Navigating North Dakota's PDPM Transition for Medicaid

Sustainable change…begins with Coretactics!

September 24, 2025

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Sarah is the Vice President of Clinical Reimbursement / Education & Training for Coretactics™ Healthcare Consulting, Inc. A national speaker with more than 25 years of experience in healthcare, Sarah is an expert in management and analysis of publicly reported quality measures, reimbursement, ICD 10 diagnostic criteria, appeals & insurance denials and regulatory compliance. By sharing her vast knowledge, Sarah provides guidance in MDS 3.0 accuracy, quality improvement and reimbursement practices. Her many years in long-term care provide the understanding required for effective interdisciplinary team development, sustainable program development, quality assurance, CMS publicly reported quality measures, reimbursement and MDS completion.

Having served as an Appeals Coordinator, Sarah works with facilities to address Medicare, Medicaid and insurance denials and has developed programs for billing and corporate compliance. Her passion for teaching brings a supportive approach in enabling interdisciplinary teams to improve quality and reimbursement outcomes.

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Coretactics™ is dedicated to raising skilled nursing facilities (SNFs) to a new level of excellence. Through customization of evidence-based practices, process enhancement, education and side-by-side training, Coretactics' consultants will guide your interdisciplinary team to positive outcomes in quality of care, regulatory compliance and accurate reimbursement.

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1. Understand a detailed breakdown of how each PDPM component (PT, OT, SLP, Nursing, and NTA services) is calculated and influenced by documentation.
2. Review best practices for collecting and verifying ICD-10 codes to accurately reflect a resident's clinical profile to support PDPM and clinical decision making.
3. Become familiar with techniques for improving interdepartmental communication and coordination to ensure all relevant information is captured on the MDS.
4. Ensure per diem Medicaid rates accurately capture the clinical complexity and needs of residents.
5. Reduce risk of audit scrutiny by ensuring documentation and coding are consistent and comprehensive.

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Making the transition…

Out with the old RUGs model…	In with the "new" PDPM model…
Volume based	Focus on Clinical Characteristics
Revolves around allocation of therapy minutes	Diagnostic Accuracy
Uses old Section G ADL documentation	Overall Care Needs

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New guidelines effective Jan. 1, 2026

NORTH Dakota | Health & Human Services

- New submission requirements for MDS to NDHSS for PDPM classifications.
- The OSA must continue to be submitted to set classifications through Dec. 31, 2025. You may need to set an ARD for the OSA after Jan. 1, 2026, depending on the admission date.

Example- Admission date 12/27/2025
-OSA with ARD 1/2 through 1/9/26 for RUG IV classification 12/27 – 12/31/25
-NC or NQ with ARD 1/2 through 1/9/26 for PDPM classification 1/1 – 3/26/2026

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Submission of MDSs for PDPM

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- An MDS for PDPM must be submitted anytime the classification will cross over Jan. 1, 2026.

Example- Admission date 7/22/2023, RUG IV classification start date is 10/22/2025

-OSA with ARD 10/15 through 10/22/2025 for RUG IV classification 10/22 – 12/31/25
-NC or NQ with ARD 10/15 through 10/22/26 for PDPM classification 1/1 – 1/21/2026

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Setting the ARD

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- The ARD (A2300) must be within the acceptable time frame for the assessment.
- Only Comprehensive Item Set (NC)- Admission, Annual, or significant change assessments or Quarterly Item Set (NQ) will be used.
- Dates used in est. classification:
  - Entry Date (A1600)- establishes the start of the classification period and the assessment reference period
  - Assessment Reference Date (ARD) (A2300)- determines if the assessment will be used for classification based on the Item Set.
  - Discharge Date (A2000)

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Setting the ARD

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- To set a PDPM classification on admission or reentry, The ARD of the assessment must be between day 7 and day 14 of the Entry Date (A1600)
- The classification start date can only change with the DC from the facility (A0310F=10, for return not anticipated; or 11- return anticipated)
- When the resident returns to the facility the Entry Date (A1600) will establish the new classification start date.

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Discharge Assessments

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- DRA- Discharge Return Anticipated (A0310F=11), must be used when the bed is being held for the resident's return.
- DRNA- Discharge Return Not Anticipated (A0310F=10), must be coded when:
  - Resident is not expected to return
  - Resident is not expected to return after a DRA, or
  - The bed is not being held for the resident's return.

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Discharge:

Return Anticipated to Return Not Anticipated

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- If a res is DCRA and the facility learns the resident will NOT be returning, a second DC assessment must be submitted to change the status from DCRA (A0310F=11) to DCRNA (A0310F=10).
- The DC Date (A2000) and ARD (A2300) of the second DC assessment is the date the facility learns the resident will not be returning.
- The DCRA and DCRNA cannot have the same ARD.

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Discharge:

Return Anticipated to Return Not Anticipated

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- If a resident is DCRA and subsequently expired in the hospital, a second DC assessment with status DCRNA must be submitted with date of death as the DC date (A2000) and DC status of deceased (A2105=13).
- On the second DC assessment (DCRNA) all fields in section A must be completed, other fields may be dashed.
- **Do not send the second discharge assessment to CMS iQIES.**

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Death in Facility

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- If a resident expires in the facility, a tracking Item Set (NT) with A0310F=12, Discharge Status (A2105=13) and DC Date (A2000) will be equal to the date of death.
- A death in facility cannot follow a DCRA.

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Classifications

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- The ARD must occur within a fixed assessment reference period for an assessment to be used for classification.
- Assessments must occur within 7-14 days of admission or reentry and recur every 3 months thereafter.
- <u>Initial Classification period:</u>
  - Reference period starts on day 7 after Entry Date (A1600) through day 14.
- If multiple assessments are accepted within that reference period, the assessment with an ARD on or closets to the 14th day is used for classification.

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Classifications

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- For subsequent classification periods, the assessment reference period is the start date of the next classification period and the 7 days immediately preceding it.
- If multiple assessments are accepted with ARD during that time frame, the assessment with an ARD on or closets to the classification start date will be used for classification.
- Classifications are established every 3 months on the same day of the month as the entry date. The start date does not change based on the ARD; or with a change in payer status (i.e. Medicare to Medicaid or private pay).

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Classifications

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- When the calculated start date is not a "real" date…

Calculated Start Date	New Classification Start Date
February 30	March 1
April 31	May 1
June 31	July 1
September 31	October 1
November 31	December 1

- When multiple assessments are submitted during any classification period, the facility must take care to provide the resident with the notice that contains the classification that will be used for payment purposes.

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Classifications

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- If the resident discharges or expires prior to day 7, the classification notice will be generated after the assessment, and the ND/NT are accepted by HHS.
- **The classification notice must be provided to the resident or the resident's representative within three business days. This is required by *North Dakota Century Code 50-24.4-01.1(4)*.**
- The classification notice will contain a three digit code.

Classification Order		
	1	Speech Language Pathology (SLP)
	2	Nursing
	3	Non-Therapy Ancillaries (NTA)

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Short Stay Scenarios

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- DC Prior to Day 7
  - ND assessment using date of DC for both ARD (A2300) and SC date (A2000)
  - No Admission assessment is required; however, the assessment (NC or NQ) must have all the required fields completed for classification.
  - The classification notice will be generated when the DC assessment is accepted.

