PDPM
Patient Driven Payment Model Overview with common coding errors
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Objectives:

- Explain how the PDPM per diem rate is calculated
- Understand the 5 case mix adjusted components of the PDPM daily rate
- Understand composition of the HIPPS code & how it translates to a daily rate for the SNF
- Explain the variable per diem adjustment schedule for the PT, OT and NTA components
- Describe effects of the variable per diem adjustment schedule
- Understand use of the Interim Payment Assessment
- Define the interrupted stay policy
- Understand requirements for the PPS 5 day assessment
- Describe correct use of the Part A PPS Discharge

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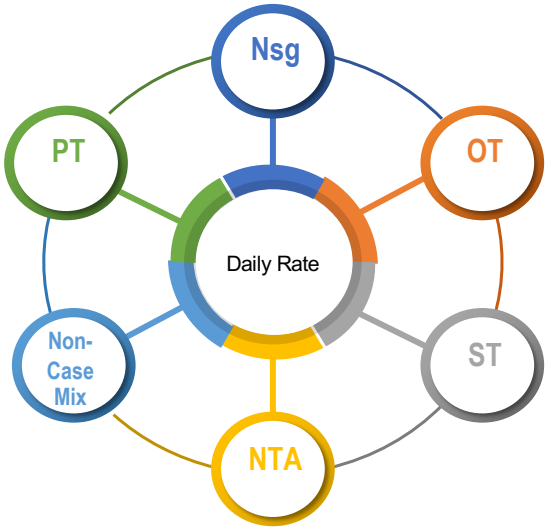
Daily rate has 5 case mix adjusted components, based on coding of PPS MDS*



PT and OT components are identical, but each has a separate CMI.

Six actual components

Set rate

*B20 HIV/AIDs on SNF claim = 8 NTA points & 18% added to nursing component rate

3

PDPM payment components

5 (really 4) case-mix adjusted components that need to be managed

1 Nsg

2 NTA

Most complex
Most money

3 PT, OT

Very simple
Identical computation
Some money

4 SLP

A few items that need to be managed
Some money

Non-Case Mix

Flat rate added on

4

5 case-mix adjusted components are sub-divided into different final case mix groups, based on cost of care for items coded on MDS.

PT/OT 16 CMG

TA
TB
TC
TD
TE
TF
TG
TH
TI
TJ
TK
TL
TM
TN
TO
TP

SLP 12 CMG

SA
SB
SC
SD
SE
SF
SG
SH
SI
SJ
SK
SL

Nsg 25 CMG

ES3	CDE2
ES2	CDE1
ES1	CBC2
HDE2	CA2
HDE1	CBC1
HBC2	CA1
HBC1	BAB2
LDE2	BAB1
LDE1	PDE2
LBC2	PDE1
LBC1	PBC2
	PA2
	PBC1
	PA1

NTA 6 CMG

NA
NB
NC
ND
NE
NF

Patients in each category are clinically similar and are expected to use the same level of resources. Each major component uses different items to compute the case mix index for that component.

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MDS Completion to SNF Payment

Complete PPS MDS → HIPPS Code Daily rate → Claim → MAC Applies VPD & other adjustments → $ to SNF

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code: K E K D 1

B. Version code: 2 . 1 0 0 0

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATES / HIPPS CODE	45 SERV. DATE
0022	Room and Board	KEKD1	011623

Other Adjustments:
Urban/rural
Labor cost
Quality Reporting Program penalty
Value Based Purchasing Incentive

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Effect of CMI on Base Rate

Example

	Base Rate	CMI	Component Rate
PT	66.06	1.48	97.76
OT	61.49	1.50	92.24
SLP	24.66	1.77	43.65
NSG	115.15	1.81	208.42
NTA	86.88	1.33	110.71
Non-Case Mix	103.12	---	115.55

FY 2023 Urban Unadjusted rates
Not adjusted for labor cost or VBP multiplier

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Why monitoring your actual rates is more important than monitoring CMI

- $24.66 X 1.77 = $43.56
- $115.15 x 1.77 = $203.81

1. Watch nursing and NTAs
2. PT/OT take care of themselves once you get primary diagnosis, surgery and function score correct.
3. SLP needs managing, but it's not first.

	Base Rate
PT	66.06
OT	61.49
SLP	24.66
NSG	115.15
NTA	86.88
Non-Case Mix	103.12

FY 2023 Urban Unadjusted rates
Not adjusted for labor cost or VBP multiplier

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Variable Per Diem Adjustment Schedule

Component	Rate Triples days 1 - 3	Reduce 2% every 7 days starting on day 21	No VPD
PT		✓	
OT		✓	
SLP			✓
Nursing			✓
NTA	✓		
Non-Case Mix			✓

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Per Diem Rate Days 1 - 3

	Component CMI Rate		VPD Factor		Per Diem Rate
PT	95.49		1		94.30
OT	90.06		1		88.95
SLP	15.94		---		15.94
NSG	202.59		---		200.09
NTA	110.71		**3**		**332.13**
Non-Case Mix	98.07		---		98.07

Example Unadjusted rates
Not adjusted for labor cost or VBP multiplier

Total Per Diem Days 1 – 3: 829.52

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Per Diem Rate Days 4-20

	Component CMI Rate	VPD Factor	Per Diem Rate
PT	95.49	1	94.30
OT	90.06	1	88.95
SLP	15.94	---	15.94
NSG	202.59	---	200.09
NTA	110.71	**1**	**110.71**
Non-Case Mix	98.07	---	98.07

Example Urban Unadjusted rates
Not adjusted for labor cost or VBP multiplier

Total Per Diem Days 4-20: $608.06

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Per Diem Rate Days 21-27

	Component CMI Rate	VPD Factor	Per Diem Rate
PT	95.49	.98	93.58
OT	90.06	.98	88.26
SLP	15.94	---	15.94
NSG	202.59	---	200.09
NTA	110.71	**1**	**110.71**
Non-Case Mix	98.07	---	98.07

Example Unadjusted rates
Not adjusted for labor cost or VBP multiplier

Total Per Diem Days 4-20: 606.65

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Recap

1. PPS 5 day MDS results in a HIPPS code that translates to an urban or rural daily rate
2. VPB (variable per diem) applied for applicable SNF days
3. Wage Index adjustment applied
4. VBP adjustment (value based purchasing multiplier) applied
5. MAC sends payment for dates of service on claim to the SNF

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PDPM Assessment Schedule

Medicare Assessment Type	ARD	Medicare Payment Days
PPS 5 Day	Days 1 – 8	All Part A days though discharge (unless IPA completed), daily rate subject to the variable per diem adjustment schedule
Interim Payment Assessment (IPA)	Optional: may be completed by providers in order to report a change in the resident's PDPM classification. (GG-13)	ARD of IPA through Part A discharge (unless subsequent IPA completed)
PPS Discharge	• Last covered day (stand-alone) • Physical Discharge (if correctly combined with OBRA Discharge)	NA

