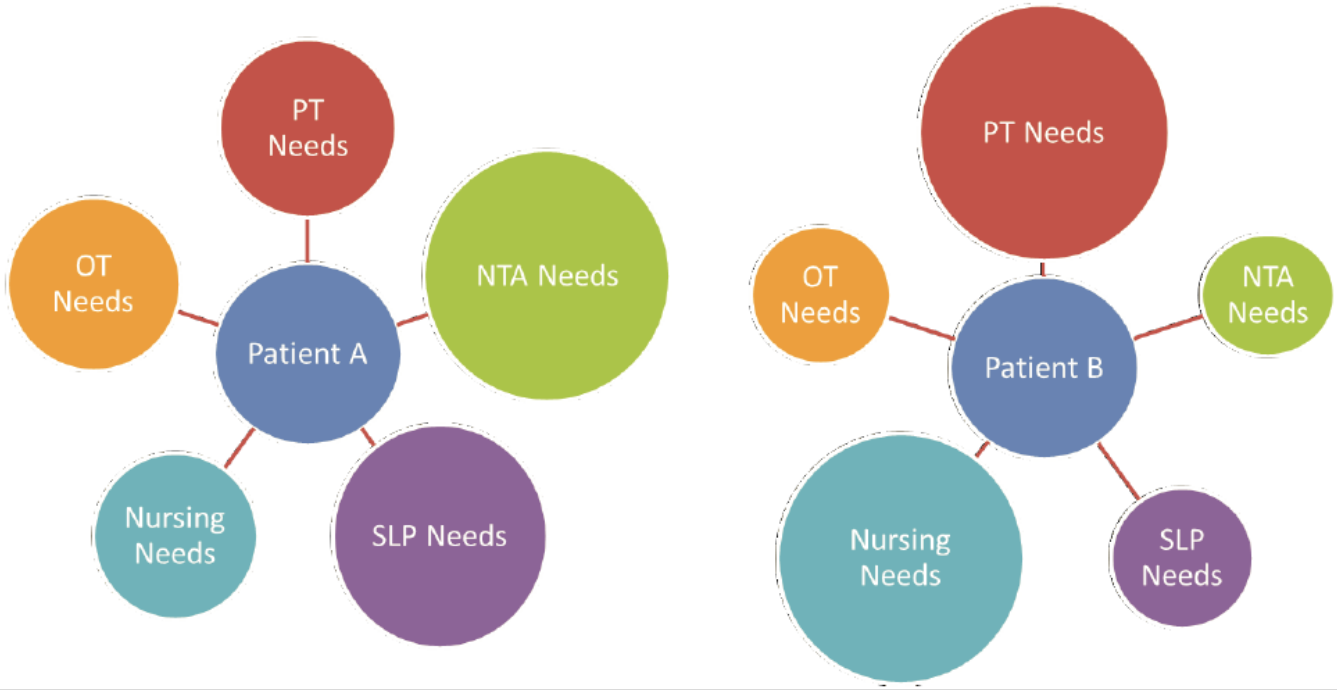
- While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:



PDPM Overview

Effect of PDPM

- By addressing each individual patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model:



PDPM Overview

PDPM Patient Classification

- Under PDPM, each patient is classified into a group for each of the five case-mix adjusted components: PT, OT, SLP, Nursing and NTA
- Each component utilizes different criteria as the basis for patient classification:
  - PT: Clinical Category, Functional Score
  - OT: Clinical Category, Functional Score
  - SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
  - Nursing: Same characteristics as under RUG-IV
  - NTA: NTA Comorbidity Score

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PDPM Overview

PDPM Clinical Categories

- SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, coded on the Minimum Data Set (MDS) in Item I0020B, are mapped to a PDPM clinical category:
  - Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J

PDPM Clinical Categories	
Major Joint Replacement or Spinal Surgery	Cancer
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic - Surgical Extremities not Major Joint	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Non-Orthopedic Surgery

PT & OT Component

PT & OT Clinical Categories

- Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification:

PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery & Acute Neurologic
Other Orthopedic
Medical Management