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Short Stay Scenarios

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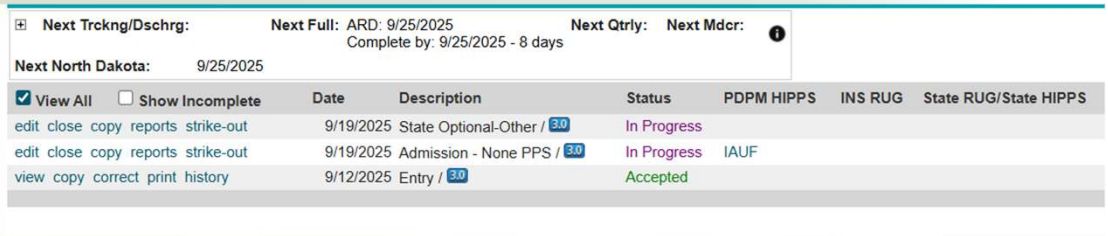
- Resident expires prior to day 7 in the facility…
  - The tracking record (NT) will be submitted with A0310F=12 and date of death will be used for SC date (A2000).
  - This NT cannot follow a DCRA.

Scheduling Practice



Entry 9/12/25- Assessment Ref Period for the initial OSA is 9/18/25 – 9/25/25. This sets classification for period 9/12 through 12/11/25.

Next subsequent assessment reference period starts 12/5 through 12/12/25. Sets classification for period 12/12 through 12/31/25 (using the OSA RUG score).

					ENTRY 9/12	2 9/13
3 9/14	4 9/15	5 9/16	6 9/17	7 9/18	Adm 8 MDS-OSA 9/19	9 9/20
10 9/21	11 9/22	12 9/23	13 9/24	14 9/25	15 9/26	16 9/27
17 9/28	18 9/29	19 9/30	20 10/1	21 10/2	22 10/3	23 10/4
24 10/5	25 10/6	26 10/7	27 10/8	28 10/9	29 10/10	30 10/11
31 10/12	32 10/13	33 10/14	34 10/15	35 10/16	36 10/17	37 10/18
38 10/19	39 10/20	40 10/21	41 10/22	42 10/23	43 10/24	44 10/25
45 10/26	46 10/27	47 10/28	48 10/29	49 10/30	50 10/31	51 11/1
52 11/2	53 11/3	54 11/4	55 11/5	56 11/6	57 11/7	58 11/8
59 11/9	60 11/10	61 11/11	62 11/12	63 11/13	64 11/14	65 11/15
66 11/16	67 11/17	68 11/18	69 11/19	70 11/20	71 11/21	72 11/22
73 11/23	74 11/24	75 11/25	76 11/26	77 11/27	78 11/28	79 11/29
80 11/30	81 12/1	82 12/2	83 12/3	84 12/4	85 12/5	86 12/6
87 12/7	88 12/8	89 12/9	90 12/10	91 12/11	Q-OSA 92 12/12	93 12/13
94 12/14	95 12/15	96 12/16	97 12/17	98 12/18	99 12/19	100 12/20

9/24/25 Core-tactics.com

Scheduling Practice

Entry 9/12/25- Assessment Ref Period for the initial OSA is 9/18/25 – 9/25/25. This sets classification for period 9/12 through 12/11/25.

Next subsequent assessment reference period starts 12/5 through 12/12/25. Sets classification for period 12/12 through 12/31/25 (using the OSA RUG score). The ND PDPM score from the 12/12 Q MDS will set the classification for period 1/1/26 through 3/11/26.

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Scheduling Practice

Next Trckng/Dschrg: Next Full: ARD Complete by: Next Qtrly: Next Mdcr:

Next North Dakota:

View All / Show Incomplete	Date	Description	Status	PDPM HIPPS	INS RUG	State RUG/State HIPPS
edit close copy reports strike-out	1/4/26	State Optional-Other / 3.0	In Progress			PB1
edit close copy reports strike-out	1/4/26	Admission - None PPS / 3.0	In Progress	IAUF		
view copy correct print history	12/28/25	Entry / 3.0	Accepted			

Entry 12/28/25- Assessment Ref Period for the initial OSA is 1/3/2026 – 1/10/26. This sets classification for period 12/28/25 through 12/31/25 using RUG IV (PB1).

The ND PDPM score (AUF) from the Admission MDS (ARD parameters apply) will set payment/classification period from 1/1/26 through 3/27/26.

9/24/25 Core-tactics.com 22

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Sun	Mon	Tue	Wed	Thurs	Fri	Sat
ENTRY 1 12/28	2 12/29	3 12/30	4 12/31	5 1/1	6 1/2	7 1/3
Adm- 8 OSA 1/4	9 1/5	10 1/6	11 1/7	12 1/8	13 1/9	14 1/10
15 1/11	16 1/12	17 1/13	18 1/14	19 1/15	20 1/16	21 1/17
22 1/18	23 1/19	24 1/20	25 1/21	26 1/22	27 1/23	28 1/24
29 1/25	30 1/26	31 1/27	32 1/28	33 1/29	34 1/30	35 1/31
36 2/1	37 2/2	38 2/3	39 2/4	40 2/5	41 2/6	42 2/7
43 2/8	44 2/9	45 2/10	46 2/11	47 2/12	48 2/13	49 2/14
50 2/15	51 2/16	52 2/17	53 2/18	54 2/19	55 2/20	56 2/21
57 2/22	58 2/23	59 2/24	60 2/25	61 2/26	62 2/27	63 2/28
64 3/1	65 3/2	66 3/3	67 3/4	68 3/5	69 3/6	70 3/7
71 3/8	72 3/9	73 3/10	74 3/11	75 3/12	76 3/13	77 3/14
78 3/15	79 3/16	80 3/17	81 3/18	82 3/19	83 3/20	84 3/21
85 3/22	86 3/23	87 3/24	88 3/25	89 3/26	90 3/27	Q- MDS 91 3/28
92 3/29	93 3/30	94 3/31	95 4/1	96 4/2	97 4/3	98 4/4

Scheduling Practice

Entry 12/28/25- Assessment Ref Period for the initial OSA is 1/3/26 – 1/10/26. This sets classification for period 12/28/25 through 12/31/25-using OSA RUG IV score.

The Admission MDS (same ARD requirements) sets classification period for 1/1/26 through 3/27/26- using ND PDPM score.

The next classification period begins on 3/28/26. The reference period for this starts 3/21/26 and ends on 3/28/26. The ND PDPM score from this assessment will set the rate during this period.

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Drawbacks to this Scheduling Requirement

- Little ability to adjust ARD to avoid QM triggers, while running one schedule of assessments.
- Limited ability to capture acute changes effecting acuity
  - Is this encouraging re-hospitalization for residents who might otherwise be treated in place?

State or Nation	Nursing Case-Mix Index
OK	1.17879
GU	1.19255
MT	1.20234
MS	1.20874
AR	1.20946
ND	1.21877
AL	1.22881
MN	1.23389
WY	1.23465
IA	1.24087
SD	1.24502
PR	1.24686
KS	1.25352
LA	1.25776
NM	1.26252
MO	1.27738
TX	1.29096
NE	1.30175
MI	1.30202
RI	1.30239
PA	1.30845
FL	1.32195
AK	1.32515
SC	1.32522
NC	1.32603
OR	1.32649
CO	1.33309
ME	1.33447
CT	1.33744
NH	1.34679
DE	1.3565
VT	1.37151
NATION	1.38148

https://data.cms.gov/provider-data/search?page=2&theme=Nursing%20homes%20including%20rehab%20services

