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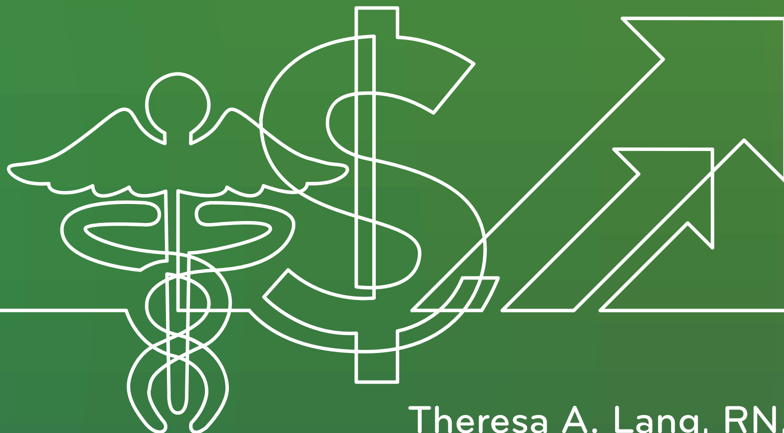
A SNF's Guide to
ICD-10 Coding and Operations Under PDPM



Theresa A. Lang, RN, BSN, WCC

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ICD-10 Coding and Operations Under PDPM

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About the Author

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CHAPTER

1

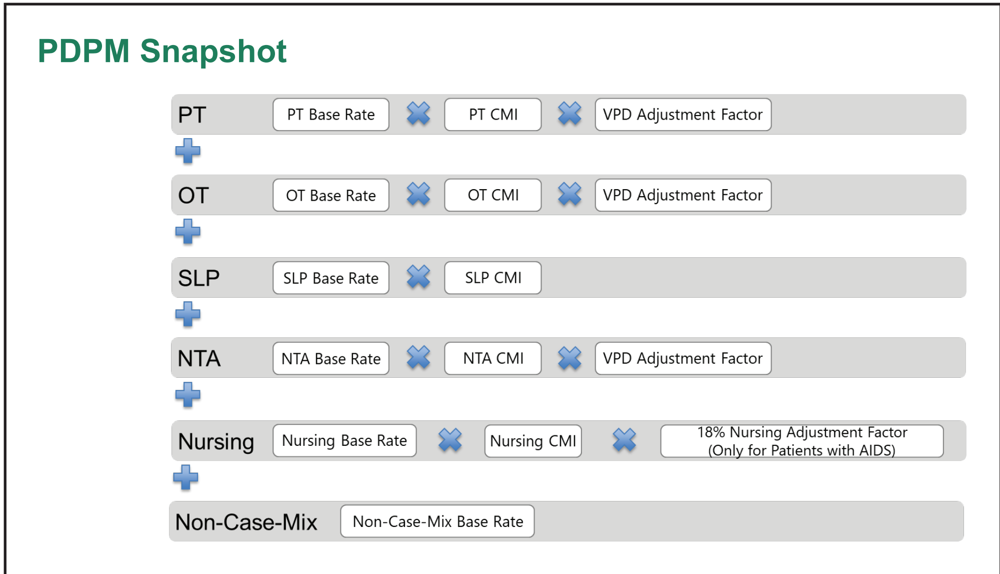
The Patient-Driven Payment Model

What Is PDPM?

The Patient-Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF)/swing-bed patients in a Medicare Part A covered stay into payment groups under the SNF prospective payment system (PPS). Effective beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

What Payers Are Affected by PDPM?

The Centers for Medicare & Medicaid Services (CMS) has only mandated PDPM for Medicare fee-for-service Part A beneficiaries. As many of the Medicare C (Medicare Advantage) plans may follow the CMS guidelines, they may also change their payments to PDPM-based payments, although doing so is not required by CMS.



CMI: case-mix index; NTA: non-therapy ancillary; OT: occupational therapy; PDPM: Patient-Driven Payment Model; PT: physical therapy; SLP: speech-language pathology; VPD: variable per diem.

The PDPM uses clinically relevant factors rather than volume-based service for determining Medicare payment. Under the PDPM, patient characteristics are used to assign patients into CMGs across the payment components to derive payment. Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.