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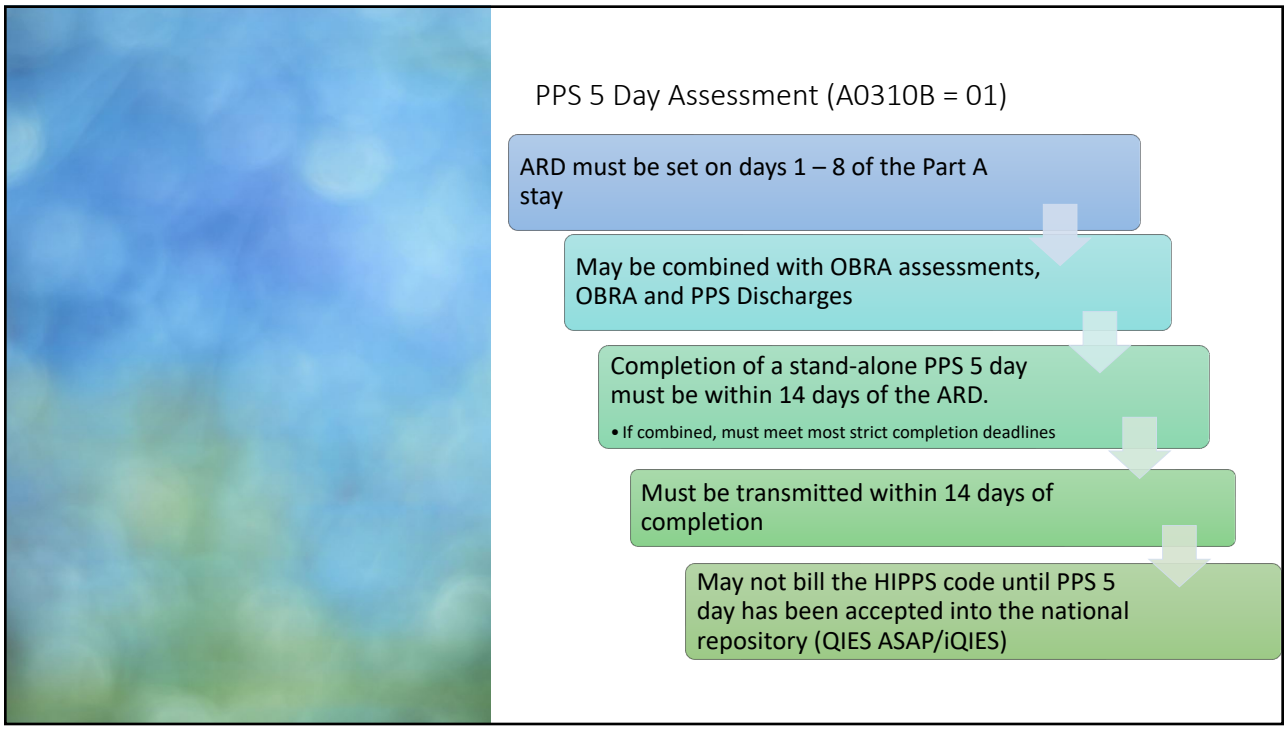

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Part A PPS Discharge (A0310H = 1)

- Required when Part A coverage ends for the purpose of calculating Skilled Nursing Facility Quality Reporting Program (SNF-QRP) quality measures.
- Two scenarios:
  1. Resident has a last covered day and remains long term
  2. Resident discharged from the SNF when Part A ends
- Never, ever do a Part A PPS Discharge along with a Death in Facility Tracking record.
  - SNF stays that end in death are not counted in the SNF-QRP measures.
  - If you do a Part A PPS DC and a DIF tracking record, you are including that stay in the QRP measures, and it won't look as good.

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Resident has a last covered day and remains long term

- Required: Part A PPS Discharge* that is not combined with an OBRA discharge
  - It may be combined with any OBRA assessment

Resident discharged from facility when Part A ends

- When the Part A stay ends on the day of physical discharge, or one day before the day of physical discharge, must complete Part A PPS Discharge combined with an OBRA discharge

In both these cases, combine OBRA DC with Part A PPS DC*

April 10	April 11
Last covered day	Physical discharge

April 10	April 11
Last covered day & physical discharge	

* Never do a Part A PPS DC for an ***interrupted stay*** (will be explained shortly)

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6.8 Non-compliance with the SNF PPS Assessment Schedule

- To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.
  - No PPS 5 Day, no payment, with exceptions
- Assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance.
- Frequent late assessment scheduling practices or missing assessments may result in additional review.
- The default rate (ZZZZZ) takes the place of the otherwise applicable Federal rate. It is equal to the sum of the rate paid for the case-mix group reflecting the lowest acuity level under each PDPM component.

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Missed Assessment

If the SNF fails to set the ARD of a PPS assessment prior to the end of the last day of the ARD window, and the resident is no longer a SNF Part A resident, and as a result a PPS assessment does not exist in the QIES ASAP system for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP system.

When a PPS assessment does not exist in the QIES ASAP system, there is not a HIPPS code the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid PPS assessment that is accepted into the QIES ASAP system. The provider must bill the HIPPS code that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, a PPS assessment may not be performed.

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2.12 Factors Impacting SNF PPS Assessment Scheduling

Resident Expires Before or On the Eighth Day of SNF Stay

- If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The provider must also complete a Death in Facility Tracking Record (and no Part A PPS Discharge)

Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay

- Same as above, just do a Part A PPS DC (& maybe combine with OBRA DC if required)

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Missed Assessment

However, there are instances when the SNF may bill the default code when a PPS assessment does not exist in the QIES ASAP system. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

Chapter 6

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ARD Outside the Medicare Part A SNF Benefit

- A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment.
- For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his or her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the HIPPS code associated with the assessment.

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Interrupted Stay is a Medicare Part A stay in which a resident is discharged from Part A & resumes care in same SNF for a Part A stay before midnight of day 3 after the last day billed to Medicare A

- No PPS 5 day allowed
- No Part A PPS Discharge allowed
- IPA is allowed but never mandatory
- The PPS MDS that was paying prior to the interruption takes up payment wherever it was on the variable per diem adjustment schedule

Chapter 2, Sec 2.5

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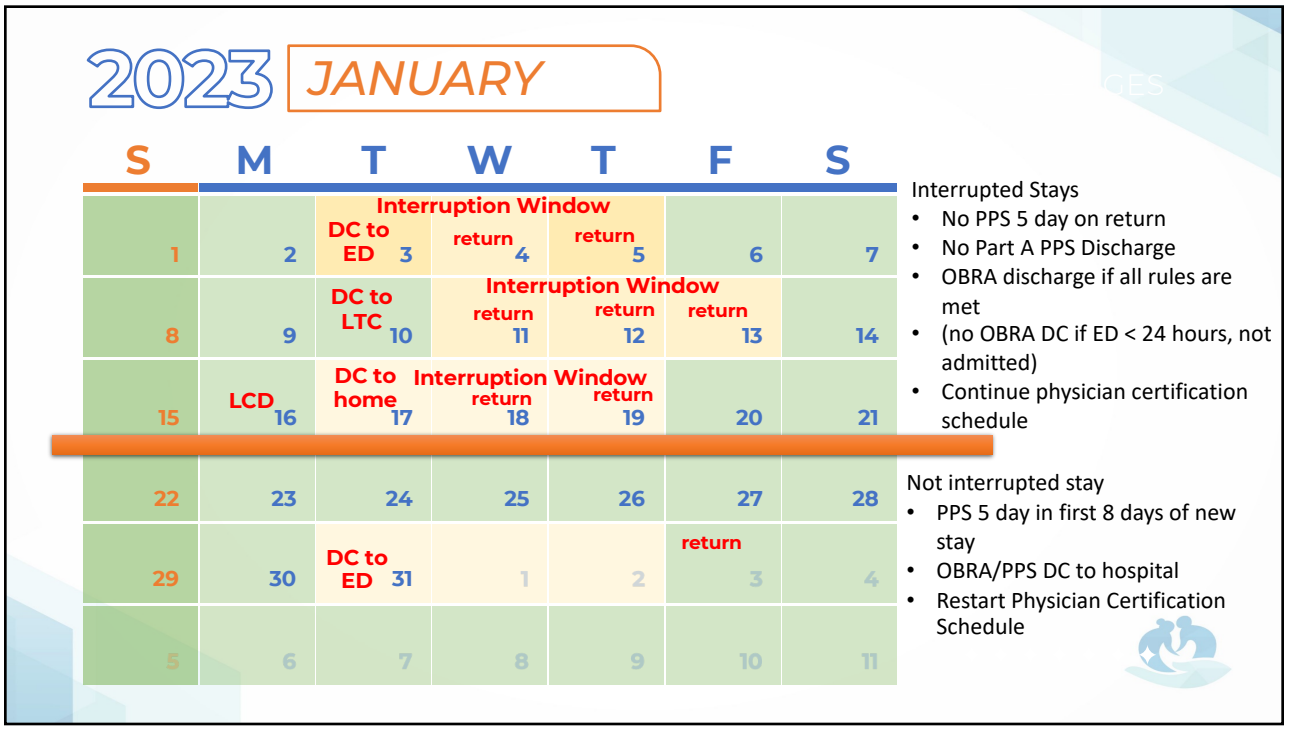
2023 JANUARY
S M T W T F S
Interruption Window
DC to ED 3
return 4
return 5
DC to LTC 10
Interruption Window
return 11
return 12
return 13
LCD 16
DC to home 17
Interruption Window
return 18
return 19
DC to ED 31
return
Interrupted Stays
• No PPS 5 day on return
• No Part A PPS Discharge
• OBRA discharge if all rules are met
• (no OBRA DC if ED < 24 hours, not admitted)
• Continue physician certification schedule
Not interrupted stay
• PPS 5 day in first 8 days of new stay
• OBRA/PPS DC to hospital
• Restart Physician Certification Schedule