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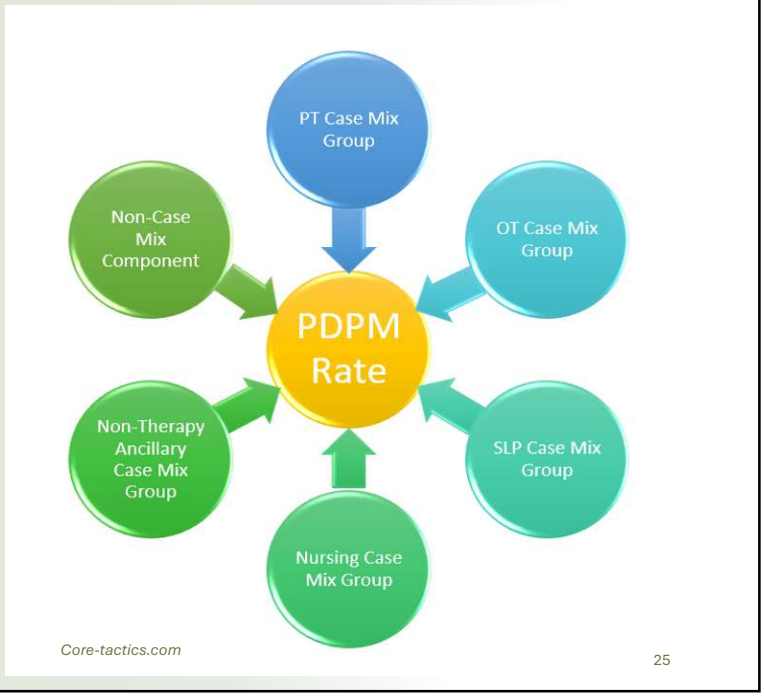
Understanding the PDPM Structure



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The Changing Role of the MDS Coordinator

- As the influence of the PDPM increases, so does the role of the MDS Coordinator or Nurse Assessment Coordinator (NAC).
- NACs cannot be expected to manage the entire process alone.
- They must instead lead an IDT that includes nurses, SW's, therapists, dietary staff, and others.
- "MDS Coordinator" is just that- the one who COORDINATES or leads the team.

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Supporting your MDS Coordinator is key

Best approach… supporting them with well-trained and collaborative interdisciplinary teams who are willing to collaborate.

Some institutions are using AI and other technology to help streamline MDS process and improve reimbursement accuracy.

These tools allow NACs to quickly review charts, gather resources and can improve efficiency and accuracy of coding.

However, NACs must use these tools cautiously. The entire chart still needs review in order to fully understand the reason for admission and to catch missing or inaccurate data.

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PDPM Components

PT and OT Clinical Components

Begins with a resident's Clinical Category
- *Major Joint Replacement or Spinal Surgery
- *Other Orthopedic
- *Medical Management
- *Non-orthopedic surgery and Acute Neurologic

Further broken down by GG Functional Score

Both PT and OT components will always result in the same case mix group, however, they will differ in the case-mix adjustment indices.

Non-Therapy Ancillary (NTA) Component

Points are assigned for conditions and extensive services based on MDS coding
- -i.e. 2 points assigned for: blood transfusion, active dx MS, active dx COPD/asthma/chronic lung disease
- -i.e. 1 point assigned for: dx morbid obesity, cystic fibrosis, Isolation while a resident, end stage liver disease
- -HIV/AIDS-point assigned based on coding of SNF claim, 8 points assigned for this

Non-Case Mix Component

This is a constant and does not change but is factored in or added to total rate calculation.

SLP Component

Starts with Dx: Acute Neurologic yes/no

Further broken down by
- -SLP comorbidities-sec I for dx or O
- -Cognitive Status- section C/BIMS
- -Mechanically Altered Diet yes/no (K0500C=2)
- -Evidence of a Swallowing Disorder (K0100A-D)

Nursing Component

Similar to RUG's III and IV categories:
- -Extensive Services
- -Special Care High
- -Special Care Low
- -Clinically Complex
- -Behavior Symptoms-Cognition
- -Reduced Physical Function

Further broken down by end splits and Section GG Function Score

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Coding Active Dx on MDS

- Identify Dx:
  - To code an active Dx, it must be documented in medical record by the physician in the last 60 days.
- Determine if the Dx is 'Active':
  - Has a direct relationship to the resident's status, medical treatments, nurse monitoring or risk of death within the past 7 day look back.
    - Exacerbation indicated by a positive study, test, or procedure
    - Presence of abnormal signs or symptoms specifically attributable to an ongoing or decompensated disease.
    - Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects.
  - Do not code Dx that resolved, do not affect resident's status or drive the resident's plan of care over the past 7 days.

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Sources of Medical Dx Supporting Documentation

- Admission H&P
  - Hospital and SNF admission Dx may not necessarily be the same.
- Medication orders should reflect accurate Dx.
- Dx should be as specific as possible.
  - Specify left/right sides of body.
  - Specify sources of infection/pneumonia.
  - Specify type of skin ulcer and location.
- Documentation to support Dx must be in medical record on or before ARD (within the appropriate look-back window).
- "Draft" notes found in EMR cannot be used- must be complete/signed.
- All hand-written notes/consults must be dated and legible.

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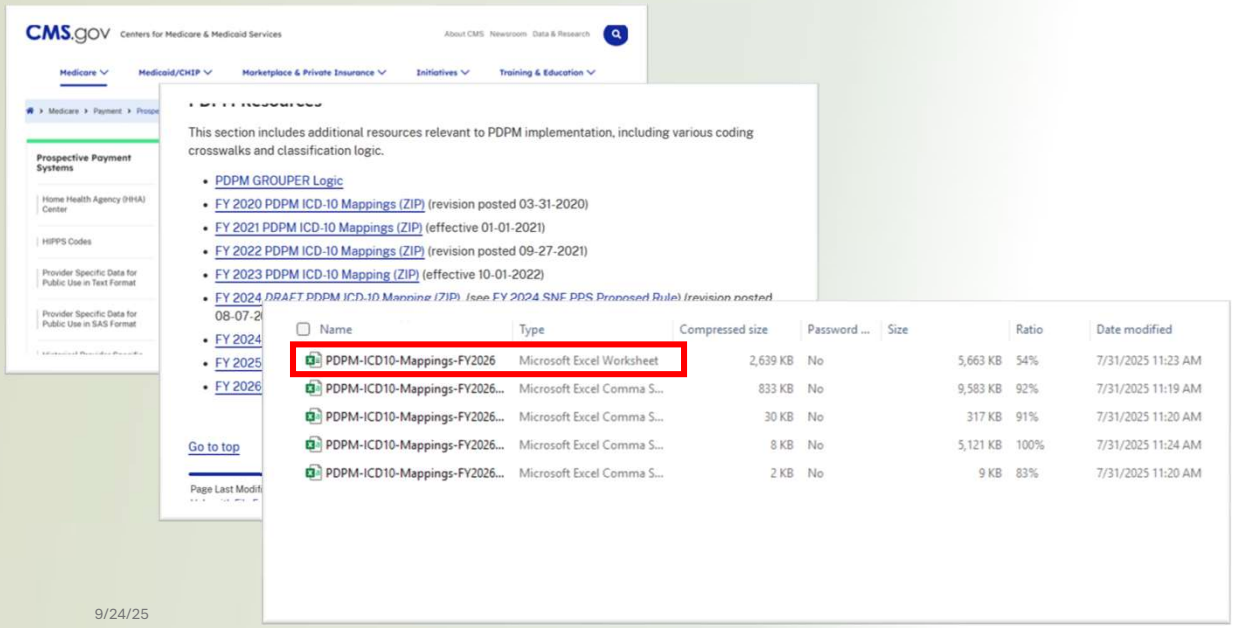
Review of CMS Tools