The chart below summarizes the components of PDPM:

PDPM component	First tier	Second tier	VPD
PT/OT	Diagnosis (I0020b) (four clinical categories)	ADL Functional Score (MDS GG)	Days 21–100: 2% reduction every seven days after day 20
SLP	Acute neurologic diagnosis (I0020b) SLP comorbidities (sections I and O of the MDS) Cognitive impairment (sections B and C of MDS)	Swallowing concerns Mechanically altered diet (MDS K)	
Nursing	MDS scoring Sections B, C, D, GG, H, I, J, K, M, O	ADL Functional Score (MDS GG) Depression Score Restorative nursing (MDS H0200, H0500, and O0500)	
NTA	50 MDS items including sections H, I, K, M, O		300% for first three days of stay

Variable Payments

SNF PPS is required to pay on a per diem basis, which means that there is a payment rate associated with each day of the patient's SNF stay. Since its inception, the SNF PPS has used a constant per diem rate, meaning that the payment rate for each day of the stay is the same, as long as the patient stays in the same payment group.

Under PDPM, an adjustment is applied to certain PDPM components that varies the per diem payment over the course of the stay. This adjustment factor is called the *variable per diem (VPD) adjustment*.

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CHAPTER

2

Coding Conventions

Coding Basics

What is coding?

Coding is the transformation of verbal descriptions into alphanumeric descriptions provided by the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) classification system.

What is a diagnosis?

A diagnosis is a word or phrase used by the physician/nurse practitioner/physician assistant to identify a disease from which a patient suffers or a condition for which the patient needs, seeks, or receives medical care.

The assignment of diagnosis codes requires a detailed thought process supported by thorough knowledge of medical terminology, anatomy, and pathophysiology.

The coding guidelines are updated annually effective October 1. Quarterly updates and clarifications to the official guidelines are found in *Coding Clinic*, the quarterly publication of the American Hospital Association; however, issues of *Coding Clinic* are not specific to SNF/LTC and may be considered an expense with little relevance to long-term care.

These guidelines should be used as a companion document to the official version of the ICD-10-CM code sets.

The coding guidelines are organized into sections:

- Section I includes the structure and conventions of the classification, general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification.
- Section II includes guidelines for selection of principal diagnoses for non-outpatient settings.
- Section III includes guidelines for reporting additional diagnoses in non-outpatient settings.
- Section IV is for outpatient coding and reporting (not used in the skilled nursing facility [SNF]).

It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

Official Coding Guidelines: Introduction

The section addresses conventions, general coding guidelines, and chapter-specific guidelines. In this book, we will address the guidelines specific to SNF environments.

The conventions, general guidelines, and chapter-specific guidelines are applicable to all healthcare settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

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The conventions for ICD-10-CM are the general rules for use of the classification independent of the coding guidelines. These conventions are incorporated with the Tabular List and Alphabetic Index of the ICD-10-CM as instructional notes.

ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding codes, and the Tabular List, a structured list of codes divided into chapters based on body system or condition.

The Alphabetical Index includes the following:

- The Index of Diseases and Injuries
- The Index of External Causes of Injury (not used in the SNF)
- The Table of Neoplasms
- The Table of Drugs and Chemicals

The Tabular Index includes Chapters A–Z (U is not used at this time):

- Chapter 1: Certain Infectious and Parasitic Diseases (A00–B99)
- Chapter 2: Neoplasms (C00–D49)
- Chapter 3: Disease of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism (D50–D89)
- Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00–E89)
- Chapter 5: Mental, Behavioral, and Neurodevelopmental Disorders (F01–F99)
- Chapter 6: Diseases of the Nervous System (G00–G99)
- Chapter 7: Diseases of the Eye and Adnexa (H00–H59)
- Chapter 8: Diseases of the Ear and Mastoid Process (H60–H95)
- Chapter 9: Diseases of the Circulatory System (I00–I99)
- Chapter 10: Diseases of the Respiratory System (J00–J99)
- Chapter 11: Diseases of the Digestive System (K00–K95)
- Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00–L99)
- Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00–M99)
- Chapter 14: Diseases of the Genitourinary System (N00–N99)
- Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00–O9A)

