"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

PDPM Refresher Part 1: Primary Diagnosis

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 0.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 1 week

PDPM Refresher Part 1: Primary Diagnosis

Learning Objectives

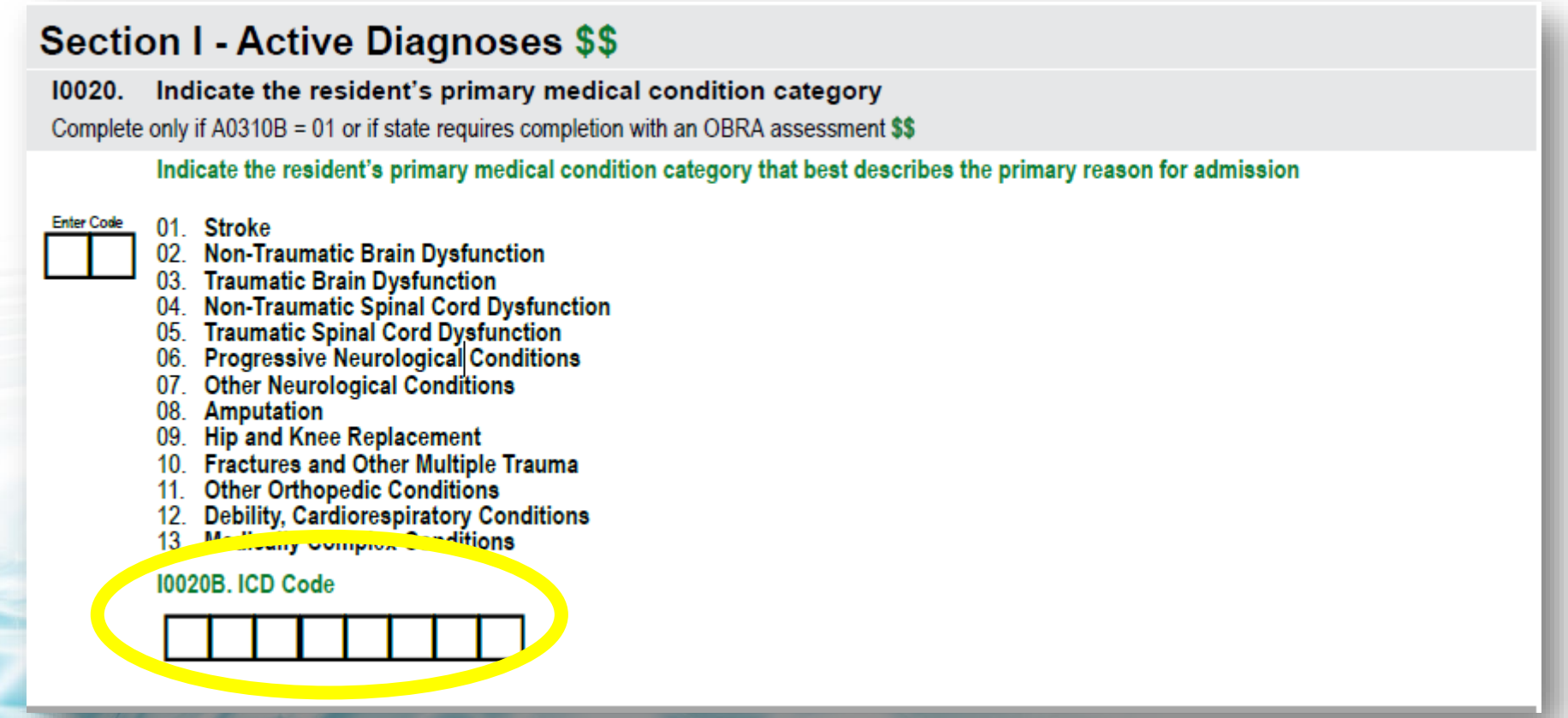
- Understand the definition of Primary diagnosis
- Recognize the regulatory and MDS guidance for proper coding
- Identify the appropriate procedure for selecting the most effective code
- Apply these principles to a primary diagnosis coding scenario

Resources

- CMS PDPM Resource
- CMS MDS 3.0 page
- Medicare Benefit Policy Manual Chapter 8
- CMS ICD-10 Resources

MDS Item I0020

- **PDPM and Some state Reimbursement – PT, OT, SLP**
- **Quality Measurement**



Section I - Active Diagnoses $$

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment **$$**

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. [illegible] Conditions

I0020B. ICD Code

MDS Item I0020

- **Coding Instructions:**
- ***Complete only if A0310B = 01 or 08***
  - Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
  - When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.
  - **Include the primary medical condition coded in item I0020B in items I0100–I8000: Active Diagnoses in the Last 7 Days**.