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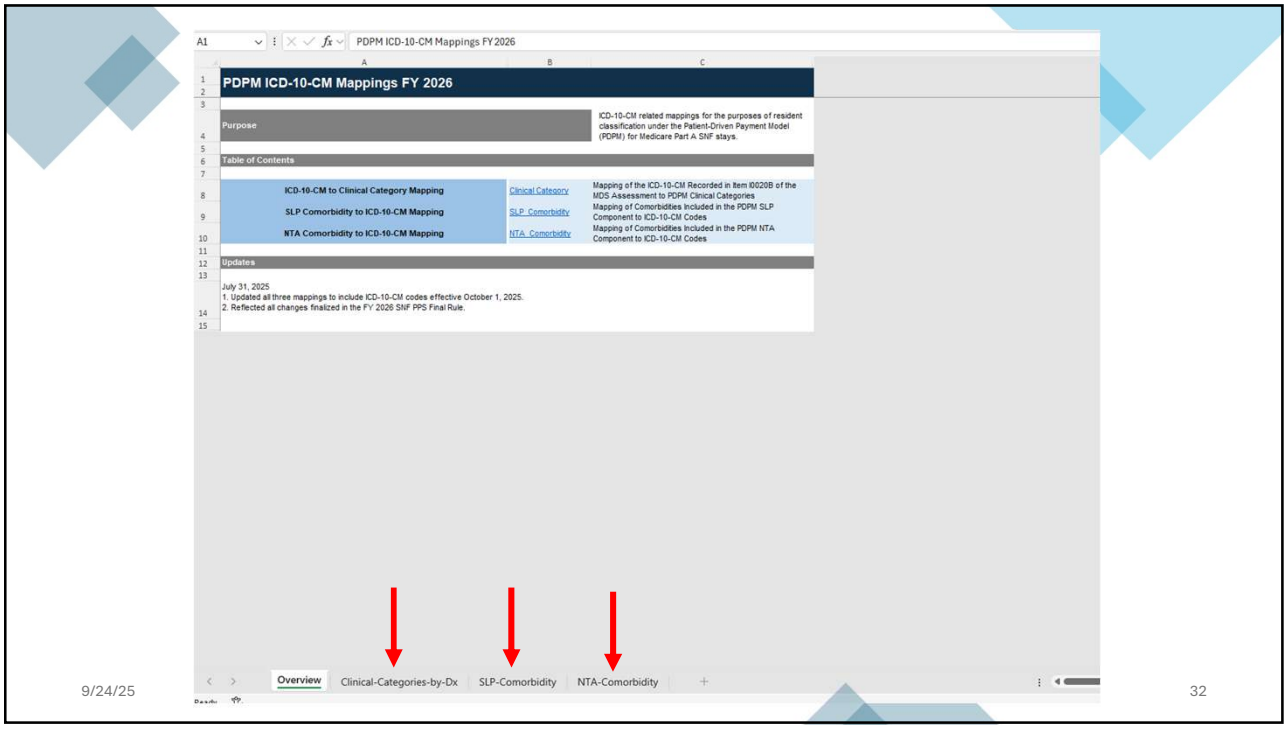

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Mapping of the ICD-10-CM Recorded in Item I0020B of the MDS Assessment to PDPM Clinical Categories

Overview

Sort Order	ICD-10-CM Code	ICD-10-CM Code Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
44438	S71.139S	Puncture wound without foreign body, unspecified thigh, sequela	Return to Provider	N/A
44439	S71.141A	Puncture wound with foreign body, right thigh, initial encounter	Medical Management	N/A
44440	S71.141D	Puncture wound with foreign body, right thigh, subsequent encounter	Medical Management	N/A
44441	S71.141S	Puncture wound with foreign body, right thigh, sequela	Medical Management	N/A
44442	S71.142A	Puncture wound with foreign body, left thigh, initial encounter	Medical Management	N/A
44443	S71.142D	Puncture wound with foreign body, left thigh, subsequent encounter	Medical Management	N/A
44444	S71.142S	Puncture wound with foreign body, left thigh, sequela	Medical Management	N/A
44445	S71.149A	Puncture wound with foreign body, unspecified thigh, initial encounter	Return to Provider	N/A
44446	S71.149D	Puncture w	Return to Provider	N/A
44447	S71.149S	Puncture w	Return to Provider	N/A
44448	S71.151A	Open bite,	Medical Management	N/A
44449	S71.151D	Open bite,	Medical Management	N/A
44450	S71.151S	Open bite,	Medical Management	N/A
44451	S71.152A	Open bite,	Medical Management	N/A
44452	S71.152D	Open bite,	Medical Management	N/A
44453	S71.152S	Open bite,	Medical Management	N/A
44454	S71.159A	Open bite,	Return to Provider	N/A
44455	S71.159D	Open bite,	Return to Provider	N/A
44456	S71.159S	Open bite,	Return to Provider	N/A
44457	S72.001A	Fracture of unspecified part of neck of right femur, initial encounter for closed fracture	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44458	S72.001B	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type I or II	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44459	S72.001C	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44460	S72.001D	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44461	S72.001E	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type I or II with routine healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44462	S72.001F	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44463	S72.001G	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with delayed healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44464	S72.001H	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type I or II with delayed healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44465	S72.001J	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44466	S72.001K	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with nonunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44467	S72.001M	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type I or II with nonunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44468	S72.001N	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44469	S72.001P	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with malunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44470	S72.001Q	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type I or II with malunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44471	S72.001R	Fracture of unspecified part of neck of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44472	S72.001S	Fracture of unspecified part of neck of right femur, sequela	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44473	S72.002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
44474	S72.002B	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type I or II	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories

Find and Replace — Find what: S72.001D — Options >> — Find All — Find Next — Close

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PT/OT Component

Clinical Category	GG Function Score	PT/OT Case Mix Group	PT Case Mix Index	OT Case Mix Index
Major Joint Replacement or Spinal Sx	0-5	TA	1.45	1.41
	6-9	TB	1.61	1.54
	10-23	TC	1.78	1.60
	24	TD	1.81	1.45
Other Orthopedic	0-5	TE	1.34	1.33
	6-9	TF	1.52	1.51
	10-23	TG	1.58	1.55
	24	TH	1.10	1.09
Medical Management	0-5	TI	1.07	1.12
	6-9	TJ	1.34	1.37
	10-23	TK	1.44	1.46
	24	TL	1.03	1.05
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.20	1.23
	6-9	TN	1.40	1.42
	10-23	TO	1.47	1.47
	24	TP	1.02	1.03

PT Component and OT Component:
PT and OT components will always result in the same case-mix group; however, the PT and OT case-mix indices/payment levels differ.

Scoring Response for Section GG Items		Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88, [-]	Dependent, refused, not attempted, resident does not walk**	0

Section GG Items		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral hygiene	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg. of 2 bed mobility items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg. of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (avg. of 2 walking items)
GG0170K1	Mobility: Walk 150 feet	

If a resident is coded as not attempted (07, 09, 10, or 88) for GG0170I1 (Walk 10 feet), then walking items for GG0170J1 (Walk 50 feet with 2 turns) and GG0170K1 (Walk 150 feet) will be scored as zero points.

