Q1: ICD 10 Give an example of M35.8 that you see
A1: Remember that M35.8 has been removed from the PDPM primary clinical category map and the NTA mapping and has been replaced by M35.81 and M35.89. See the following web resources from the CDC regarding MIS in adults.
https://www.cdc.gov/mis-c/mis-a.html
https://www.cdc.gov/mmwr/volumes/69/wr/mm6940e1.htm
Here it is indicated that, *"CDC is still learning about MIS-A and how it affects adults, so we do not know why some adults have gotten sick with MIS-A and others have not. We also do not know if adults with certain health conditions are more likely to develop MIS-A. These are among the many questions CDC is working to understand."*

Q2: I am from a case mix state and having to do a primary diagnosis on our OBRA assessments. This has posed some difficulties as some of our residents have been here for many years and when looking back at MD progress notes they are often inconsistent with what would be considered a "technical" primary diagnosis as many of their diagnosis are often interchanged on when they are addressed, or they were skilled for something that now would no longer be considered active. For example: a primary dx would have been a hip fracture, but now that it has since healed and the resident remains in the facility for one reason or another. Do you have any suggestions on how to accurately code a primary diagnosis for our long term, non-skilled residents?
A2: Here are the guidelines that I have gleaned from CMS and other states that have provided training related to this issue.

- In I0020 Indicate the resident's primary medical condition category that best describes the primary reason for the stay.
- this will be most current medical condition and diagnosis and thus may not be the same as the reason for admission.
- item I0020 is intended to capture the resident's primary diagnosis, which represents the main reason the resident is in the facility and receiving care.
- the primary diagnosis referenced should be the primary diagnosis at the time the assessment is being conducted
- In the case of the OBRA assessments where the state has elected to calculate the PDPM, a valid ICD-10 code is expected in I0020B. CMS has provided a list of valid ICD- 10 codes that may be appropriate for a non-skilled long-stay resident (OBRA NC and NQ assessments) here
- As of 10/1/2020, these ICD-10 codes ("Return to Provider") will be accepted in I0020B for the OBRA assessments when the state elects to calculate the PDPM on the OBRA NC and NQ. These Return to Provider codes will be mapped to a category of Medical Management

Q3: Regarding principal diagnosis on SNF claim matching I0020B: When an ICF resident goes to the hospital and returns SNF, AHIMA's coding guidance states the reason for the ICF stay remains the primary, first listed diagnosis. The reason for SNF services should be assigned as first secondary diagnosis during the skilled stay. Should the long-term care setting overide AHIMA's guidance by changing the ICF primary diagnosis to match I0020B in such circumstances? Thanks.
A3: Here is what the CMS 100-2 Chapter 8, the RAI Manual and PDPM FAQ say with regard to the Primary diagnosis at I0020B and it's relationship to the Principle diagnosis listed on the UB-04.

- **CMS 100-2 Ch. 8** clarifies that, "To be covered the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated

the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

- **The RAI Manual** indicates for item I0020 and I0020B that;
    - **Intent:** The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.
    - **Steps for Assessment:**
        - I0020 - Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.
        - I0020B - Enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
    - The data set itself indicates, "Indicate the resident's primary medical condition category that best describes the primary reason for admission.
- **The PDPM FAQ** indicates the following.
    - **Q 1.8** - Is it required that the principal diagnosis on the SNF claim match the primary diagnosis coded in item I0020B? **A** - While we expect that these diagnoses should match, there is no claims edit that will enforce such a requirement.
    - **Q 1.9** - Is it required that the SNF primary diagnosis match the primary diagnosis reported for the qualifying hospital stay? **A** - No, the primary diagnosis for the SNF stay may differ from the primary diagnosis reported for the hospital stay that serves as the qualifying hospital stay necessary for SNF coverage.
    -

Q4: Principle dx by county: does metabolic encephalopathy pay better than UTI?
A4: The short answer is that the ICD-10 code for Metabolic Encephalopathy, G93.41, maps to the clinical category of Acute Neurologic while many UTI related ICD-10 codes map to Acute Infections. Acute Neurologic generally has a higher reimbursement. That said, primary diagnosis should always be selected according to the guidelines noted in question 3 above.

Q5: Is it recommended that every single diagnosis from hospital paperwork be entered into EMR or can just the main ones be entered i.e. Primary and Admission?
A5: Generally, the diagnoses that are active for the resident are entered into the EMR. The diagnosis list should be a dynamic tool that records in real time diagnosis that impact the resident's health status and would be useful not only for ongoing care at the nursing facility but would also be useful in communicating with other providers. Therefore, the list that is contained within the EMR may contain codes that indicate a history of a certain condition etc.
The coding guidelines for section I of the MDS are much more stringent, however.