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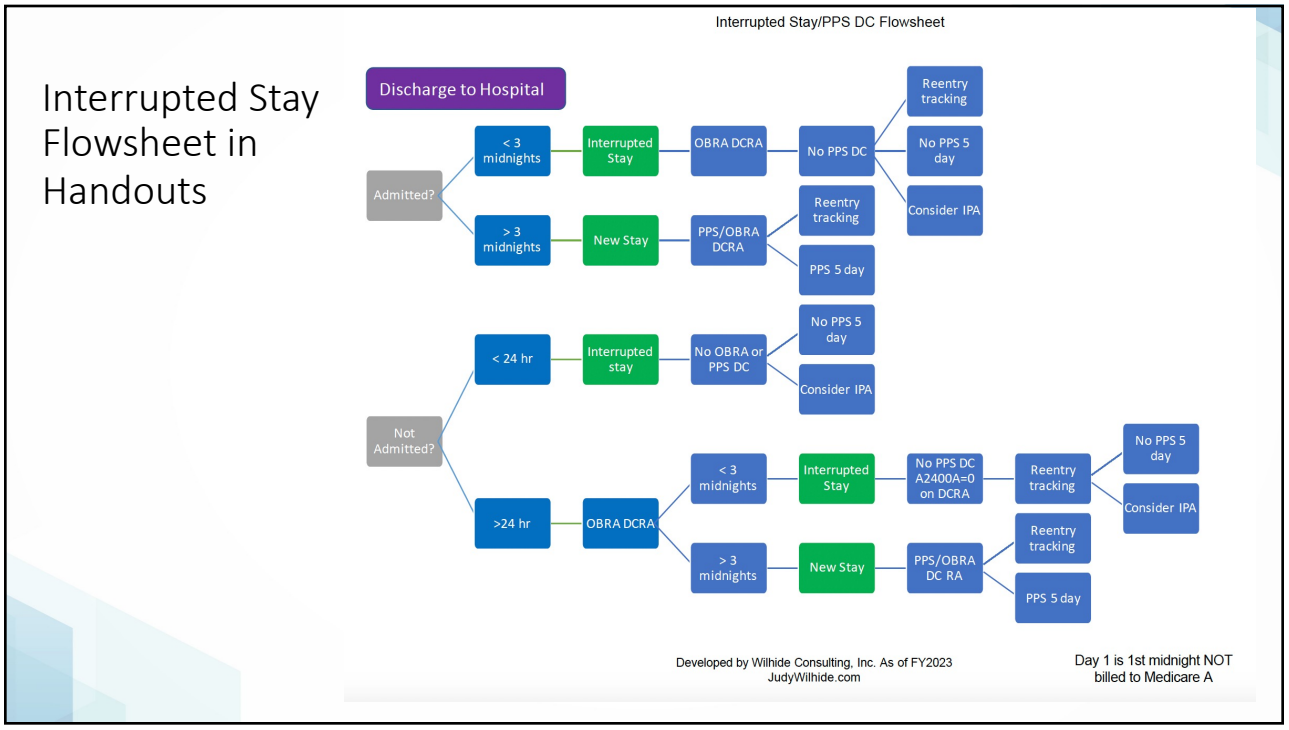
Interrupted Stay Flowsheet in Handouts
Interrupted Stay/PPS DC Flowsheet
Discharge to Hospital
Admitted?
< 3 midnights
Interrupted Stay
OBRA DCRA
No PPS DC
Reentry tracking
No PPS 5 day
Consider IPA
> 3 midnights
New Stay
PPS/OBRA DCRA
Reentry tracking
PPS 5 day
Not Admitted?
< 24 hr
Interrupted stay
No OBRA or PPS DC
No PPS 5 day
Consider IPA
>24 hr
OBRA DCRA
< 3 midnights
Interrupted Stay
No PPS DC A2400A=0 on DCRA
Reentry tracking
No PPS 5 day
Consider IPA
> 3 midnights
New Stay
PPS/OBRA DC RA
Reentry tracking
PPS 5 day
Developed by Wilhide Consulting, Inc. As of FY2023
JudyWilhide.com
Day 1 is 1st midnight NOT billed to Medicare A

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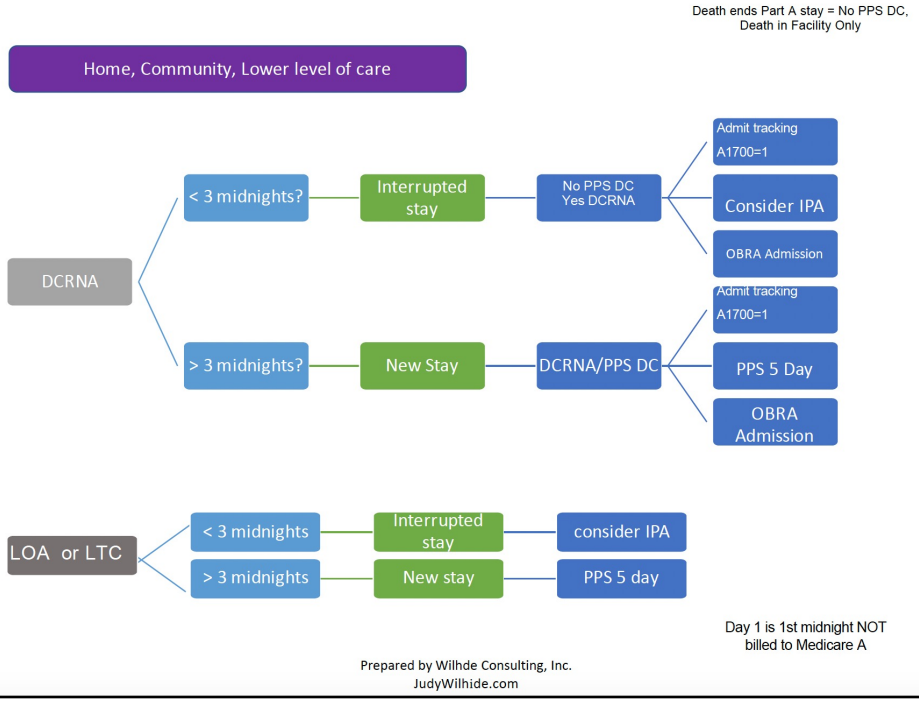
Interrupted Stay Flowsheet in Handouts



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HIPPS Code

Health Insurance Prospective Payment System

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code:

N	H	N	C	1		

- Each SNF claim contains a five-position **HIPPS code in Z0100** for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC).
  - HIPPS code comes directly from the PPS MDS, either PPS 5 day or IPA
- The HIPPS code consists of four codes representing the resident's PDPM classification directly from certain item coding on the PPS MDS.
  - These four codes are all associated with a daily rate.
  - 1st: PT/OT
  - 2nd: SLP
  - 3rd: Nsg
  - 4th: NTA
  - 5th: AI Code

HIPPS code guides on PDPM All in One Tip sheet in handouts

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PDPM Explained

How MDS coding translates into the payment rate

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The Function Score: Section GG

- A team of clinicians, using clinical judgement, determines a resident's baseline functional performance from independent to dependent in selected activities of daily living in Section GG
- The function score is used in setting three PDPM components:
  - PT
  - OT
  - Nursing
- Nursing Function Score uses three fewer data elements than PT/OT
- The PT/OT and Nursing Function Score are used to set final case mix group
- Heavier care does not mean more money

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Section GG *Function Score* Data Elements:

PT and OT components
10 ADL Activities for final score based on 5 functional areas