34

SLP Component

Presence of • Acute Neurologic Condition, • SLP-Related Comorbidity*, or • Cognitive Impairment**	Presence of: • Swallowing Disorder (K0100A-D) OR • Mechanically Altered Diet (K0510C2)	SLP Case-Mix Group	SLP Case Mix Index
None	Neither	SA	0.64
	Either	SB	1.72
	Both	SC	2.52
Any One	Neither	SD	1.38
	Either	SE	2.21
	Both	SF	2.82
Any Two	Neither	SG	1.93
	Either	SH	2.70
	Both	SI	3.34
All Three	Neither	SJ	2.83
	Either	SK	3.50
	Both	SL	3.98

***SLP-Related Comorbidities:**

Aphasia (I4300); CVA, TIA, or Stroke (I4500); Hemiplegia or Hemiparesis (I4900); (I8000)

TBI (I5500); Tracheostomy (O0100E2); Ventilator (I0100F2);

Apraxia (I8000), Dysphagia (I8000) Speech and Language Deficits (I8000) Laryngeal Cancer, ALS, Oral Cancers

**BIMS of 12 or less is Cognitive Impairment

35

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

Overview

Sort Order	ICD-10-CM Code	ICD-10-CM Code Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
5005	G11.8	Leukodystrophy with vanishing white matter disease	Acute Neurologic	N/A
5006	G11.8	Other hereditary ataxias	Acute Neurologic	N/A
5007	G11.9	Hereditary ataxia, unspecified	Acute Neurologic	N/A
5008	G12.0	Infantile spi	Acute Neurologic	N/A
5009	G12.1	Other inheri	Acute Neurologic	N/A
5010	G12.20	Motor neuro	Acute Neurologic	N/A
5011	G12.21	Amyotrophi	Acute Neurologic	N/A
5012	G12.22	Progressive	Acute Neurologic	N/A
5013	G12.23	Primary late	Acute Neurologic	N/A
5014	G12.24	Familial moto	Acute Neurologic	N/A
5015	G12.25	Progressive	Acute Neurologic	N/A
5016	G12.29	Other motor	Acute Neurologic	N/A
5017	G12.8	Other spina	Acute Neurologic	N/A
5018	G12.9	Spinal muscu	Acute Neurologic	N/A
5019	G13.0	Paraneoplastic neuromyopathy and neuropathy	Return to Provider	N/A
5020	G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease	Return to Provider	N/A
5021	G13.2	Systemic atrophy primarily affecting the central nervous system in myxedema	Return to Provider	N/A
5022	G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere	Return to Provider	N/A
5023	G14	Postpolio syndrome	Acute Neurologic	N/A
5024	G20.A1	Parkinson's disease without dyskinesia, without mention of fluctuations	Acute Neurologic	N/A
5025	G20.A2	Parkinson's disease without dyskinesia, with fluctuations	Acute Neurologic	N/A
5026	G20.B1	Parkinson's disease with dyskinesia, without mention of fluctuations	Acute Neurologic	N/A
5027	G20.B2	Parkinson's disease with dyskinesia, with fluctuations	Acute Neurologic	N/A
5028	G20.C	Parkinsonism, unspecified	Acute Neurologic	N/A
5029	G21.0	Malignant neuroleptic syndrome	Acute Neurologic	N/A
5030	G21.11	Neuroleptic induced parkinsonism	Acute Neurologic	N/A
5031	G21.19	Other drug induced secondary parkinsonism	Acute Neurologic	N/A
5032	G21.2	Secondary parkinsonism due to other external agents	Return to Provider	N/A
5033	G21.3	Postencephalitic parkinsonism	Acute Neurologic	N/A
5034	G21.4	Vascular parkinsonism	Acute Neurologic	N/A
5035	G21.8	Other secondary parkinsonism	Acute Neurologic	N/A
5036	G21.9	Secondary parkinsonism, unspecified	Acute Neurologic	N/A
5037	G23.0	Hallervorden-Spatz disease	Acute Neurologic	N/A
5038	G23.1	Progressive supranuclear ophthalmoplegia [Steele-Richardson-Olszewski]	Acute Neurologic	N/A
5039	G23.2	Striatonigral degeneration	Acute Neurologic	N/A
5040	G23.3	Hypomyelination with atrophy of the basal ganglia and cerebellum	Acute Neurologic	N/A

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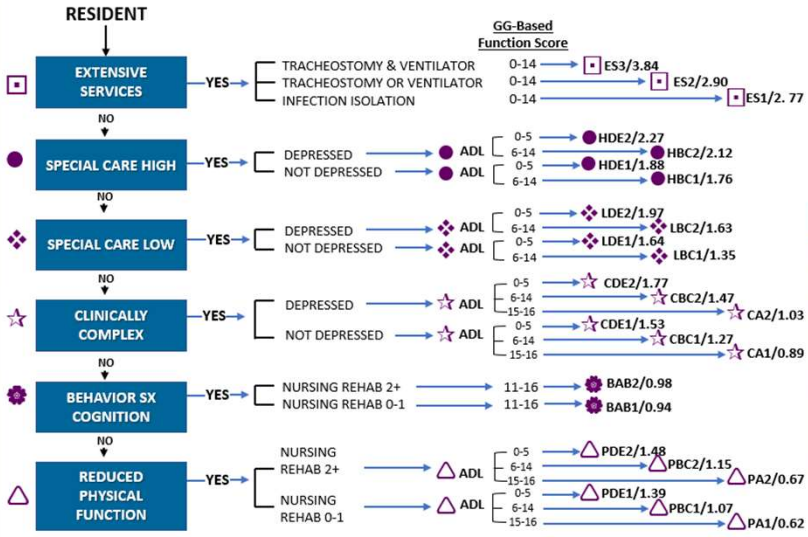
Nursing Component



Scoring Response for Section GG Items		Score
05,06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88, [-]	Dependent, refused, not attempted	0

Section GG Items		Score
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg. of 2 bed mobility items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg. of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	

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Nursing Component

Ext. Svc.

Extensive Services

- Resident's GG function score ≤ 14 **AND** is coded for ONE of the following
  - Tracheostomy while a patient
  - Ventilator or respirator while a patient
  - Isolation or quarantine for active infectious disease while a patient

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Infectious Isolation (O0110M1b)

Ext. Svc.

Code for "single room isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. **The resident is in a room alone because of an active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.**
4. The resident must remain in his/her room. This requires that all services be brought to the resident (i.e. rehab, activities, dining, etc.).

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Supporting Documentation for Infectious Isolation

Ext. Svc.

- Care plan- is it in place and specific?
- Physician order, be specific.
- Documentation on meal delivery to room
- Consider therapy notes, are they specific?
- Is Activity staff/SW staff conducting room visits and documenting this?
- Coding of Section GG W/C or walking items, 50 ft or 150 ft may come into question, be careful here.

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Nursing Component

Special Care High

Special Care High

- Resident's Nursing Function Score ≤ 14 **AND** is coded for ONE of the following
  - Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, & GG0170F1 all equal 01, 09, or 88)
  - Septicemia
  - Diabetes with **BOTH** insulin injections for all 7 days AND insulin order changes on 2 or more days
  - Quadriplegia with Nursing Function Score ≤ 11
  - COPD **AND** SOB when lying flat
  - Fever **AND** one of the following:
    - Pneumonia
    - Vomiting
    - Weight loss
    - Feeding tube (≥51% total calories or 26-50% of calories and ≥501cc fluid/day)
  - Parenteral/IV feedings
  - Respiratory therapy for all 7 days

**If the resident meets at least one of the special care conditions and the Nursing Function Score = 15 or 16, they classify as Clinically Complex.

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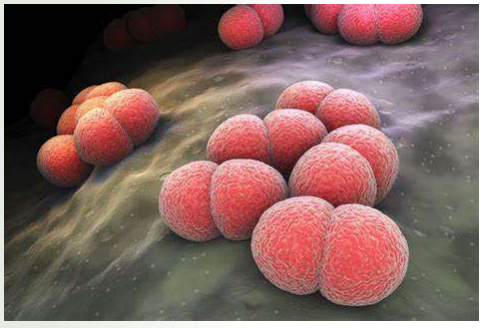
Coding of Septicemia (I2100)

Special Care High

- For sepsis to be considered septicemia, there must be inflammation due to sepsis and evidence of a microbial process.
- This does NOT include a hospital DC note referencing septicemia during hospitalization without active treatment during the observation period.