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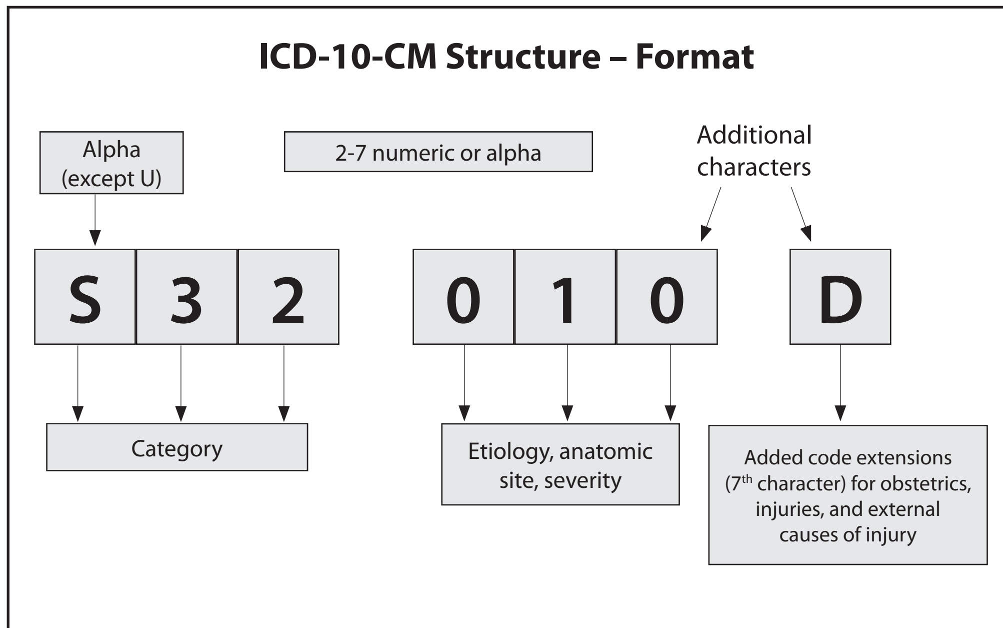
Example:

G35 Multiple sclerosis
    Disseminated multiple sclerosis
    Generalized multiple sclerosis
    Multiple sclerosis NOS
    Multiple sclerosis of brain stem
    Multiple sclerosis of cord

Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.



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The ICD-10-CM Alphabetic Index uses an indented format for ease of reference.

Main Term (always bold)
With (always appears at the beginning)
Subterm (identify site, cause, clinical type)
Further Subterm
Further Subterm

Examples from Alphabetic Index:

Incontinence R32
urge N39.41
and stress (female) (male) N39.46

Example:

Hernia, hernial (acquired) (recurrent) K46.9
with
gangrene -see Hernia, by site, with, gangrene
incarceration -see Hernia, by site, with, obstruction
irreducible -see Hernia, by site, with, obstruction
obstruction -see Hernia, by site, with, obstruction
strangulation -see Hernia, by site, with, obstruction
abdomen, abdominal K46.9
with
gangrene (and obstruction) K46.1
obstruction K46.0

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

Special Care High

J1550A, others fever and one of the following:

I2000	Pneumonia
O0400D2	Respiratory therapy for all seven days
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident

Clinically Complex

I2000	Pneumonia
O0100C2	Oxygen therapy while a resident

Official Coding Guidelines

10. **Chapter 10: Diseases of the Respiratory System (J00–J99)**

a. **Chronic Obstructive Pulmonary Disease [COPD] and Asthma**

1) **Acute exacerbation of chronic obstructive bronchitis and asthma**

The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

Example: Acute bronchitis with acute exacerbation of COPD

J20.9	Acute bronchitis, unspecified
J44.0	COPD with acute lower respiratory infection
J441.1	COPD with (acute) exacerbation

Example: Resident has acute viral pneumonia and acute respiratory failure

J96.00	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J12.9	Viral pneumonia, unspecified

c. Influenza due to certain identified influenza viruses

Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus. However, coding should be based on the provider’s diagnostic statement that the patient has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10.

If the provider records “suspected” or “possible” or “probable” avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J11, Influenza due to unidentified influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned nor should a code from category J10, Influenza due to other identified influenza virus.

Author’s note: When a SNF or community is experiencing an influenza outbreak, cultures may be obtained on two to three residents. If the result is positive, it is considered to be an outbreak, and additional cases can be diagnosed on symptoms without culture results.

Source: Centers for Disease Control and Prevention. (2016). Infection control in health care facilities. Retrieved from www.cdc.gov/flu/professionals/infectioncontrol/index.htm

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Table L.1: Impact on PDPM Clinical Mapping

Chapter 12: Diseases of the Skin and Subcutaneous Tissue will map to two of the 10 PDPM clinical categories, as highlighted in this table.