Supporting an active diagnosis

- **Documentation to support an active diagnosis**
  - Documentation to support an active diagnosis on the MDS is crucial to accurate MDS coding.
  - Diagnoses coded in section I of the MDS affect **care planning, reimbursement**, and **quality measures**.
  - The RAI Manual requires specific documentation to support these areas.
  - The intent is to generate an updated, accurate picture of the resident's current health status.
  - Coding conventions must be followed using both the Tabular List and Alphabetic Index of ICD-10-CM. The science of ICD-10 is specificity!

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
    - **FUNCTIONAL LIMITATIONS**: Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.
    - **NURSING MONITORING**: Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - There are two look-back periods:
    - Diagnosis identification: **(Step 1)** is a 60-day look-back period.
      - 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.
      - Medical record sources for physician diagnoses include: - progress notes, - the most recent history and physical, - transfer documents, - discharge summaries, - diagnosis/ problem list, etc.
      - If a diagnosis/problem list is used, **only diagnoses confirmed by the physician** should be entered.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.
    - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
    - For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - There are two look-back periods:
    - Diagnosis status: Active or Inactive **(Step 2)** is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).
      - 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.
      - **Do not include** conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.
      - Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: - transfer documents, - physician progress notes, - recent history and physical, - recent discharge summaries, - nursing assessments, - nursing care plans, medication sheets, - doctor's orders, - consults and - official diagnostic reports, etc.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:
    - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days.
    - Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
    - Ongoing therapy with medications or other **interventions to manage a condition that requires monitoring** for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days.

Supporting an active diagnosis

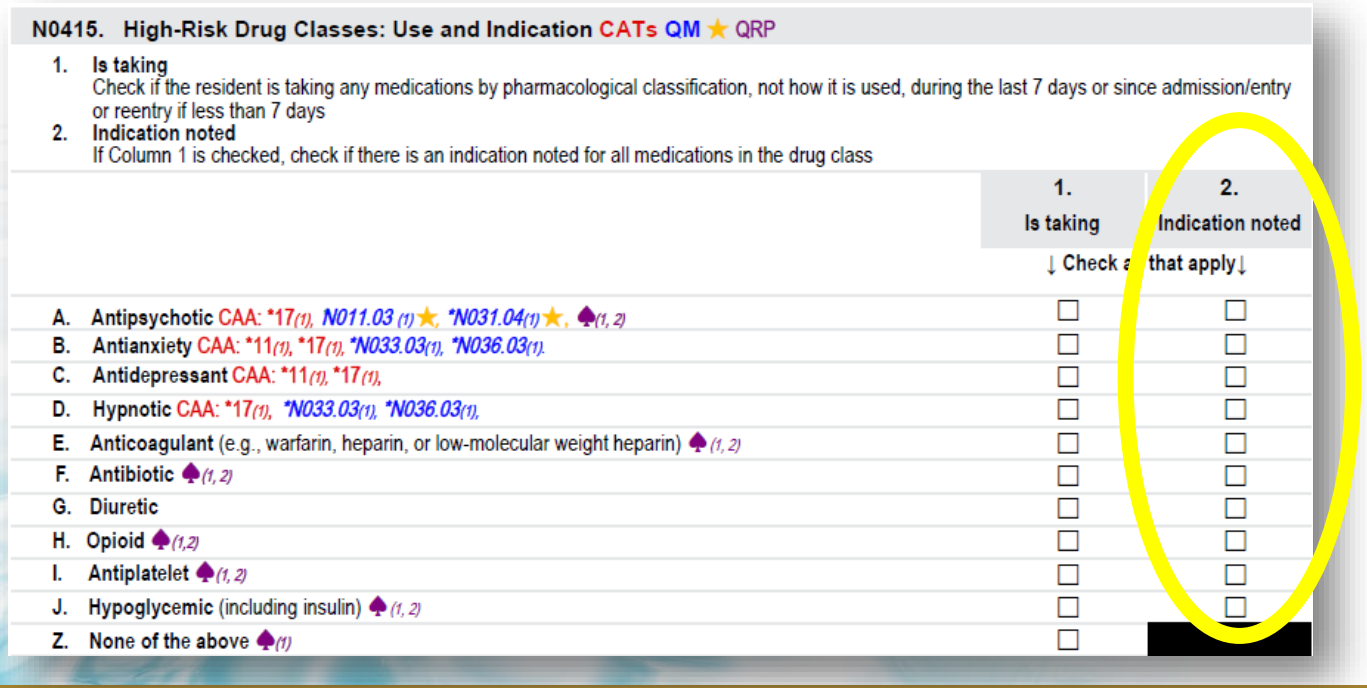
- **Definition of an active diagnosis**
  - Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list **is not sufficient** for determining active or inactive status.
  - It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice. For coding purposes, this monitoring relates to management of pharmacotherapy and **not to** management or monitoring of the underlying disease.
  - In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded.