Eating	GG0130A1 Eating
Oral Hygiene	GG0130B1 Oral Hygiene
Toileting Hygiene	GG0130C1 Toileting Hygiene
Average Bed Mobility	GG0170B1 Sit to Lying
	GG0170C1 Lying to Sitting on Side of Bed
Average Transfer	GG0170D1 Sit to Stand
	GG0170E1 Chair/Bed-to-Chair
	GG0170F1 Toilet Transfer
Average Walking	GG0170J1 Walk 50 Feet with Two Turns
	GG0170K1 Walk 150 Feet

Nursing component
7 ADL Activities for final score based on 4 functional areas

Eating	GG0130A1 Eating
Toileting Hygiene	GG0130C1 Toileting Hygiene
Average Bed Mobility	GG0170B1 Sit to Lying
	GG0170C1 Lying to Sitting on Side of Bed
Average Transfer	GG0170D1 Sit to Stand
	GG0170E1 Chair/Bed-to-Chair
	GG0170F1 Toilet Transfer

Oral Hygiene and Walking in OT/PT only

Start of PPS Stay Section GG on PPS 5 day MDS
IPA Interim Payment Assessment

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Section GG Responses	Function Score
Independent or Set-up (05,06)	4
Supervision or touching assistance (04)	3
Partial/moderate assistance (03)	2
Substantial/maximal assistance (02)	1
Dependent, refused, N/A or cannot walk (01,07,09,10, 88 or "could not walk 10 feet") (GG0170H = any code for "not attempted" 07,07,11,88), missing value	0

PT/OT Function Score Range 0 – 24
Nursing Function Score Range 0 - 16

Higher score = greater independence

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Function Score must be supported in clinical record

- Gather documented info from therapy and nursing in 3-day look-back periods.
- Write reconciliation note justifying coding in GG
- If not supported, MAC will bring PT, OT and Nursing down to lowest payment within the component group.
- Function score must be accurate, whether good, bad or indifferent. It's important for the outcomes measures
  - Not like the old ADL score where more assistance always meant more money.

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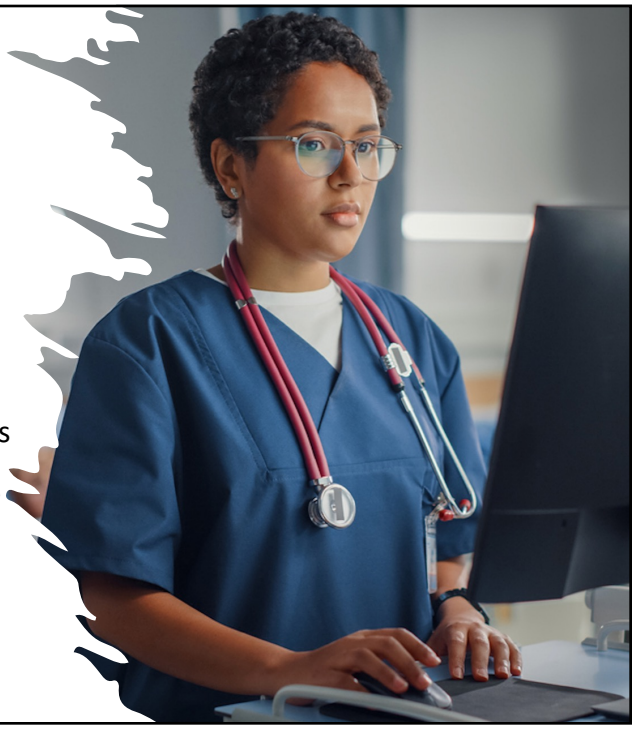
Example Reconciliation Note:

Based on direct observation, resident/family self-reports, reports from qualified clinicians, direct care staff, as documented in the resident's medical record during the three-day assessment period for the [PPS 5 day/IPA/PPS DC] with ARD {date}. There were conflicting reports of functional status for some activities. The IDT discussed these discrepancies and, using the coding guidance in the current RAI manual, determined true baseline status for this look-back period. This note affirms an IDT of qualified clinicians has determined the baseline functional status as coded on this MDS assessment in Section GG0130 and GG0170.

-Signature of an RN, PT, OT or SLP (qualified clinician)



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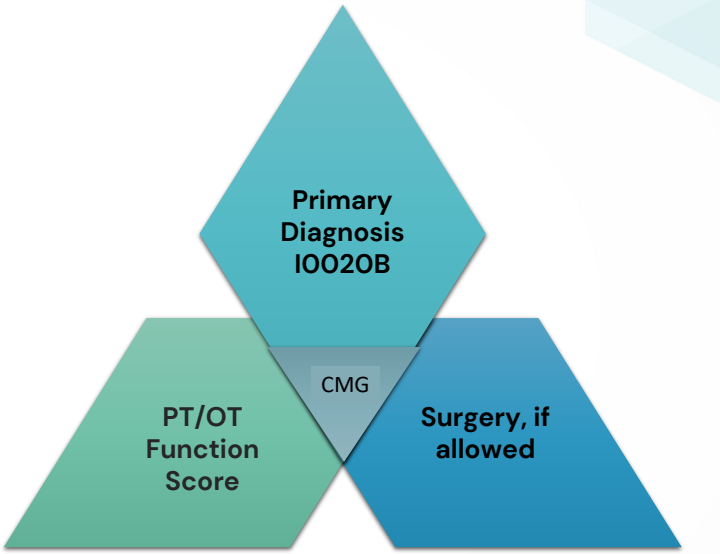
PT/OT Component
Case Mix Group Elements



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PT/OT Category	Function Score	CMG	PT CMI	OT CMI	HIPPS
1 Major Joint Replacement & Spinal Surgery	0-5	TA	1.49	1.45	A
	6-9	TB	1.65	1.59	B
	10-23	TC	1.83	1.64	C
	24	TD	1.87	1.49	D
2 Other Ortho	0-5	TE	1.38	1.37	E
	6-9	TF	1.57	1.56	F
	10-23	TG	1.62	1.60	G
	24	TH	1.13	1.12	H
4 Medical Management	0-5	TI	1.10	1.15	I
	6-9	TJ	1.38	1.41	J
	10-23	TK	1.48	1.50	K
	24	TL	1.06	1.08	L
3 Non-Ortho Surgery & Acute Neurologic	0-5	TM	1.24	1.26	M
	6-9	TN	1.44	1.46	N
	10-23	TO	1.51	1.51	O
	24	TP	1.05	1.06	P

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I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code

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

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. **Medically Complex Conditions**

I0020B. ICD Code

- 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 ICD code for that condition, including the decimal.
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

Assigning a diagnosis code must be done using techniques required by the official ICD-10 Coding Guidelines found in an ICD 10 Coding Manual

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Primary diagnosis code + surgery checkbox,(if mapping tool allows) = Clinical Category

ICD-10-CM Code	Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
Z48811	Encounter for surgical aftercare following surgery on the nervous system	Medical Management	N/A
Z48812	Encounter for surgical aftercare following surgery on the circulatory system	Medical Management	N/A
S72001D	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with r	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
J13	Pneumonia due to Streptococcus pneumoniae	Pulmonary	N/A
I10	Essential (primary) hypertension	Return to Provider	N/A

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

If Default Clinical Category = Return to Provider, you may not use it as primary

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- **Surgery must:**
  - **Be related to primary diagnosis in I0020B**
  - **Have occurred during inpatient stay that immediately preceded SNF admission**
  - **Within 30-day look-back of ARD**
  - **Carry some degree of risk to the resident's life or the potential for severe disability.**

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08	
Enter Code ☐	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**

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Example:

I0020B. ICD Code

S	7	2	.	0	0	1	D

Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing

1. No surgery: Other Ortho
2. Surgery to repair but not replace joint: Other Ortho
3. Hip replacement surgery: Major Joint Repl & Spinal Surgery

Reminder: Z47.1 Aftercare for Joint Replacement may not be used if the replacement was due to a fracture