PT & OT Functional Score: GG Items

- The functional score for the PT & OT components is calculated as the sum of the scores on ten Section GG items:

Section GG Item		Functional Score Range
GG0130A1 – Self-care: Eating		0 – 4
GG0130B1 – Self-care: Oral Hygiene		0 – 4
GG0130C1 – Self-care: Toileting Hygiene		0 – 4
GG0170B1 – Mobility: Sit to Lying	(bed mobility)	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed		
GG0170D1 – Mobility: Sit to Stand	(transfer)	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer		
GG0170F1 – Mobility: Toilet Transfer		
GG0170J1 – Mobility: Walk 50 feet with 2 turns	(walking)	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet		

SLP Component

SLP Component

- For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:
  - Acute Neurologic clinical classification
  - Certain SLP-related comorbidities
  - Presence of cognitive impairment (**BIMS/CPS – assessed exactly the same way as under RUG-IV**)
  - Use of a mechanically-altered diet
  - Presence of swallowing disorder

SLP Component

SLP-Related Comorbidities

- Twelve SLP comorbidities were identified as predictive of higher SLP costs:
  - Conditions and services combined into a single SLP-related comorbidity flag
  - Patient qualifies if any of the conditions/services is present

SLP Comorbidities	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

Nursing Component

SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, coded on the Minimum Data Set (MDS) in Item I0020B, are mapped to a PDPM clinical category:

- Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J

PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:

- Function score based on Section GG of the MDS 3.0
- Collapsed functional groups, reducing the number of nursing groups from 43 to 25

Nursing Functional Score: GG Items

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- Section GG items included in the Nursing Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
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GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	

NTA Component

NTA classification is based on the presence of certain comorbidities or use of certain extensive services

Comorbidity score is a weighted count of comorbidities:

- Comorbidities associated with high increases in NTA costs grouped into various point tiers
- Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000

One comorbidity Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV:

- The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS

Variable Per Diem Adjustment

Variable Per Diem Adjustment

- The Social Security Act requires the SNF PPS to pay on a per-diem basis
- Constant per diem rates do not accurately track changes in resource utilization throughout the stay and may allocate too few resources for providers at beginning of stay
- To account more accurately for the variability in patient costs over the course of a stay, under PDPM, an adjustment factor is applied (for certain components) and changes the per diem rate over the course of the stay:
  - Similar to what exists under the Inpatient Psychiatric Facility PPS
- For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay

Coding Regulations

- ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 (October 1, 2018 - September 30, 2019)

- ICD-10-PCS Official Guidelines for Coding and Reporting 2019

Coding Regulations ICD-10-CM

- These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

Coding Regulations ICD-10-CM

- 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)

Coding Conventions ICD-10-CM

- NEC “Not elsewhere classifiable”
- This abbreviation in the Alphabetic Index represents “other specified.” When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.
- NOS “Not otherwise specified”
- This abbreviation is the equivalent of unspecified.

Coding Conventions ICD-10-CM

- [ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.
- ( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic”.

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Coding Conventions ICD-10-CM

- **Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)**
  - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the prop

Coding Conventions ICD-10-CM

- **Multiple coding for a single condition**
  - In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added, if known.

Coding Conventions ICD-10-CM

- **Signs and symptoms**
  - Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
- **Conditions that are an integral part of a disease process**
  - Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
  - Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present

Coding Conventions ICD-10-CM

- **Acute and Chronic Conditions**
  - If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Coding Conventions ICD-10-CM

- **Combination Code**
  - A combination code is a single code used to classify:
    - Two diagnoses, or
    - A diagnosis with an associated secondary process (manifestation)
    - A diagnosis with an associated complication

Coding Conventions ICD-10-CM

- **Sequela (Late Effects)**
  - A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

Coding Conventions ICD-10-CM

- **Reporting Same Diagnosis Code More than Once**
  - Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

Coding Conventions ICD-10-CM

- **Laterality**
  - Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

Coding Conventions ICD-10-CM

- **Uncertain diagnosis**
  - Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Coding Conventions ICD-10-CM

- **Chronic diseases**
  - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

Coding Conventions ICD-10-CM

- **Code all documented conditions that coexist**
  - Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.