Supporting an active diagnosis

- **Definition of an active diagnosis**
  - **Example:** The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.
  - **Rationale:** Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, of the resident's mental, physical, psychosocial, and functional status and persistent behaviors for the time period required.

Supporting an active diagnosis

- **Section N – Indication for use.**
  - INDICATION: The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.



N0415. High-Risk Drug Classes: Use and Indication CATs QM ★ QRP

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking ↓ Check a	2. Indication noted ↓ that apply ↓
A. Antipsychotic CAA: *17(1), N011.03 (1)★, *N031.04(1)★, ♠(1, 2)	☐	☐
B. Antianxiety CAA: *11(1), *17(1), *N033.03(1), *N036.03(1).	☐	☐
C. Antidepressant CAA: *11(1), *17(1),	☐	☐
D. Hypnotic CAA: *17(1), *N033.03(1), *N036.03(1),	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) ♠(1, 2)	☐	☐
F. Antibiotic ♠(1, 2)	☐	☐
G. Diuretic	☐	☐
H. Opioid ♠(1,2)	☐	☐
I. Antiplatelet ♠(1, 2)	☐	☐
J. Hypoglycemic (including insulin) ♠(1, 2)	☐	☐
Z. None of the above ♠(1)	☐	

Supporting an active diagnosis

- **Definition of an active diagnosis exception - UTI**
  - The UTI has a look-back period of 30 days for active disease instead of 7 days. **Code only if both of the following are met in the last 30 days**:
    - It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, **AND**
    - A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
  - If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.

Supporting an active diagnosis

- **Definition of an active diagnosis exception - UTI**
  - When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

Supporting an active diagnosis

- **Definition of an active diagnosis Clarification - Quadriplegia**
  - 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 can also cause functional paralysis that may extend to all limbs. For individuals with these types of severe physical disabilities, their primary physician-documented diagnosis should be coded on the MDS and **not the resulting paralysis** from that condition.

Supporting an active diagnosis

- **Active Diagnosis or Not:**
  - **1.** A resident is prescribed hydrochlorothiazide for hypertension. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.
    - **Yes:** This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

Supporting an active diagnosis

- **Active Diagnosis or Not:**
  - **2.** The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.
    - **No:** The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would not be considered an active diagnosis.

Back to I0020B: The Primary Diagnosis

- **Coding Instructions (RAI Manual)**
- ***Complete only if A0310B = 01 or 08***
  - Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
  - When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.
  - **Include the primary medical condition coded in item I0020B in items I0100–I8000: Active Diagnoses in the Last 7 Days**.

Back to I0020B: The Primary Diagnosis

- **CMS 100-2 Ch. 8:** 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.

Back to I0020B: The Primary Diagnosis

- **PDPM and Primary Dx (PT and OT categories)**
- Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B.
- To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.
- Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history.
- For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by items J2100 – J5000.