Major Joint Replacement
J2300. Knee Replacement - partial or total
J2310. Hip Replacement - partial or total
J2320. Ankle Replacement - partial or total
J2330. Shoulder Replacement - partial or total
Spinal Surgery
J2400. Involving the spinal cord or major spinal nerves
J2410. Involving fusion of spinal bones
J2420. Involving lamina, discs, or facets
J2499. Other major spinal surgery
Other Orthopedic Surgery
J2500. Repair fractures of the shoulder (including clavicle and scapula)
J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot
J2520. Repair but not replace joints
J2530. Repair other bones (such as hand, foot, jaw)
J2599. Other major orthopedic surgery
Neurological Surgery
J2600. Involving the brain, surrounding tissue or blood vessels (excl
J2610. Involving the peripheral or autonomic nervous system - open
J2620. Insertion or removal of spinal or brain neurostimulators, elec
J2699. Other major neurological surgery
Cardiopulmonary Surgery
J2700. Involving the heart or major blood vessels - open or percutane
J2710. Involving the respiratory system, including lungs, bronchi, tr
J2799. Other major cardiopulmonary surgery
Genitourinary Surgery
J2800. Involving male or female organs (such as prostate, testes, ovari
J2810. Involving the kidneys, ureters, adrenal glands, or bladder - op nephrostomies or urostomies)
J2899. Other major genitourinary surgery
Other Major Surgery
J2900. Involving tendons, ligaments, or muscles
J2910. Involving the gastrointestinal tract or abdominal contents fr pancreas, or spleen - open or laparoscopic (including creation o
J2920. Involving the endocrine organs (such as thyroid, parathyroid),
J2930. Involving the breast
J2940. Repair of deep ulcers, internal brachytherapy, bone marrow
J5000. Other major surgery not listed above

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Primary Diagnosis Clinical Category errors

- Choosing the highest paying diagnosis in I0020b, that is not the primary reason
- Checking wrong surgery/not checking surgery
- Not reconciling function score
- ICD-10 coding errors
- Choosing the primary diagnosis by 1 person without discussion with provider/Nurse Management/IDT
- Not being willing to change what you had to "put in to get the chart open"
- Not communicating the primary diagnosis to direct care nursing or therapy staff for focused charting.

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R55 Syncope and collapse Medical Management

RTP Discussion

Sometimes the primary diagnosis isn't clear at all, due to RTP

Falling
Failure to thrive
Weakness

What is the medical condition most likely to cause these things?

Cardiovascular?
Pulmonary?
Endocrine?
Malnutrition?

Discuss with provider, therapists, carefully read complete medical records

R55: Syncope and Collapse = Medicare Management, Ensure this in on H&P diagnosis list

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Step 1	Step 2 SLP Category			
Service Count: Acute Neuro, SLP Comorbidity, Cognitive Impairment	Mech. Altered Diet or S/S Swallow Disorder	CMG	CMI	HIPPS
None	Neither	SA	0.66	A
	Either	SB	1.77	B
	Both	SC	2.60	C
Any One	Neither	SD	1.42	D
	Either	SE	2.28	E
	Both	SF	2.90	F
Any Two	Neither	SG	1.98	G
	Either	SH	2.78	H
	Both	SI	3.43	I
Any Three	Neither	SJ	2.91	J
	Either	SK	3.60	K
	Both	SL	4.10	L

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Tier One Points: 0 - 3

Tier 1 Point: Acute Neurologic:
Same as PT and OT, based on SNF Primary Diagnosis Clinical Category

Tier 1 Point: SLP related co-morbidity
Very short list of diagnosis codes, included in handouts (entire list in handouts)

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia (I69-)
I8000	Dysphagia (I69-)
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits (I69-)
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

Tier 1 Point: Cognitive Impairment:

BIMS ≤ 12
OR
At least mild impairment in Staff Assessment for Mental Status: (any **one**)

1. Cognitive skills for daily decision making: modified independence or worse
2. Makes self understood: usually or worse
3. ST Memory Problem: yes

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

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Tier 2: Neither, Either Both

Swallowing Disorder:

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

In last 7 days or since admission did any of these happen at least once:

- K0100A, loss of liquids/solids from mouth when eating or drinking.
- K0100B, holding food in mouth/cheeks or residual food in mouth after meals.
- K0100C, coughing or choking during meals or when swallowing medications.
- K0100D, complaints of difficulty or pain with swallowing.

Mechanically Altered diet while resident

K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last **7 days**

1. While NOT a Resident: Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident: Performed ***while a resident*** of this facility and within the ***last 7 days***	1. While NOT a Resident	2. While a Resident
	Check all that apply	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

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Common errors

Not training direct care staff to monitor, report & document K0100 issues

Not supporting B0700, C0700, C1000 when used for cognition

Not doing the BIMs per RAI manual instructions

Not capturing SLP comorbidities

Not knowing what the SLP comorbidities are

Selecting an Acute Neuro dx from your list when it's not really primary

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TBI

- Not capturing I5500 TBI when diagnostic imaging shows brain injury
  - Intracranial hematoma, contrecoup
  - TBI is caused by a bump, blow, or jolt to the head that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. The severity of a TBI may range from "mild" (i.e., a brief change in mental status or consciousness) to "severe" (i.e., an extended period of unconsciousness or memory loss after the injury). Most TBIs that occur each year are mild, commonly called concussions. (brainline.org)
- Falls and being struck by object are leading causes of TBI (brainline.org)

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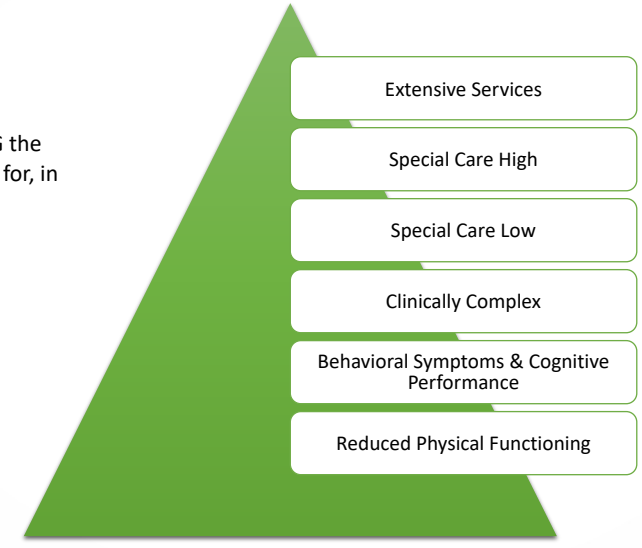
Nursing Case Mix Group (CMG)

Refer to PDPM All in One Guide in Handouts

Hierarchy: First CMG the assessment qualifies for, in the hierarchy, will be assigned.



NFS = Nursing Function Score

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Nursing Case Mix Groups

If HIPPS is R or below, may be missing opportunities to include setting ARD closer to admission

PDPM Nursing Categories

Extensive Services	Qualifiers	CMG	CMI	HIPPS
Nursing function score must be 0 - 14. If 15 or 16, will group to Clinically Complex.	Trach Care (O0100F2) AND Ventilator (O0100F2) both while resident	ES3	4.06	A
	Trach Care (O0100F2) OR Ventilator (O0100F2) while resident	ES2	3.07	B
	Isolation for active infection (O0100M2) while resident	ES1	2.93	C

Special Care High (If NFS 15 or 16 will be Clinically Complex)	NFS	Depression*	CMG	CMI	HIPPS
Comatose (B0100) & NFS dependent or did not occur[1]	0-5	Yes	HDE2	2.4	D
Septicemia (I2100)	0-5	No	HDE1	1.99	E
Diabetes (I2900) + 7 days Insulin Inj (N0350A) + >= 2 days insulin Rx changes (N0350B)	6-14	Yes	HBC2	2.24	F
	6-14	No	HBC1	1.86	G
Quadraplegia (I5100) + NFS <= 11	*Depression = Score >=10 on PHQ-9 (D0300) or PHQ-9OV(D0600)				
COPD (I6200) + SOB lying flat (J1100C)	[1]GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88				
Parental/IV Feeding while OR while not resident (K0150A1 or 2)	[2]Tube feeding classification requirements:				
Fever (J1550A) + one of the following: pneumonia (J2000) or vomiting (J1550B) or wt loss (K0300 = 1 or 2) or tube feeding (K0510B1 or 2)[2]	(1) K0710A3 is 51% or more of total calories OR (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.				
Respiratory Therapy x 7 days (O0400D2 = 7)					