- **Identify the Diagnosis:** The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.
- **Determine whether the diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Q6: So, does the Primary DX code need to be what we are skilling a Med A resident for. If, so how would we skill for a primary DX of dementia?
A6: See answer to Q3 above. Many of the Dementia codes map to the PDPM category of Medical Management. See Publication CMS 100-2 Chapter 8 for specific guidelines related to how to determine if a skilled level of care is being provided. CMS indicates in that document, "While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled." There may be cases where dementia is the primary reason is receiving skilled services. Each case must be considered on it's own merits.

Q7: What Supporting Documentation do Medicare Auditors look at to verify accuracy of I0020b? Are there any error trends noted from Medicare Audits on this MDS Item?
A7: See answer to questions 3 and 5 above.

Q8: I0020B is starting to be tracked for Case mix states. Any advice on how we choose the primary code on OBRA assessments?
A8: See answer to question 2 above.

Q9: Recently had a case, resident in the hospital for respiratory issues, admitted post for rehab. Resident with respiratory ended up with a shoulder with a loose prothesis that was not DDX in the hospital for the acute respiratory stay because she had been at another hospital prior to the most recent stay where she had a fall. This was affecting her care by decreased participation in therapy etc. If the MDS was completed with the ICD 10 for the Respiratory category, (Medical Management,) but the H&P was later Obtained about the shoulder, would it be appropriate to complete an IPA with a different DDX category or would the original MDS be modified?
A9: An IPA may be completed where the primary diagnosis is different that a prior PPS assessment. Consider the guidelines in section 5.5 of chapter 5 of the RAI Manual to determine whether a modification of the 5-day assessment may be performed in the case that you present. Each case would need to be considered based on its own merits. In my opinion, it would depend on the clinical picture of the resident based on the initial assessment vs. what is true based on the new data, i.e. did the care plan change etc. Don't forget the possibility of a SCOS here as well.

Q10: What are your thoughts of providing respiratory therapy as prophylaxis to covid exposure patients? and is it a billable service to Medicare part A to provide prophylaxis?
A10: Please refer to CMS 100-2 Chapter 8 for specific guidance on what is considered a skilled service and therefore billable to Medicare Part A. It is possible that these services are skilled in nature and billable to Medicare A. However, it is difficult to make a definitive determination related to the case you present as it is difficult to tell from the details you present whether a skilled service is being provided or not. Remember, to place into the Special care High category, respiratory therapy must meet the definition in Appendix A of the RAI manual and be provided for 15 minutes all 7 days of the lookback period. Then there is the consideration as to whether the skills of a nurse are necessary to provide the type of respiratory care that a particular resident receives. Further review of the particulars of this case from the MR would be needed to determine these issues.

Q11: How do you feel about assigning COVID 19 (U07.1) as the primary diagnosis if the patient is still recovering, but tests negative prior to transfer to SNF? The SNF physician documents COVID pneumonia in his/her H&P.

A11: See pages 28-32 of the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 (October 1, 2020 - September 30, 2021) for specific guidelines related to coding U07.1. Part of that guidance indicates the following. g. Coronavirus infections

- 1) COVID-19 infection (infection due to SARS-CoV-2)
  - (a) Code only confirmed cases
  - Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient.
  - If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

In this context I believe it is appropriate to use U07.1 as the primary as long as the resident is experiencing COVID disease and the guidelines are met for coding an active dx in section I of the MDS as noted in the answer to question 5 above.

Q12: Where can we identify the best reimbursement codes to use when a Resident has multiple diagnosis and more than one is actually primary or secondary?
A12: Please see the answer to question 3 above to determine from a list of codes which would be the best suited to select as primary. As for the reimbursement question, remember that PDPM was developed with an eye to helping providers make better care decisions. Therefore, in as much as the clinical category placement sets the clinical picture and care pathway development so does the particular reimbursement pathway. A thorough working knowledge of the PDPM clinical mapping structure found here is necessary to understand the variety of coding options relative to the clinical characteristics that your resident presents with.

Q13: How do you handle having no PDPM diagnosis on hospital discharge paperwork?
A13: See answer to question 3 above regarding the primary diagnosis selection process. If there is lack of documentation from your hospital system that contains a working primary diagnosis for skilled care it would be in your facility's best interest to have a conversation with the hospital leadership and get that resolved.