Back to I0020B: The Primary Diagnosis

- **PDPM mapping**

Mapping of the ICD-10-CM Code Recorded in Item I0020B of the MDS Assessment to PDPM Clinical Categories

D-10-CM Co	ICD-10-CM Code Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
G93.1	Anoxic brain damage, not elsewhere classified	Acute Neurologic	N/A
D44.9	Neoplasm of uncertain behavior of unspecified endocrine gland	Medical Management	May be Eligible for the Non-Orthopedic Surgery Category **3**
M80.842D	Other osteoporosis with current pathological fracture, left hand, subsequent encounter for fracture with routine healing	Non-Surgical Orthopedic/Musculoskeletal	**1 or 2** May be Eligible for One of the Two Orthopedic Surgery Categories

1. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the **major joint replacement or spinal surgery clinical category**

2. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the **Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category.**

3. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the **non-orthopedic surgery clinical category.**

Back to I0020B: The Primary Diagnosis

- **PDPM mapping**

Primary Diagnosis Clinical Category	PT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

Back to I0020B: The Primary Diagnosis

- **PDPM mapping**

PT Clinical Categories	Section GG Function Score	PT Case-Mix Group	PT Case-Mix Index
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.45
	6-9	TB	1.61
	10-23	TC	1.78
	24	TD	1.81
Other Orthopedic: (Non-Surgical Orthopedic/ Muscoloskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	0-5	TE	1.34
	6-9	TF	1.52
	10-23	TG	1.58
	24	TH	1.1
Medical Management: (Medical Management, Acute Infections, Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.07
	6-9	TJ	1.34
	10-23	TK	1.44
	24	TL	1.03
Non-Orthopedic Surgery And Acute Neurologic: (Non-Orthopedic Surgery , Acute Neurologic)	0-5	TM	1.2
	6-9	TN	1.4
	10-23	TO	1.47
	24	TP	1.02

OT Clinical Category	Section GG Function Score	OT Case-Mix Group	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.41
	6-9	TB	1.54
	10-23	TC	1.6
	24	TD	1.45
Other Orthopedic: (Non-Surgical Orthopedic/Muscoloskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	0-5	TE	1.33
	6-9	TF	1.51
	10-23	TG	1.55
	24	TH	1.09
Medical Management: (Medical Management, Acute Infections Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.12
	6-9	TJ	1.37
	10-23	TK	1.46
	24	TL	1.05
Non-Orthopedic Surgery And Acute Neurologic: (Non-Orthopedic Surgery , Acute Neurologic)	0-5	TM	1.23
	6-9	TN	1.42
	10-23	TO	1.47
	24	TP	1.03

Back to I0020B: The Primary Diagnosis

- **Examples:**
- Resident E is an 82-year-old individual who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Resident E's primary medical condition as total hip replacement (THR) in their medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.
- **Coding:** I0020 would be coded **10, Fractures and Other Multiple Trauma**. I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).
- **Rationale:** Medical record documentation demonstrates that Resident E had a total hip replacement due to a hip fracture and required rehabilitation. Because they were admitted for rehabilitation as a result of the hip fracture and total hip replacement, Resident E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Back to I0020B: The Primary Diagnosis

- **Examples:**
- Resident K is a 67-year-old individual with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Resident K's history and physical by the admitting physician.
- **Coding:** I0020 would be coded **01, Stroke**. I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage).
- **Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Resident K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Back to I0020B: The Primary Diagnosis and QRP

Discharge Function Score

Covariates

Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF Stays.

1. Age group
2. Admission function – continuous form[65]
3. Admission function – squared form[66]
4. Primary medical condition category
5. Interaction between admission function and primary medical condition category
6. Prior surgery
7. Prior functioning: self-care
8. Prior functioning: indoor mobility (ambulation)
9. Prior functioning: stairs
10. Prior functioning: functional cognition
11. Prior mobility device use
12. Stage 2 pressure ulcer/injury
13. Stage 3, 4, or unstageable pressure ulcer/injury
14. Cognitive abilities
15. Communication impairment
16. Urinary Continence
17. Bowel Continence
18. History of falls
19. Nutritional approaches
20. High BMI
21. Low BMI
22. Comorbidities
23. No physical or occupational therapy at the time of admission

See covariate details in *Table RA-5* and *Table RA-8* in the associated Risk-Adjustment Appendix File.

Discharge Self-Care Score

Covariates

Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stay.