Special Care Low (If NFS 15 or 16 will be Clinically Complex)	NFS	Depression*	CMG	CMI	HIPPS
NFS <= 11 and any one: Cerebral Palsy (M400) OR Multiple Sclerosis (I5200) OR Parkinson's Disease (I5300)	0-5	Yes	LDE2	2.08	H
	0-5	No	LDE1	1.73	I
Respiratory failure (I6300) AND oxygen while resident (O0100C2)	6-14	Yes	LBC2	1.72	J
Tube Feeding[2]	6-14	No	LBC1	1.43	K
2+ St 2 pressure ulcers AND 2+ qualifying skin treatments[2]	*Depression = Score >=10 on PHQ-9 (D0300) or PHQ-9OV(D0600)				
St 3 (M0300C1) OR st 4 (M0300D1) OR slough/eschar(M0300F1) AND 2+ qualifying skin tx[2]	[2]Tube feeding classification requirements: (1) K0710A3 is 51% or more of total calories OR (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.				
2+ venous/arterial ulcers AND 2+ selected skin tx[2]					
1 st 2 pressure ulcer (M0300B1) AND 1 venous/arterial ulcer (M1030) w/ 2+ skin tx[2]					
Foot infection (M1040A), diabetic foot ulcer(M1040B) or other open lesion of foot(M1040C) with application of dressings to the feet (M1200I)	[2]Selected skin tx: M1200A,B pressure relief bed/chair**; M1200C Turn/repo, M1200D nut/hydrat;M1200E PU care; M1200G dsg not to feet; M1200H ointment not to feet				
Radiation while res (O0100B2) OR Dialysis while res (O0100J2)	**count as 1 if both coded				

Clinically Complex (If NFS 15 or 16, then Ext Svc, SC hi, SC lo will group here)	NFS	Depression*	CMG	CMI	HIPPS
Pneumonia (I2100)	0-5	Yes	CDE2	1.87	L
Hemiplegia (I4900) AND NFS <=11	0-5	No	CDE1	1.62	M
Open lesions (M1040D) with any selected skin treatment[3]	6-14	Yes	CBC2	1.55	N
Surgical wound (M1040E)	15-16	Yes	CA2	1.09	O
Burns (M1040F)	6-14	No	CBC1	1.34	P
Chemo while resident (O0100A2)	15-16	No	CA1	0.94	Q
Oxygen while resident (O0100C2)	*Depression = Score >=10 on PHQ-9 (D0300) or PHQ-9OV(D0600)				
IV med while resident (O0100H2)	[3]Selected Skin Tx: M1200F Surg wound care, M1200G Nonsurg dsg, M1200H ointments/med				
Transfusion while resident (O0100I2)					

Behavioral Symptoms and Cognitive Performance (any one)*	NFS	BNP**	CMG	CMI	HIPPS
BIMS Score (C0500) <=9 OR cog impair via staff assmt[4]	11-16	Yes	BAB2	1.04	R
Hallucinations (E0100A) or Delusions (E0100B)	11-16	No	BAB1	0.99	S
E0200A,B,C Physical, verbal or other behavior sym(Coded 2 or 3)	[4]See page 6-13 RAI Manual, *If NFS <11 Reduced Phys. Function				
E0800 Reject care OR E0900 Wandering (Coded 2 or 3)	**Two qualifying restorative programs, See page 6-26 RAI Man				

Reduced Physical Function	NFS	RNP	CMG	CMI	HIPPS
Only Nursing Function Score + Qualifying RNP	0-5	Yes	PDE2	1.57	T
RNP: 2 programs, 6 days week, 15 min/day	0-5	No	PDE1	1.47	U
See Page 6-13 RAI Manual for qualifying restorative programs	6-14	Yes	PBC2	1.22	V
	6-14	No	PA2	0.70	W
	15-16	Yes	PBC1	1.13	X
	15-16	No	PA1	0.66	Y

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HIPPS A, B, C

While a resident

Extensive Services with NFS <14:

A — Trach AND Vent → ES3

B — Trach OR Vent → ES2

C — Isolation for Active Infectious Disease → ES1

Must have the infection, remain in room, all services in room, transmission-based precautions

If NFS 15 or 16, will group to Clinically Complex

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Special Care High CMG Qualifiers

HIPPS D,E,F,G

- Comatose & NFS Completely dependent or did not occur
- Septicemia
- Diabetes w/daily Insulin inj & Insulin Rx changes on ≥ 2 days
- Quadriplegia & NFS ≤ 11
- I6200: Asthma, COPD, or chronic lung disease & SOB lying flat (J1100C)
- IV Fluid (while or while not a resident)
- Respiratory Therapy 7 days
- Fever & 1:
  - Pneumonia
  - Weight Loss
  - Qualifying Feeding Tube all 7 days:
    - >=51% calories
    - 26-50% calories & 501cc fluid

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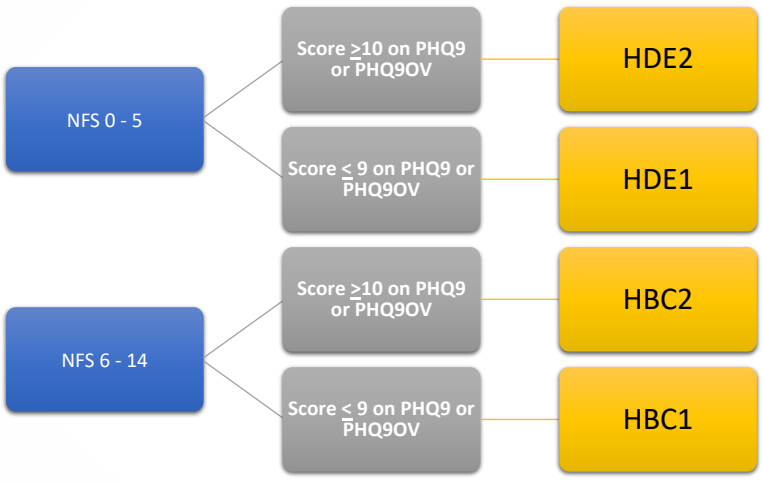
Special Care High



If FS 15 or 16, will group to Clinically Complex

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Special Care High Errors

- Not setting ARD on day 3,4 or 5 to capture:
  - Hospital IV Fluid
  - Septicemia
  - MDRO
  - Pneumonia
- Not capturing fever of 100.4 on admit
- Not capturing(or supporting) SOB lying flat with I6200: COPD, asthma, chronic lung disease
- Not realizing everything that can be captured in I6200

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Special care Low Part I

If NFS 15 or 16, groups to Clinically Complex

HIPPS H, I, J, K

- Cerebral Palsy & NFS ≤ 11
- Multiple Sclerosis & NFS ≤ 11
- Parkinson's Disease & NFS ≤ 11
- Qualifying Tube Feeding (entire 7 days)
- Foot Infection, Diabetic foot ulcer, or open lesions on foot w/ dressings to feet.
- Radiation therapy while resident.
- Respiratory Failure and Oxygen therapy while resident.
- Dialysis while resident.

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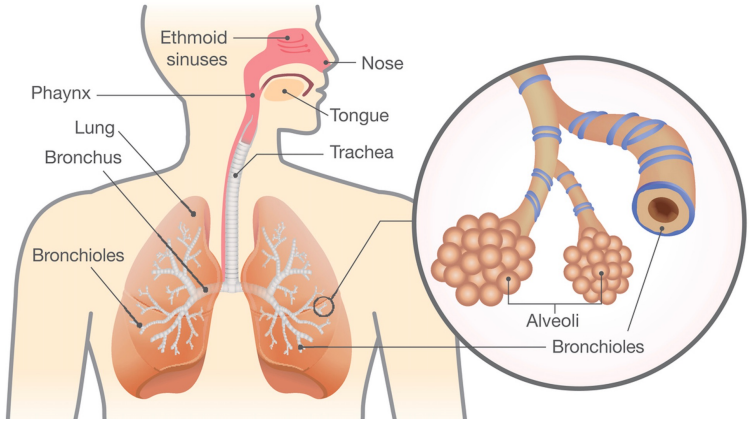
Managing Special Care Low

Let's talk about "Respiratory Failure"

COPD
CHF
Pneumonia
Covid



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Respiratory Failure American College of Physicians

- Chronic respiratory failure contributes significantly to the severity level, complexity and costs of care.
- Many patients with severe COPD also have **chronic respiratory failure**. If a patient is admitted for an this, always look for findings consistent with chronic respiratory failure. Typically, they require supplemental home oxygen therapy, so the ***diagnosis should be strongly considered for any patient using home oxygen.***
- Even if the patient's chronic respiratory failure is stable, unchanged or at baseline, it should be documented in the medical record as a significant comorbid condition that needs to be coded
- -*Richard D. Pinson,* MD, FACP, CDIP, CCS*, American College of Physicians, ACP Weekly, March 2011*

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Oxygen Use: Query the provider

What causes chronic respiratory failure?