Q14: Do you think that Prednisone dose during covid can trigger the unstable blood sugar in Diabetic resident and non-diabetic elderly resident?
A14: Here is the link to the article that we mentioned during the call.
https://www.mcknights.com/news/clinical-news/new-diabetes-cases-linked-to-covid-19/

In that article the author states, "Others have been treated with the steroid dexamethasone during their illness, which can cause elevated blood glucose." This piece links to the larger work in the Washington Post.

Q15: In addition to Metabolic Encephalopathy, is there an acute neuro mapping relating to Covid-19? We are seeing a neurological/cognitive impact?
A15: Best practice is to code for the actual documented diagnosis. Always research the PDPM maps found at the CMS PDPM website for specific ICD-10 code mapping. Also, see the link to the ICD-10

coding guidelines for COVID found in the answer to question 11 above. There may very well be other neuro manifestations, like the residual "brain fog" reported by many COVID-19 survivors, related to COVID-19 that present for your resident and are legitimate codeable conditions and may be mapped related to PDPM.

Q16: What does Spades stand for?
A16: Standardized **P**atient **D**ata **E**lement**s**. These are the elements that are common to all post-acute care assessment tools, IRF PAI, OASIS, MDS and LTCH LCDS. These have been mandated by the IMPACT Act. See the following web resource, 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

Q17: Can you speak about the "Principle Dx by State Q2 2020" document that is included with the slides? I see stress incontinence listed in many states. I don't understand how that is being used as a primary dx for a skilled stay, especially for Medicare A reimbursement?
A17: As noted in the presentation, we used the principal diagnosis on the SNF claim for our analysis. That said, there may be times when that does not match I0020B even though it is CMS' expectation that it should match. Also note that the document we provided does not show all codes used in each state.

Q18: What would be an appropriate primary dx for someone that is not actively infectious with Covid but still has the lingering effects of Covid requiring skilled care?
A18: See the answer to question 11 above.

Q19: The State Principal Dx handout has dx codes that do not match the code description. For instance, N39.0 is the code for UTI (not stress incontinence).
A19: We thank you for pointing this out. This was discovered shortly after the presentation and a correction notice was sent to all participants as well as the corrected document was posted to the materials link associated with this presentation that same evening.

Q20: A lot of hospital stays are from UTI but once skilled they are no longer being treated (resolved) now have weakness what do you suggest as Primary if they do not have other conditions?
A20: See answer to question 3 above related to selecting a primary diagnosis. This would need to be determined based on an analysis of the resident condition at the time in conjunction with the physician/non-physician practitioner to determine an appropriate diagnosis.

Q21: How often do you recommend that you reach out to your local hospital administrators and update them on what you are doing as a campus, to decrease rehospitalization rates?
A21: As often as necessary. This is an important conversation to maintain in order to understand the hospital system needs with regard to rehospitalizations. This is a moving target in many ways and requires ongoing dialogue.

Q22: Active Diagnosis in the MDS Section I, versus Rehab Treatment Diagnosis. Do we need to include the rehab Treatment Diagnosis in the MDS?
A22: Yes, if they meet the 2-part definition of active diagnosis in section I of the RAI manual. See answer to question 5 above. Additional consideration should also be given to proactive diagnosis sequencing and considerations associated with CMS Local Coverage Determinations and Articles within your specific region as therapy may have additional recommendation to follow.

Q23: Where is the CMS information located regarding using the COVID dx as primary when positive during hospitalization?
A23: See answer to question 11 above.

Q24: M62.81 (Muscle weakness) is an RTP code. I am wondering how it was the most common principle Dx in DC and IA.?
A24: See answer to question 17 above.

Q25: Can SLP, OT, PT add diagnosis, and can these be used on MDS?
A25: See answer to question 22 above. Additionally, as a best practice, therapists should add recommended ICD-10 coding as part of their hands-on evaluation as evidence in plan of care which followed by timely signature to meet certification standards. CERTIFICATION is the physician's/ nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.

Q26: Clarify MDS versus UB for that last question on the Rehab Tx DDX?
A26: The UB-04 generally reflects the diagnosis list that has been prepared and ranked in the RMR. If the treatment dx is an active diagnosis listed and ranked in the EMR, then it would be appropriately appended to the UB-04. See answer to question 22 above related to the MDS.

Q27: Where is the CMS information located regarding using the COVID dx as primary when positive during hospitalization but negative upon admission?
A27: See answer to question 11 above.