1. Age group
2. Admission self-care – continuous form
3. Admission self-care – squared form
4. Primary medical condition category
5. Interaction between primary medical condition category and admission self-care
6. Prior surgery
7. Prior functioning: self-care
8. Prior functioning: indoor mobility (ambulation)
9. Prior mobility device use
10. Stage 2 pressure ulcer
11. Stage 3, 4, or unstageable pressure ulcer/injury
12. Cognitive abilities
13. Communication Impairment
14. Urinary Continence
15. Bowel Continence
16. Tube feeding or total parenteral nutrition
17. Comorbidities
18. No physical or occupational therapy at admission

See covariate details in *Table RA-5* and *Table RA-6* in the associated Risk-Adjustment Appendix File.

Discharge Mobility Score

Covariates

Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stays.

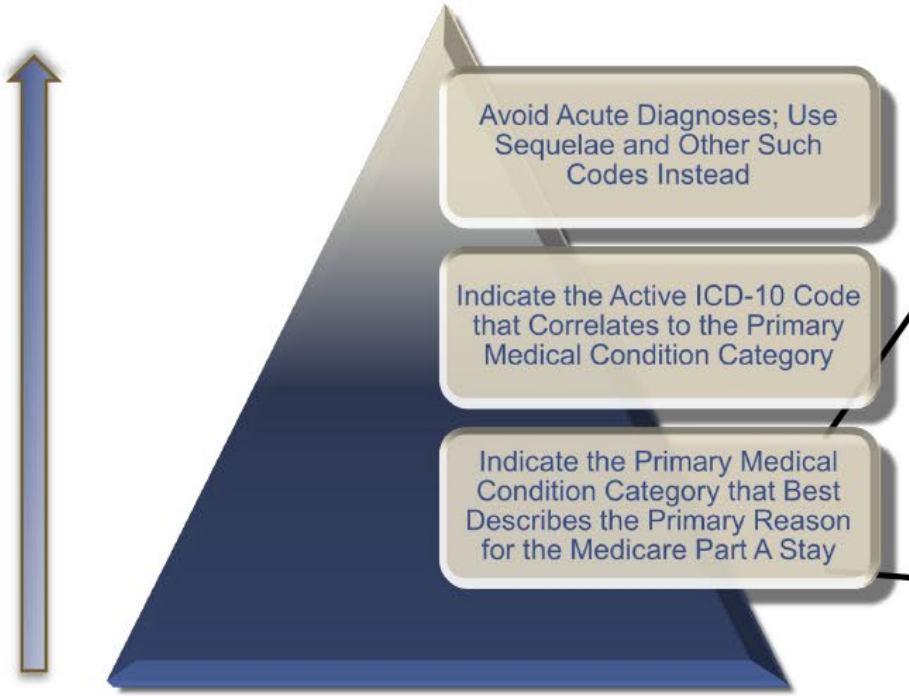
1. Age group
2. Admission mobility – continuous form
3. Admission mobility – squared form
4. Primary medical condition category
5. Interaction between primary medical condition category and admission mobility
6. Prior surgery
7. Prior functioning: indoor mobility (ambulation)
8. Prior functioning: stairs
9. Prior functioning: functional cognition
10. Prior mobility device use
11. Stage 2 pressure ulcer
12. Stage 3, 4, or unstageable pressure ulcer/injury
13. Cognitive abilities
14. Communication impairment
15. Urinary Continence
16. Bowel Continence
17. History of falls
18. Tube feeding or total parenteral nutrition
19. Comorbidities
20. No physical or occupational therapy at admission

See covariate details in *Table RA-5* and *Table RA-7* in the associated Risk-Adjustment Appendix File.

SELECTING A PRIMARY MEDICAL DIAGNOSIS

ICD-10-CM to be entered into I0020B of MDS Assessment

(This should match the Primary Code (FL67) on the UB04)



Primary Medical Condition Categories

1. Stroke
2. Non-Traumatic Brain Dysfunction
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5. Traumatic Spinal Cord Dysfunction
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7. Other Neurological Conditions
8. Amputation
9. Hip and Knee Replacement
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13. Medically Complex Conditions

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 precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.** – *Chapter 8 Section 20.1 CMS Benefit Policy Manual*