Major Joint Replacement or Spinal Surgery	Cancer
Nonsurgical; Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Nonorthopedic Surgery

Table L.2: Unspecified RTP Codes

In Chapter 12, many unspecified codes result in RTP, such as the following:

L97301	Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin
L97302	Non-pressure chronic ulcer of unspecified ankle with fat layer exposed
L97303	Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle
L97304	Non-pressure chronic ulcer of unspecified ankle with necrosis of bone
L97305	Non-pressure chronic ulcer of unspecified ankle with muscle involvement without evidence of necrosis
L97306	Non-pressure chronic ulcer of unspecified ankle with bone involvement without evidence of necrosis
L97308	Non-pressure chronic ulcer of unspecified ankle with other specified severity
L97309	Non-pressure chronic ulcer of unspecified ankle with unspecified severity
L97804	Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone
L97805	Non-pressure chronic ulcer of other part of unspecified lower leg with muscle involvement without evidence
L97806	Non-pressure chronic ulcer of other part of unspecified lower leg with bone involvement without evidence
L97808	Non-pressure chronic ulcer of other part of unspecified lower leg with other specified severity
L97809	Non-pressure chronic ulcer of other part of unspecified lower leg with unspecified severity

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ICD-10-CM Chapter 14: Diseases of the Genitourinary System (N00–N99)

Excludes2: Certain conditions originating in the perinatal period (P04–P96)

- Certain infectious and parasitic diseases (A00–B99)
- Complications of pregnancy, childbirth, and the puerperium (O00–O9A)
- Congenital malformations, deformations, and chromosomal abnormalities (Q00–Q99)
- Endocrine, nutritional, and metabolic diseases (E00–E88)
- Injury, poisoning, and certain other consequences of external causes (S00–T88)
- Neoplasms (C00–D49)
- Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00–R94)

This chapter contains the following blocks:

N00–N08	Glomerular diseases
N10–N16	Renal tubulo-interstitial diseases
N17–N19	Acute kidney failure and chronic kidney disease
N20–N23	Urolithiasis
N25–N29	Other disorders of kidney and ureter
N30–N39	Other diseases of the urinary system
N40–N53	Diseases of male genital organs
N60–N65	Disorders of breast
N70–N77	Inflammatory diseases of female pelvic organs
N80–N98	Noninflammatory disorders of female genital tract
N99	Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified

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Table N.1: Impact on PDPM Clinical Mapping

Chapter 14: Diseases of the Genitourinary System will map to two of the 10 PDPM clinical categories, as highlighted in this table. Many symptoms found in this chapter are RTP.

Major Joint Replacement or Spinal Surgery	Cancer
Nonsurgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Nonorthopedic Surgery

Impact on NTA

There are no diagnosis codes from Chapter 14 that provide additional points for the NTA portion of the rate.

Impact on nursing CMG

There are no specific diagnosis codes from I8000 related to the genitourinary system that affect the nursing CMG.

There are no items on the MDS that indicate conditions that may impact the nursing CMG.

Official Coding Guidelines

14. Chapter 14: Diseases of Genitourinary System (N00-N99)

a. Chronic kidney disease

1) Stages of chronic kidney disease (CKD)

The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, code N18.3, equates to moderate CKD; and stage 4, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code N18.6 only.

Author's note:

When coding:

N40.1, Enlarged prostate with lower urinary tract symptoms (LUTS)—Use additional code for associated symptoms, when specified:

- Incomplete bladder emptying (R39.14)
- Nocturia (R35.1)
- Straining on urination (R39.16)
- Urinary frequency (R35.0)
- Urinary hesitancy (R39.11)
- Urinary incontinence (N39.4-)
- Urinary obstruction (N13.8)
- Urinary retention (R33.8)
- Urinary urgency (R39.15)
- Weak urinary stream (R39.12)

When coding N39.0, Urinary tract infection, site not specified, it should be noted that the criteria for establishing a diagnosis by the provider are not the same criteria used to code UTI on the MDS or to place the resident on the infection control listing.

To code UTI on the MDS, the following criteria must be met:

- Item 12300, Urinary tract infection (UTI)
  - The UTI has a lookback period of 30 days for active disease instead of seven days.
  - **Code only if both of the following are met in the past 30 days:**
    1. It was determined that the resident has a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the past 30 days; **AND**
    2. A physician (or a nurse practitioner, physician assistant, or clinical nurse specialist, if allowable under state licensure laws) documented UTI diagnosis in the past 30 days.