- Certain lung diseases can cause chronic respiratory failure. Conditions that affect the way in which the brain, muscles, bones, or surrounding tissues support breathing can also cause chronic respiratory failure.
- Diseases and conditions that commonly lead to chronic respiratory failure include:
  - chronic obstructive pulmonary disease (COPD)
  - pneumonia (acute and/or chronic)
  - spinal cord injuries
  - stroke
  - muscular dystrophy
  - ALS (Lou Gehrig's disease)
  - injury to the chest
  - drug or alcohol misuse
  - Smoking
  - CHF (Acute and/or chronic)

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Respiratory Failure

- When diagnosed, ALWAYS
  - Check I6300 AND use ICD-10-CM diagnosis code in I8000
    - I6300 + oxygen while resident is Special Care Low
    - Respiratory failure diagnosis code is 1 NTA point

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Special Care Low Part 2

- >=2 Stage 2 PU & >=2 skin treatments
- >=1 Stage III, IV, or unstageable slough/eschar PU & >=2 skin treatments
- >=2 venous/arterial ulcers & >=2 skin treatments
- 1 St II PU & 1 venous/arterial ulcer & >=2 skin treatments.

Qualifying skin tx

- Pressure relieving chair or bed* (count as 1)
- Turning/repositioning
- Nutrition or hydration intervention
- Ulcer care
- Application of dressings (not to feet)
- Application of ointments (not to feet)

JudyWilhide.com 59

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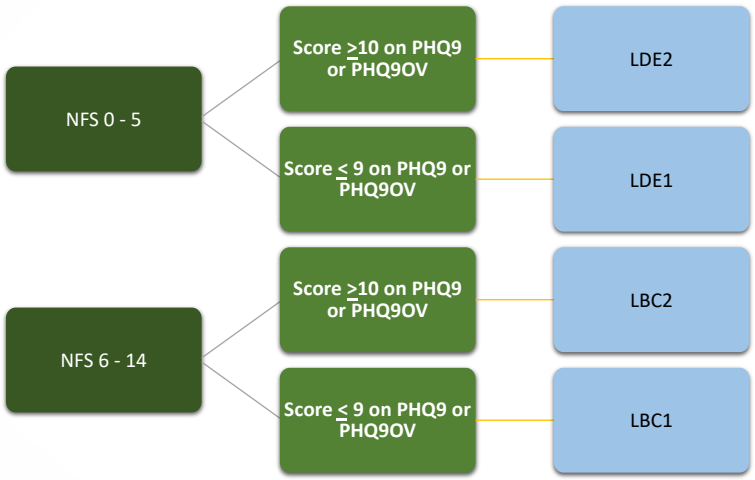
Special Care Low



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Special Care Low Errors

- Pressure Ulcers and other skin conditions in SC low coding on MDS do not match chart documentation for 7-day look-back period.
- Not following RAI manual instructions for coding pressure ulcers and other skin conditions

Example of obscure coding tips

Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.

If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.

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Special Care Low Errors

Coding turning/repositioning without following RAI manual guidance

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

TURNING/ REPOSITIONING PROGRAM

Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

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Clinically Complex: Any NFS Score
Depression End Split 10 PHQ9/OV

HIPPS L, M, N, O, P, Q

Extensive Services, Special Care High or Low with NFS score >14
Pneumonia
Hemiplegia/Hemiparesis and NFS ≤ 11
Surgical wounds or open lesions w/treatment
Burns
Chemotherapy while resident
Oxygen therapy while resident
IV Medications while resident
Transfusions while resident

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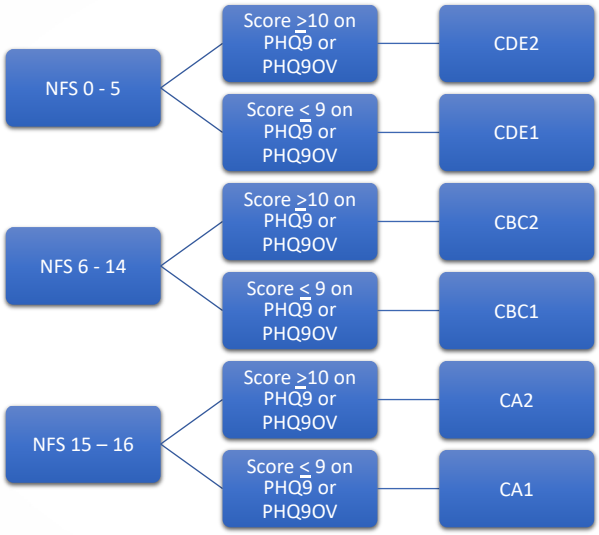
Clinically Complex



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Clinically Complex Errors

- Coding Oxygen Use without provider query for respiratory failure
- Not coding M1040D Open lesions correctly.

M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do **not** code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
- Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

Note: IV med while resident is 5 NTA points. Always do IPA if not captured on 5 day.

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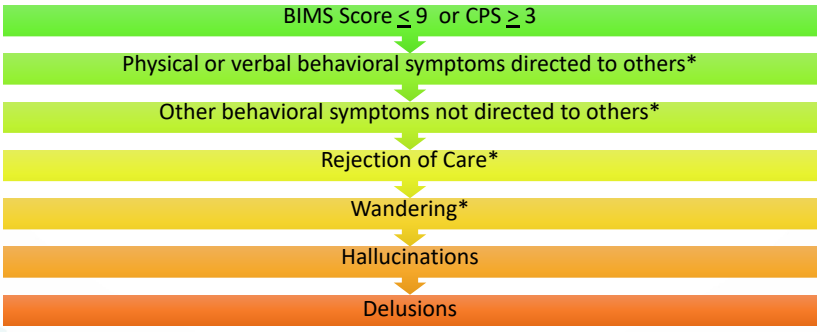
Behavioral Symptoms & Cognitive Performance

Any 1:



*≥ 4 days

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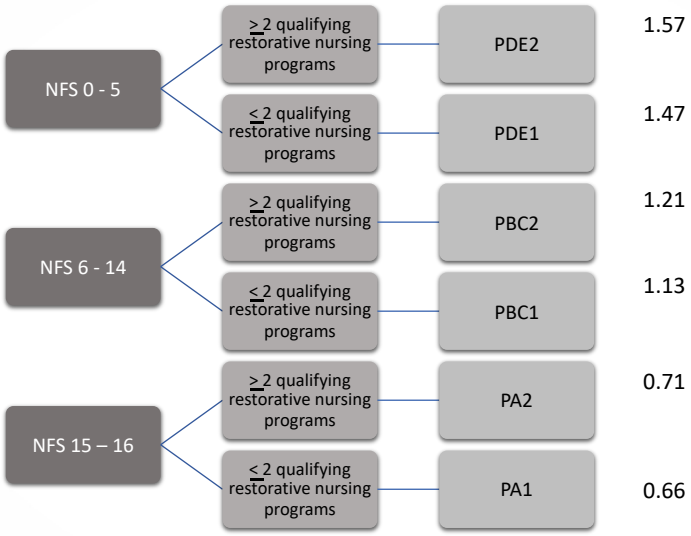
Reduced Physical Function



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50 categories used to set NTA Comorbidity Score

- 24 items on MDS
- 26 ICD 10 CM Code categories ≈ 1500 ICD10CM codes
- Items/codes do not have equal value
- More points = higher CMI, up to 12

Certain diagnoses and clinical services are indicative of higher NTA costs

NTA Category			
Score	CMG	CMI	HIPPS
12+	NA	3.24	A
9-11	NB	2.53	B
6-8	NC	1.84	C
3-5	ND	1.33	D
1-2	NE	0.96	E
0	NF	0.72	F