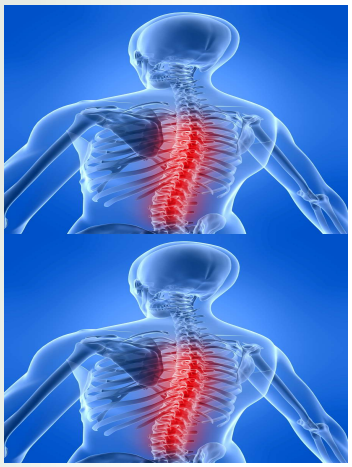


42

Coding of Quadriplegia (I5100)

Special Care High

- Nursing Function score ≤ 11
- Documentation from physician of spinal cord injury that causes total paralysis of all four limbs and is not the result of another condition.
- Does NOT include functional quadriplegia, immobility due to severe disability or frailty that extends to all limbs.



43

COPD/Asthma and SOB Lying Flat

Special Care High

- Item I6200 - per RAI, Dx listed in parentheses are examples, not an all-inclusive list.

	Pulmonary
☐	**I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)

- Shortness of Breath when Lying Flat (J1100), when coded with I6200, will trigger a score in Special Care High category.
- This requires documentation of the condition in the 7-day look back.

J1100.	Shortness of Breath (dyspnea)
↓	Check all that apply
☐	A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	B. **Shortness of breath** or trouble breathing **when sitting at rest**
☐	C. **Shortness of breath** or trouble breathing **when lying flat**
☐	Z. **None of the above**

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Coding of Shortness of Breath When Lying Flat (J110C)

Special Care High

- Must have documentation in the 7-day look back of the presence of or observation of SOB, or trouble breathing when lying flat; or
- Documentation of staff interview (incl. date staff reported this) that indicates resident's experience; or,
- Documentation that indicates resident avoids lying flat due to SOB including the interventions applied to avoid SOB during the observation period.

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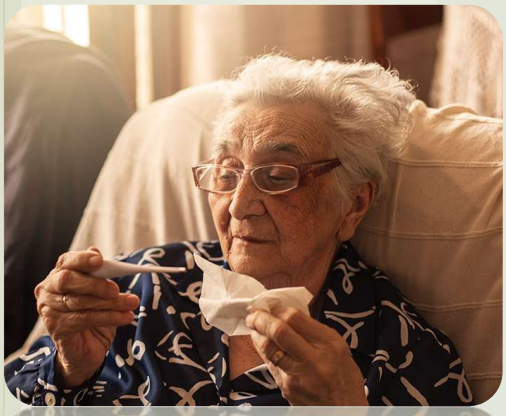
Fever (J1550A)

Special Care High



- Fever of 2.4º F. above the baseline temperature.
- Baseline temps should be established, based on facility policy, before the ARD.
- A temperature of 100.4º F. on admission (prior to establishment of the baseline temp), is considered a fever and should be coded here.

46

Parenteral/IV Feeding

Special Care High

- Includes any hydration and nutrition received during the observation period, either before admission at the hospital or in the nursing home.
- Documentation must support that the additional fluid intake is to address a nutrition or hydration need.

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Parenteral/IV Feeding

Special Care High

DOES NOT include:

- IV meds
- IV fluids used to reconstitute and/or dilute meds
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- IV fluids administered solely as flushed
- IV fluids administered in conjunction with chemotherapy or dialysis.

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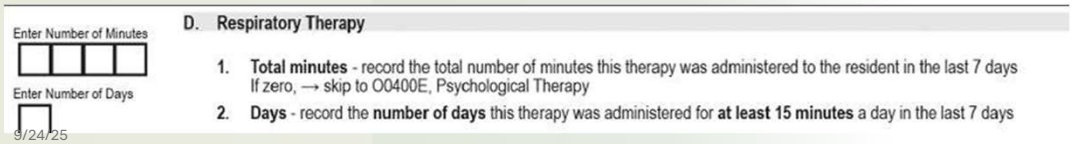
Respiratory Therapy Requirements

Special Care High

- Includes coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc.
- Physicians order including a statement of treatment specific to the resident's needs, i.e., frequency, duration and scope of treatment.
- Documentation of the actual direct minutes on a daily basis along with initials/signatures to support the total number of minutes or RT provided.
- Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective.



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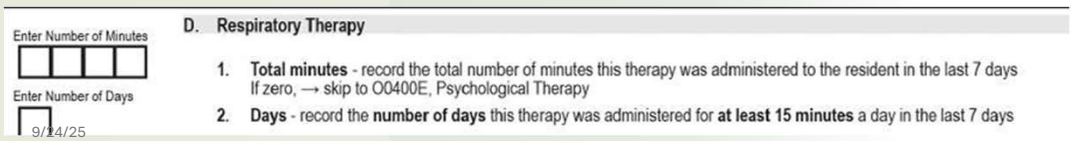
Respiratory Therapy Requirements

Special Care High

- Documentation that the respiratory nurse has been trained in the modalities provided through specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.
- Respiratory evaluation during the observation period by a (trained) licensed nurse or RT.
- Documentation of a change in condition requiring RN/RT intervention, i.e., exacerbation of a chronic respiratory condition or onset of a new respiratory condition.



50

Nursing Component

Special Care Low

Special Care Low

- Cerebral Palsy, Multiple Sclerosis **OR** Parkinsons Disease and the Nursing Function Score is ≤11
- Resident's Nursing Function Score ≤ 14 **AND** is coded for ONE of the following
  - Respiratory failure **AND** O2 therapy while a patient
  - Feeding tube (≥51% total calories or 26-50% of calories and ≥501cc fluid/day)
  - Radiation treatment while a resident
  - Dialysis treatment while a resident
  - Two or more stage 2 pressure ulcers with 2 or more treatments*
  - Two or more venous/arterial ulcers with 2 or more treatments*
  - Any stage 3, 4 or Unstageable r/t slough/eschar pressure ulcer with 2 or more treatments*
  - One stage 2 pressure ulcer AND one venous/arterial ulcer with 2 or more treatments*
  - Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to feet

**Treatment refers to selection of any 2 skin treatments: M1200A and/or B, M1200C, M1200D, M1200E, M1200G, M1200H.

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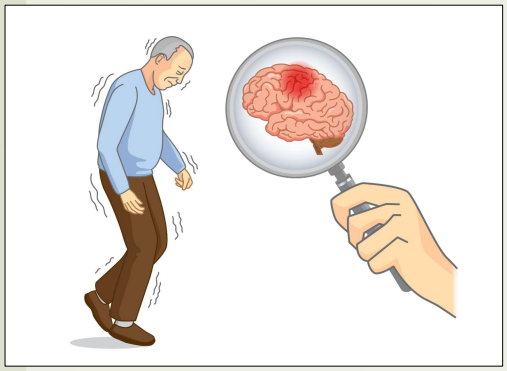
Parkinson's Disease vs. Parkinsonism

Special Care Low



- Parkinson's disease is a progressive neurodegenerative disorder where damage to neurons leads to a decrease in neurotransmitters like dopamine. Symptoms may include movement problems, tremors, depression, and communication issues. G20.A1, G20.A2, G20.B1, G20.B2
- Parkinsonism is a more generic term for a group of conditions that can cause movement problems similar to those seen in people with Parkinson's disease. G20.C
- It can be difficult to distinguish between Parkinson's disease and Parkinsonism early on since both conditions can develop with similar symptoms.

- https://www.healthline.com/health/parkinsons-disease/parkinsons-vs-parkinsonism
- https://pmc.ncbi.nlm.nih.gov/articles/PMC3405828/

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Documentation Requirements of Oxygen Therapy (O0110C1b)

Special Care Low

- Can be used continuous or intermittently via mask, cannula, etc., delivered to relieve hypoxia during the observation period.
- Documentation of precipitating event for PRN usage resulting in the application of O_2 must be included in the record.

