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

Theresa A. Lang, RN, BSN, WCC
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About the Author

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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.
PDPM Snapshot

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:

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

**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*. 
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.
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 Alphabetic 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)
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.
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
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.

### 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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>Cancer</td>
</tr>
<tr>
<td>Nonsurgical; Orthopedic/Musculoskeletal</td>
<td>Pulmonary</td>
</tr>
<tr>
<td>Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)</td>
<td>Cardiovascular and Coagulations</td>
</tr>
<tr>
<td>Acute Infections</td>
<td>Acute Neurologic</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Nonorthopedic Surgery</td>
</tr>
</tbody>
</table>

### Table L.2: Unspecified RTP Codes

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L97301</td>
<td>Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin</td>
</tr>
<tr>
<td>L97302</td>
<td>Non-pressure chronic ulcer of unspecified ankle with fat layer exposed</td>
</tr>
<tr>
<td>L97303</td>
<td>Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle</td>
</tr>
<tr>
<td>L97304</td>
<td>Non-pressure chronic ulcer of unspecified ankle with necrosis of bone</td>
</tr>
<tr>
<td>L97305</td>
<td>Non-pressure chronic ulcer of unspecified ankle with muscle involvement without evidence of necrosis</td>
</tr>
<tr>
<td>L97306</td>
<td>Non-pressure chronic ulcer of unspecified ankle with bone involvement without evidence of necrosis</td>
</tr>
<tr>
<td>L97308</td>
<td>Non-pressure chronic ulcer of unspecified ankle with other specified severity</td>
</tr>
<tr>
<td>L97309</td>
<td>Non-pressure chronic ulcer of unspecified ankle with unspecified severity</td>
</tr>
<tr>
<td>L97804</td>
<td>Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone</td>
</tr>
<tr>
<td>L97805</td>
<td>Non-pressure chronic ulcer of other part of unspecified lower leg with muscle involvement without evidence</td>
</tr>
<tr>
<td>L97806</td>
<td>Non-pressure chronic ulcer of other part of unspecified lower leg with bone involvement without evidence</td>
</tr>
<tr>
<td>L97808</td>
<td>Non-pressure chronic ulcer of other part of unspecified lower leg with other specified severity</td>
</tr>
<tr>
<td>L97809</td>
<td>Non-pressure chronic ulcer of other part of unspecified lower leg with unspecified severity</td>
</tr>
</tbody>
</table>
### 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:

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

<table>
<thead>
<tr>
<th>Major Joint Replacement or Spinal Surgery</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonsurgical Orthopedic/Musculoskeletal</td>
<td>Pulmonary</td>
</tr>
<tr>
<td>Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)</td>
<td>Cardiovascular and Coagulations</td>
</tr>
<tr>
<td>Acute Infections</td>
<td>Acute Neurologic</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Nonorthopedic Surgery</td>
</tr>
</tbody>
</table>

**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.
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.

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Code Description Lung Transplant Status (3 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T8630–T8639</td>
<td>Complication of heart-lung transplant</td>
</tr>
<tr>
<td>T86810–T86819</td>
<td>Complication of lung transplant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Code Description Major Organ Transplant Not Lung (2 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T8600–T8609</td>
<td>Complication of bone marrow transplant</td>
</tr>
<tr>
<td>T8610–T8619</td>
<td>Complication of kidney transplant</td>
</tr>
<tr>
<td>T8620–T86299</td>
<td>Complication of heart transplant</td>
</tr>
<tr>
<td>T8630–T8639</td>
<td>Complication of heart-lung transplant</td>
</tr>
<tr>
<td>T8640–T8649</td>
<td>Complication of liver transplant</td>
</tr>
<tr>
<td>T865</td>
<td>Complications of stem cell transplant</td>
</tr>
<tr>
<td>T86850–T86859</td>
<td>Complication of Intestine transplant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Code Description Complications of Specified Implanted Device or Graft (1 point)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>T86842</td>
<td>Corneal transplant infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Code Description Severe Skin Burn or Condition (1 point)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1230</td>
<td>Acquired epidermolysis bullosa, unspecified</td>
</tr>
<tr>
<td>L1231</td>
<td>Epidermolysis bullosa due to drug</td>
</tr>
<tr>
<td>L1235</td>
<td>Other acquired epidermolysis bullosa</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Code Description Severe Skin Burn or Condition (1 point)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L511</td>
<td>Stevens-Johnson syndrome</td>
</tr>
<tr>
<td>L512</td>
<td>Toxic epidermal necrosis [Lyell]</td>
</tr>
<tr>
<td>L513</td>
<td>Stevens-Johnson syndrome-toxic epidermal necrosis overlap syndrome</td>
</tr>
<tr>
<td>T311x–T3199</td>
<td>Burns involving % of body surface and % of third degree</td>
</tr>
<tr>
<td>T3211–T3299</td>
<td>Corrosions % of body surface with % third degree corrosion</td>
</tr>
</tbody>
</table>
Figure S-T.1: Rule of Nines

Author’s note:
Burns are identified based on the rule of nines:
9% Entire head                                      18% Complete back
9% Complete left arm                                1% Groin
9% Complete right arm                               18% Complete left leg
9% Entire chest                                     18% Complete right leg
9% Entire abdomen
There are indicators on the MDS that indicate conditions that may impact the nursing CMG, such as the following:

### Extensive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O0100E2</td>
<td>Tracheostomy care while a resident</td>
</tr>
<tr>
<td>O0100F2</td>
<td>Ventilator or respirator while a resident</td>
</tr>
</tbody>
</table>

### Special Care Low

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0510B1 or K0510B2</td>
<td>Feeding tube</td>
</tr>
<tr>
<td>O0100B2</td>
<td>Radiation treatment while a resident</td>
</tr>
<tr>
<td>O0100J2</td>
<td>Dialysis treatment while a resident</td>
</tr>
</tbody>
</table>

### Clinically Complex

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O0100C2</td>
<td>Oxygen therapy while a resident</td>
</tr>
<tr>
<td>O0100A2</td>
<td>Chemotherapy while a resident</td>
</tr>
</tbody>
</table>

**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.
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.
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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