NTA Handout

Complete list of Dx codes on CMS Clinical Category Mapping Spreadsheet

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NTA Items	MDS Item	Points
HIV/AIDS Diagnosis Code B20	N/A (SNF claim)	8
3 - 7 Points Each		
MDS coded Items		
Parenteral IV Feeding: Level High: IV fluid while resident ≥ 51% of calories	K0510A2, K0710A2	7
Intravenous Medication While Resident	O0100H2	5
Ventilator or Respirator While Resident	O0100F2	4
Parenteral IV feeding: Level Low IV fluid while resident ≥ 26% calories **AND** 501 cc fluid	K0510A2, K0710A2, K0710B2	3
ICD 10 Code Categories		
Lung Transplant Status	I8000	3
2 Points Each		
MDS Coded Items		
Wound Infection	I2500	2
Diabetes Mellitus (DM)	I2900	2
Multiple Sclerosis	I5200	2
Asthma COPD Chronic Lung Disease	I6200	2
Transfusion While Resident	O0100I2	2
ICD 10 Code Categories		
Major Organ Transplant Status, Except Lung	I8000	2
Opportunistic Infections	I8000	2
Bone/Joint/Muscle Infections/Necrosis - Not Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
1 Point Each		
MDS Coded Items		
Ostomy	H0100C	1
Intermittent catheterization	H0100D	1
Ulcerative Colitis, Crohn's Disease, Irritable Bowel Disease	I1300	1
Multi-Drug Resistant Organism (MDRO)	I1700	1
Malnutrition or Risk of Malnutrition	I5600	1
Feeding Tube while a resident	K0510B2	1

NTA Guide Handouts

1 Point Each		
MDS Coded Items		
Foot Infection OR Diabetic Foot Ulcer OR Other Open Lesion on Foot	M1040A, M1040B, M1040C	1
Tracheostomy Care While Resident	O0100E2	1
Radiation While Resident	O0100B2	1
Isolation While Resident	O0100M2	1
Suctioning While Resident	O0100D2	1
Stage 4 Pressure Ulcer present ≥ 0, 1 NTA point no matter how many	M0300D1	1
ICD 10 Code Categories		
Immune Disorders	I8000	1
Disorders of Immunity - Except Immune Disorders	I8000	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Cirrhosis of Liver	I8000	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Morbid Obesity	I8000	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Diabetic Retinopathy not proliferative	I8000	1
Complications of Specified Implanted Device or Graft	I8000	1
Aseptic Necrosis of Bone	I8000	1
Endocarditis	I8000	1
Cardio-Respiratory Failure and Shock	I8000	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1

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PDPM ICD-10-CM Mappings FY2021

Purpose	ICD-10-CM related mappings for the purposes of resident classification under the Patient-Driven Payment Model (PDPM) for Medicare Part A SNF stays.

Table of Contents

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

Comorbidity Description	RxCC/CC	ICD-10-CM Code	ICD-
Cirrhosis of Liver	CC28	K7030	Alcoholic cirrhosis of liver without ascites
Cirrhosis of Liver	CC28	K7031	Alcoholic cirrhosis of liver with ascites
Cirrhosis of Liver	CC28	K7040	Alcoholic hepatic failure without coma
Cirrhosis of Liver	CC28	K7041	Alcoholic hepatic failure with coma
Cirrhosis of Liver	CC28	K709	Alcoholic liver disease, unspecified
Cirrhosis of Liver	CC28	K743	Primary biliary cirrhosis
Cirrhosis of Liver	CC28	K744	Secondary biliary cirrhosis
Cirrhosis of Liver	CC28	K745	Biliary cirrhosis, unspecified
Cirrhosis of Liver	CC28	K7460	Unspecified cirrhosis of liver
Cirrhosis of Liver	CC28	K7469	Other cirrhosis of liver

Example: Cirrhosis category

Overview | Clinical_Categories_By_Dx | SLP_Comorbidity | NTA_Comorbidity | +

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM

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Common NTA Dx codes

J9600	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J9601	Acute respiratory failure with hypoxia
J9602	Acute respiratory failure with hypercapnia
J9610	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J9611	Chronic respiratory failure with hypoxia
J9612	Chronic respiratory failure with hypercapnia
J9620	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J9621	Acute and chronic respiratory failure with hypoxia
J9622	Acute and chronic respiratory failure with hypercapnia
J9690	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
J9691	Respiratory failure, unspecified with hypoxia
J9692	Respiratory failure, unspecified with hypercapnia

E6601	Morbid (severe) obesity due to excess calories
E662	Morbid (severe) obesity with alveolar hypoventilation
Z6841	Body mass index [BMI]40.0-44.9, adult
Z6842	Body mass index [BMI] 45.0-49.9, adult
Z6843	Body mass index [BMI] 50.0-59.9, adult
Z6844	Body mass index [BMI] 60.0-69.9, adult
Z6845	Body mass index [BMI] 70 or greater, adult

M8600	Acute hematogenous osteomyelitis, unspecified site
M86011	Acute hematogenous osteomyelitis, right shoulder
M86012	Acute hematogenous osteomyelitis, left shoulder
M86019	Acute hematogenous osteomyelitis, unspecified shoulder
M86021	Acute hematogenous osteomyelitis, right humerus
M86022	Acute hematogenous osteomyelitis, left humerus
(Any location, very long list)	

Decimal point goes after first 2 characters

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Common NTA checkboxes

Wound Infection	I2500	2
Diabetes Mellitus (DM)	I2900	2
Asthma COPD Chronic Lung Disease	I6200	2
Multi-Drug Resistant Organism (MDRO)	I1700	1
Malnutrition or Risk of Malnutrition	I5600	1

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NTA errors

- Not knowing what the NTAs are when reading a clinical record
  - Success depends on studying the NTA mapping tool
- Not adding NTA ICD-10 code to I8000
- Not checking MDS box for NTA when it is supported in record
- Not having dietitian assess risk for malnutrition upon admission and querying provider for diagnosis
- Not knowing the difference between Irritable bowel syndrome and Irritable bowel disease
- Not capturing MDRO, due to: not getting/reading records
- Not querying provider for morbid obesity diagnosis
- Coding Pulmonary Fibrosis and other chronic lung disorders in I8000 (1 NTA) but not checking I6200: asthma, COPD, chronic lung disease (2 NTA)

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I6200: Asthma, COPD, Chronic Lung Disease

- Selected Pulmonary Fibrosis and Other **Chronic Lung Disorders**
- **If chronic lung disorder, check I6200: Asthma, COPD and chronic lung disorder and use ICD-10 code in I8000 for NTA point (If on list here)**

B4481	Allergic bronchopulmonary aspergillosis
J470	Bronchiectasis with acute lower respiratory infection
J471	Bronchiectasis with (acute) exacerbation
J479	Bronchiectasis, uncomplicated
J700	Acute pulmonary manifestations due to radiation
J701	Chronic and other pulmonary manifestations due to radiation
J702	Acute drug-induced interstitial lung disorders
J703	Chronic drug-induced interstitial lung disorders
J704	Drug-induced interstitial lung disorders, unspecified
J8410	Pulmonary fibrosis, unspecified
J84111	Idiopathic interstitial pneumonia, not otherwise specified
J84112	Idiopathic pulmonary fibrosis
J84113	Idiopathic non-specific interstitial pneumonitis
J84114	Acute interstitial pneumonitis
J84115	Respiratory bronchiolitis interstitial lung disease
J84116	Cryptogenic organizing pneumonia
J84117	Desquamative interstitial pneumonia
J8417	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
J842	Lymphoid interstitial pneumonia
J8481	Lymphangioleiomyomatosis
J8489	Other specified interstitial pulmonary diseases
J849	Interstitial pulmonary disease, unspecified
J99	Respiratory disorders in diseases classified elsewhere
M3213	Lung involvement in systemic lupus erythematosus

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Review:

- PPS Payment depends on:
  - Medical complexity
  - Ability and willingness of staff to thoroughly research every condition the resident may have
  - Buy in by providers to thoroughly exam and document all relevant diagnoses and conditions
  - Big money is in Nursing and NTA components

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- Questions/Discussion

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