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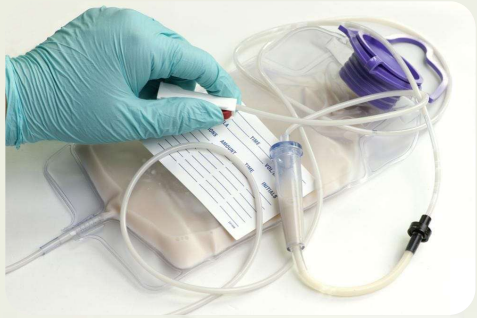
Feeding Tube with Caloric Intake Documentation (K0520B)

Special Care Low



- Includes NG tubes, G tubes, J tubes, PEG tubes
- Must have current physician order.
- Documentation includes any and all nutrition and hydration received in the last 7 days, at the NH or at the hospital, and the documentation supports the need for nutrition or hydration.

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Feeding Tube with Caloric Intake Documentation (K0710A)

Special Care Low

Documentation must support the proportion of calories received through tube feeding during the 7-day observation period.

- Calculate tube feeding provided each day within the observation window.
- Calculate oral feeding provided each day within the observation window.
- Percent of total calories provided by tube feeding within the look back period

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Feeding Tube with Caloric Intake Documentation (K0710A)

Special Care Low

Oral and Tube Feeding Intake		
	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

- Total oral is 2,450
- Total Tube is 15,000
- Total calories is 17,450
- 15,000/17,450=.859 x 100 = 85.9%
- **Code K0710A columns 2 and 3 as 3, 51% or more**

A. Proportion of total calories the resident received through parenteral or tube feeding
   1. 25% or less
   2. 26-50%
   3. 51% or more

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Coding Tips for Pressure Ulcers (M0300)

Special Care Low

- Documentation of Pressure Ulcers (PU)/injuries within the observation period must include but is not limited to, identification of wound as a PU, location and description.
- For each PU, there must be documentation from MD or RN that includes stage of the wound, description including location dimensions, drainage, tissue type, color, etc., within the 7-day observation period.*
- Do not reverse or back-stage wounds.
- Included here are stage II, III, IV, unstageable wounds due to sloth or eschar.

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Other Wound Documentation

Special Care Low

- Venous/arterial ulcers (M1030), and Diabetic Foot Ulcers (M1040B)
  - Documentation must be noted during the observation window including identification of the wound as venous, arterial or diabetic, location and description.
  - Also, include dimensions, drainage tissue color, etc.
  - For venous/arterial, there must be a diagnosis of PVD or PAD, as appropriate.*
  - For diabetic wounds, key areas include the plantar surface of the foot, especially the metatarsal heads. Include ulcers caused by neuropathic and small blood vessel complications of diabetes.

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Nursing Component

Clinically Complex

Clinically Complex

- Resident is coded for ONE of the following:
  - Pneumonia
  - Hemiplegia/hemiparesis AND Nursing Function Score ≤ 11
  - Open lesions (other than ulcers, rashes and cuts) with any treatment*
  - Surgical wounds with M1200F, M1200G or M1200H checked
  - Burns
  - Chemotherapy while a patient
  - IV medications while a patient
  - Transfusions while a patient
  - Oxygen use while a patient

*Treatments refers to selection of any 2 skin treatments: M1200A and/or B, M1200C, M1200D, M1200E, M1200G, M1200H

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Coding Tips for Clinically Complex

Clinically Complex

- Pneumonia: Does not include only a hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period.
  - Active treatment…could this mean PT, OT, RT?
- Hemiplegia: Can be challenging to show how the care and services are directed at this dx, consider your ADL care plan, therapy assessments and Plans of Care.
- Chemotherapy: Includes any type/any route using anticancer drug for the purpose of cancer treatment. Must also have a documented diagnosis of cancer. *
- Oxygen: As noted under Special Care Low.

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Clinically Complex

Coding Tips for IV Medications

- IV Meds: needs physician order
- Includes epidural, intrathecal, and baclofen pumps, IV push, IV drip through central or peripheral port- during the observation period.
- Does not include:
  - IV fluid without medications
  - Subcutaneous pumps
  - IV meds during dialysis or chemotherapy
  - Lactated Ringers (code under IVF)

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Nursing Component

Behavioral Symptoms and Cognitive Performance

- Nursing Function Score ≥ 11 AND BIMS summary Score is ≤ 9
- Coma (B0100 = 1)
- Severely impaired cognitive skills for daily decision making (C1000=3)
- Two or more of the following are present:
  - Usually, sometimes or rarely/never understood (B0700 > 0)
  - Short-term memory problem (C0700 = 1)
  - Impaired cognitive skills for daily decision making (C1000 > 0)
- **OR** one or more of the following are present
  - Sometimes or rarely/never makes self understood (B0700 ≥ 2)
  - Moderately or severely impiared cognitive skills for daily decision making (C1000 ≥ 2)
- **OR** Resident presents with ONE of the following:
  - Hallucinations
  - Delusions
  - Physical behavorial symptoms directed toward others
  - Verbal behavioral symptoms directed toward others
  - Rejection of care
  - Wandering

CORE TACTICS Healthcare Consulting

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Nursing Component

Reduced Physical Function

- Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behaioral Symptoms & Cognitive Performance but have a nursing function score < 11, are placed in this category.

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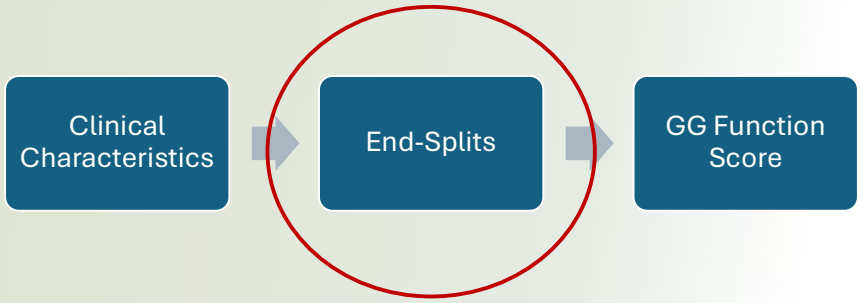
Pulling It All Together



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End-Splits

Depression

- Impacts three of the Nursing Groups
  - Special Care High
  - Special Care Low
  - Clinically Complex
- MDS questions D0150 (PHQ 2 to 9) or D0500 (PHQ-9-OV) Staff Assessment are used.
  - Scores of 10 or higher trigger the Depression End Split.
- This Depression end split can add or increase the per diem CMI rate.

65

PHQ 2 to 9 Resident Interview (D0150A-I)

- Interview items must be completed within the observation window and validated either through Z0400 dated on or before the ARD, or there must be documentation in the medical record to support Resident Mood Interview within the look back period.
- Must be conducted as a scripted interview, cannot paraphrase based on other discussion with resident.

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PHQ 2 to 9 Special Considerations

- This is one of the most frequently under-reported PDPM areas
- Attempt to establish a rapport with the resident being interviewed beforehand.
- Ensure residents do not fear consequences of answering mood interview questions honestly.
- Accurately capture s/s depression not only impacts reimbursement, but more importantly allows a more accurate and effective patient driven plan of care.

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End-Splits

Restorative Nursing

- Increases the end split on the "lower 8" case mix groups.
- The financial impact may be minimal, however, the quality of providing the care may be a goal.
- Requirements:
  - At least 2 activities, 6 days per week, 15 minutes (or more) each day
    - To maintain/prevent functional deterioration
    - Requires additional training for nursing personnel
- Cost vs Benefit analysis may be a consideration.

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Restorative Nursing Requirements

Documentation must include the below criteria:

- Measurable objectives and interventions must be documented in the care plan and in the medical record.
- Evaluation of the program by a licensed nurse.
- Staff trained in the proper techniques.
- Supervised by licensed nurse.
- No more than 4 residents per supervising helper or caregiver.