To include on the infection control surveillance, the facility uses its established standard, typically McGeer or Loeb.

It is possible for a UTI to appear on the facility diagnosis list, even though it is not coded on the MDS or infection surveillance logs.

ICD-10-CM Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00–Q99)

Note: Codes from this chapter are not for use on maternal records.

Excludes2: Inborn errors of metabolism (E70–E88)

This chapter contains the following blocks:

Q00–Q07	Congenital malformations of the nervous system
Q10–Q18	Congenital malformations of eye, ear, face, and neck
Q20–Q28	Congenital malformations of the circulatory system
Q30–Q34	Congenital malformations of the respiratory system
Q35–Q37	Cleft lip and cleft palate
Q38–Q45	Other congenital malformations of the digestive system
Q50–Q56	Congenital malformations of genital organs
Q60–Q64	Congenital malformations of the urinary system
Q65–Q79	Congenital malformations and deformations of the musculoskeletal system
Q80–Q89	Other congenital malformations
Q90–Q99	Chromosomal abnormalities, not elsewhere classified

The coding guidelines instruct us to do the following:

- Assign an appropriate code(s) from categories Q00–Q99, Congenital malformations, deformations, and chromosomal abnormalities, when a malformation/deformation or chromosomal abnormality is documented. A malformation, deformation, or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.
- When a malformation/deformation or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

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associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

h. Death NOS

Not used in the SNF

i. NIHSS Stroke Scale

The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).

At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

See Section I.B.14 for NIHSS stroke scale documentation by clinicians other than patient's provider.

Author's note: The NIHSS is not typically used in the SNF setting, as use of I63 codes is not appropriate in the SNF unless:

- The stroke occurred in the SNF
- The stroke was diagnosed in the SNF
- All care and treatment is provided in the SNF

Once the resident is evaluated at the emergency room or clinic, I63 cannot be used by the SNF.

Table S-T.4: Impact on NTA

The following diagnosis codes from Chapter 19 provide additional points for the NTA portion of the rate.

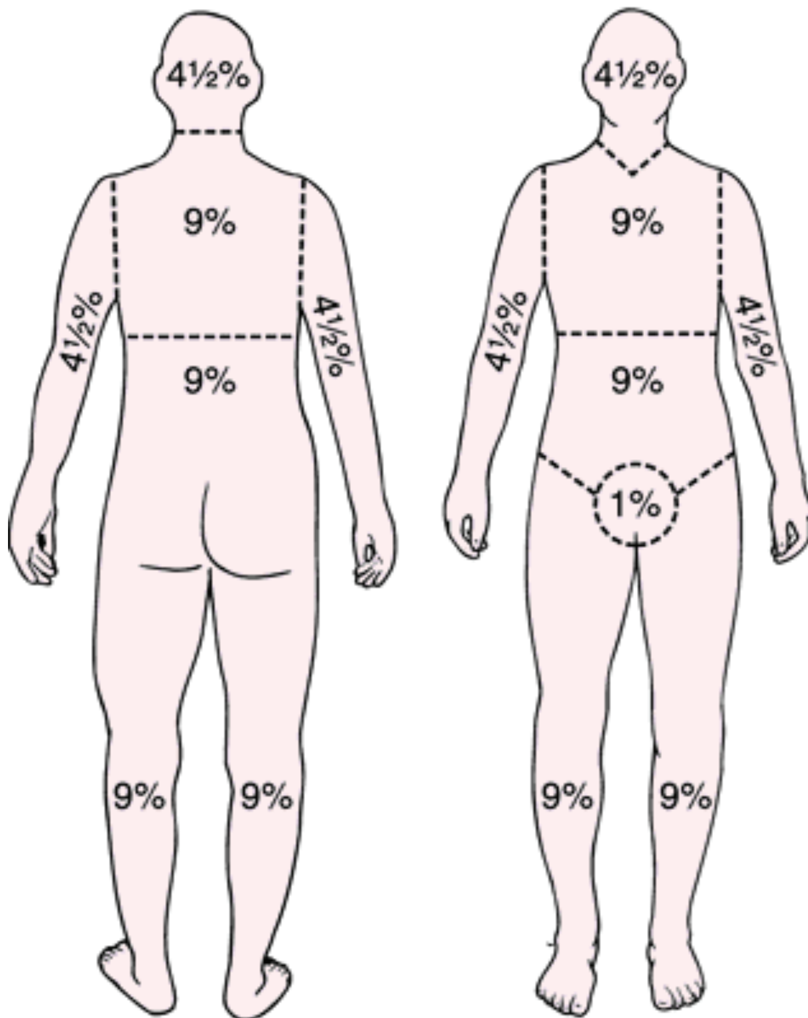
ICD-10-CM Code	**ICD-10-CM Code Description Lung Transplant Status (3 points)**
T8630–T8639	Complication of heart-lung transplant
T86810–T86819	Complication of lung transplant
ICD-10-CM Code	**ICD-10-CM Code Description Major Organ Transplant Not Lung (2 points)**
T8600–T8609	Complication of bone marrow transplant
T8610–T8619	Complication of kidney transplant
T8620–T86299	Complication of heart transplant
T8630–T8639	Complication of heart-lung transplant
T8640–T8649	Complication of liver transplant
T865	Complications of stem cell transplant
T86850–T86859	Complication of Intestine transplant
ICD-10-CM Code	**ICD-10-CM Code Description Complications of Specified Implanted Device or Graft (1 point)**
	The codes identified in the clinical mapping tool in this area all end in the seventh character A (initial encounter) as the SNF would never be treating the initial encounter for these situations; they have not been included in this table.
T86842	Corneal transplant infection
ICD-10-CM Code	**ICD-10-CM Code Description Severe Skin Burn or Condition (1 point)**
L1230	Acquired epidermolysis bullosa, unspecified
L1231	Epidermolysis bullosa due to drug
L1235	Other acquired epidermolysis bullosa
ICD-10-CM Code	**ICD-10-CM Code Description Severe Skin Burn or Condition (1 point)**
L511	Stevens-Johnson syndrome
L512	Toxic epidermal necrolysis [Lyell]
L513	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome
T311x–T3199	Burns involving % of body surface and % of third degree
T3211–T3299	Corrosions % of body surface with % third degree corrosion