Coding Considerations

- Always use current ICD-10 coding materials
- Diagnosis selected would need to meet RAI Manual criteria for Active Diagnosis (see page I-7)
- Follow ICD-10 conventions and guidelines for sequencing **(CMS website)
- Code to most specific option
- Use specific laterality coding (i.e., right-sided)
- Avoid Unspecified, NOS, NEC type codes; if possible
- Use maximum number of characters possible; including the essential 7th character when applicable
- Primary Diagnosis should be listed as Primary Medical Diagnosis on all Therapy Evaluations

**https://www.cms.gov/Medicare/Coding/ICD10

Takeaways

- The primary diagnosis **is an active diagnosis!**
- Choosing a primary diagnosis requires a careful analysis of the resident's health status
- Don't assume! Follow the documentation.
- Understand the mapping and category placement
- Apply the ICD-10 coding guidelines
- Querry the physician when more specificity is needed
- When there a re more than one appropriate primary diagnosis choices, always select the one that best describes the reason for the SNF stay.
- Remember the QM impact

Questions?

Don’t Forget!

- **May 15th -** BRR Reflections – FY 2026 SNF PPS Proposed Rule

2025 BRR Insiders™ Summer Series (CMS 100-2 Chapter 8 Refresher)

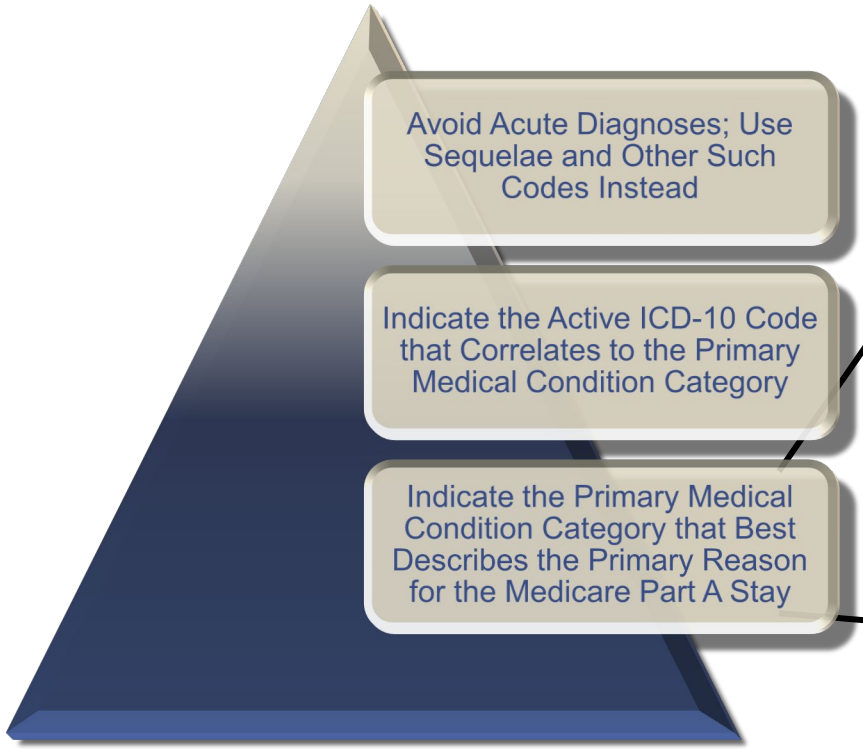
All sessions are from 12:00 pm – 21:30 pm EST, 0.5 hours NAB and ANCC

- **June 6th –** Part A Coverage Criteria and 3-Day Hospital Stay (Shannon Hayes)
- **June 20th –** Medical Appropriateness Exception and 30-day transfer rule (Cathy Wuest)
- **July 11th –** Physician Certification and Recertification requirements (Dr. Gwen Pointer)
- **July 25th –** Denial of Payment for New Admissions Criteria (Joel VanEaton)
- **August 8th –** Consolidated Billing (Joel VanEaton)
- **August 22nd –** Direct Nursing Skilled Services and Indirect Nursing Skilled Services (Amy Garrison)

SELECTING A PRIMARY MEDICAL DIAGNOSIS

ICD-10-CM to be entered into I0020B of MDS Assessment

(This should match the Primary Code (FL67) on the UB04)



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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 precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.** – *Chapter 8 Section 20.1 CMS Benefit Policy Manual*