Figure S-T.1: Rule of Nines

Author's note:

Burns are identified based on the rule of nines:

9% Entire head
9% Complete left arm
9% Complete right arm
9% Entire chest
9% Entire abdomen
18% Complete back
1% Groin
18% Complete left leg
18% Complete right leg



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There are indicators on the MDS that indicate conditions that may impact the nursing CMG, such as the following:

Extensive Services

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident

Special Care Low

K0510B1 or K0510B2	Feeding tube
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

Clinically Complex

O0100C2	Oxygen therapy while a resident
O0100A2	Chemotherapy while a resident

Official Coding Guidelines

21. ICD-10-CM Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z Codes in Any Healthcare Setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

b. Z Codes Indicate a Reason for an Encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

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CHAPTER

4

SNF Operations

The Patient-Driven Payment Model (PDPM) will provide an additional revenue stream to the skilled nursing facility (SNF) for provision of skilled nursing services. Under Resource Utilization Groups (RUG), the highest-weighted case-mix index (CMI) resulted in the payment; this was therapy in most situations. PDPM will not only recognize the therapy components of the rate but will also recognize comorbidities via the nontherapy ancillary portion of the rate and nursing via a RUGs-based case mix group.

The PDPM payment change is resulting in a financial incentive to increase the acuity of care being provided in the SNF. The definition of *daily skilled services* has not changed under PDPM.

30.6 - Daily Skilled Services Defined

(Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially

a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

30.2.1 - Skilled Services Defined

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

A patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

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A SNF's Guide to

ICD-10 Coding and Operations Under PDPM

Theresa A. Lang, RN, BSN, WCC

A SNF's Guide to ICD-10 Coding and Operations Under PDPM is the go-to guide for ensuring proper reimbursement under the Patient-Driven Payment Model (PDPM). This book includes chapter-specific coding guidelines, featuring examples and language specific to SNFs, with an instructional guide on how specific coding will map to PDPM clinical categories and its impact on non-therapy ancillary billing. Written by MDS expert Theresa A. Lang, RN, BSN, WCC, an AHIMA-approved ICD-10 trainer with years of experience serving as a SNF reimbursement specialist, this guide understands what MDS coordinators and other staff need to know about ICD-10 coding and operations.

With this guide, ensure your facility never loses money through inaccurate diagnosis coding. This guide reviews PDPM, coding conventions with examples SNFs are familiar with, and all coding guidelines that relate to SNFs. As a bonus, Lang also reviews how SNFs need to change their operations under PDPM.

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