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Restorative Nursing Program Does NOT Include:

- Requirement for physician order.
- Procedures or techniques carried out by or under the direction of qualified therapists.
- For both passive and active range of motion, movement by a resident that is incidental to care does not count as part of a formal restorative nursing program.
- Treatment for less than 15 direct minutes per day.

O0500A (Passive Range of Motion) and O0500B (Active Range of Motion) count as one service even if both are provided.

O0500D (Bed Mobility) and O0500F (Walking) count as one service even if both are provided.

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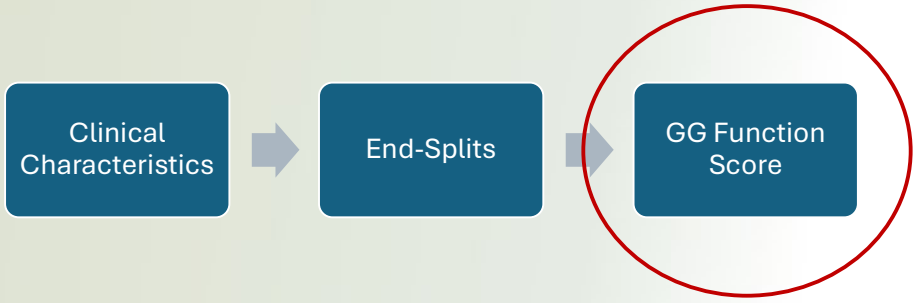
Pulling It All Together



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Section GG Functional Assessment

- Assessment must be based on direct observation, resident self-report, reports from direct care staff and other qualified clinicians or family documented in the medical record.
- Allow the resident to perform activities as independently as possible as long as they are safe. Assistive devices can be used.
- Record the resident's usual performance. Do not code the best or the worst. Code for usual performance over the 3-day assessment period.
- Must be assessed by a Qualified Clinician working in their scope of practice, and consistent with Federal, Stage, and local law and regulations.

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GG Assessment Look-Back Period

For OBRA assessments:

-Admission MDS- first 3 days of the stay
-Quarterly, Annual, Significant Change- ARD and 2 previous calendar days

For PPS Assessments
-5-day PPS- first 3 days of the Med A stay
-IPA-ARD plus 2 previous calendar days

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Section GG Usual Performance

DEFINITION USUAL PERFORMANCE:

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, ***record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance. RAI Manual, page GG-15***

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Non-Therapy Ancillary (NTA) Component

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0520A3, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0110H1b	5
Special Treatments/Programs: Invasive Mechanical Ventilator or Respirator Post-admit Code	MDS Item O0110F1b	4
Parenteral IV Feeding: Level Low	MDS Item K0520A3, K0710A2, K0710B2	3
Lung transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0110I1b	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis – except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End Stage Liver Disease	MDS Item I8000	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0110E1b	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special treatments/Programs: Isolation Post-admit Code	MDS Item O0110M1b	1
Specified Hereditary Metabolic/Immune Disorders	MDS Items I8000	1
Morbid Obesity	MDS Item I8000	1

NTA Score Range	NTA Case-Mix Group	CMI
12+	NA	3.06
9-11	NB	2.39
6-8	NC	1.74
3-5	ND	1.26
1-2	NE	0.91
0	NF	0.68

***High level**: K0710A2 = 3. 51% or more (while a resident)

****Low level**: K0710A2 = 2 (26–50%, while a resident) and K0710B2 = 2 (501cc/day or more, while a resident)

Continued

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Non-Therapy Ancillary (NTA) Component, Cont.

Condition/Extensive Service	Source	Points
Special Treatments/Programs: Radiation Post-admit Code	MDS item O0110B1b	1
Highest Stage of Unhealed Pressure Ulcer—Stage 4	MDS item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS item I8000	1
Chronic Pancreatitis	MDS item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS item I8000	1
Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Code	MDS item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS item H0100D	1
Inflammatory Bowel Disease	MDS item I1300	1
Aseptic Necrosis of Bone	MDS item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS item O0110D1b	1
Cardio-Respiratory Failure and Shock	MDS item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS item I8000	1
Diabetic Retinopathy-Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS item K0520B3	1
Severe Skin Burn or Condition	MDS item I8000	1
Intractable Epilepsy	MDS item I8000	1
Active Diagnoses: Malnutrition Code	MDS item I5600	1
Disorders of Immunity- Except: RxCC97: Immune Disorders	MDS item I8000	1
Cirrhosis of Liver	MDS item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS item H0100C	1
Respiratory Arrest	MDS item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS item I8000	1

NTA Score Range	NTA Case-Mix Group	CMI
12+	NA	3.06
9-11	NB	2.39
6-8	NC	1.74
3-5	ND	1.26
1-2	NE	0.91
0	NF	0.68

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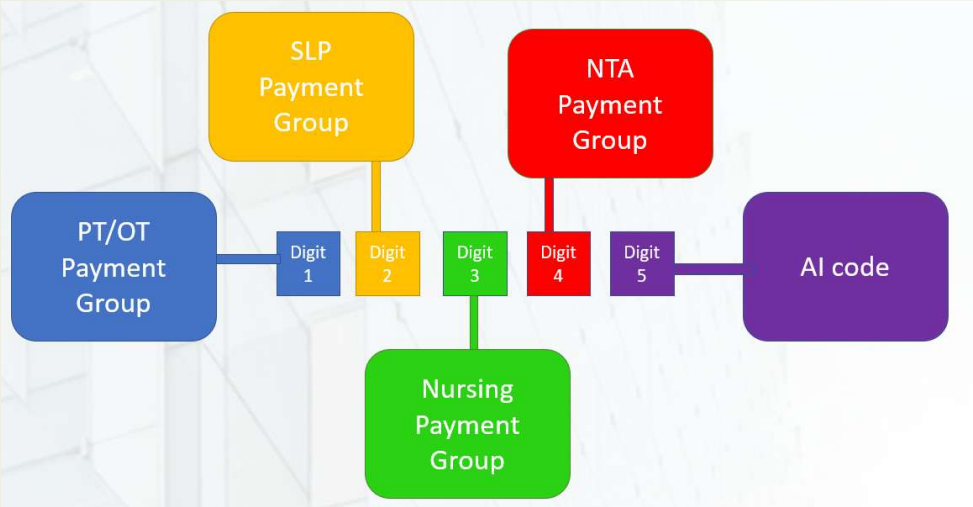
HIPPS Coding



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Care vs. Capture

- This is an art and requires "all hands-on deck" approach
  - Are all staff educated on PDPM components, not just your NAC's?
  - Is your EMR or documentation tools guiding staff?
  - Are NAC's communicating with team re scheduling of assessments?
  - What is the communication between facility staff and medical providers?
  - Who enters ICD-10 codes to your record?
- Pre-submission MDS audits and Triple Check are key in catching errors and omissions prior to billing your claims.

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CMI Scoring Impact

- Case Mix Index will be based on
  - 20% SLP
  - 60% Nursing
  - 20% NTA
- Score of AKE
  - SA- no SLP qualifiers
  - K (LBC1)- Special Care Low- (resident has Stage IV pressure ulcer with 2 treatments, ADL nursing function score of 6, not depressed.
  - NE (point)- stage IV pressure ulcer
- (A) SLP= 0.64 CMI X .20 (20%)= 0.128 CMI
- (K) Nursing = 1.35 CMI X .60 (60%)= .81 CMI
- (E) NTA = 0.91 CMI X .20 (20%) = .182 CMI
- 0.128 (SLP) + 0.81 (Nursing) +.182 (NTA) = 1.12 overall CMI

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Let's review some common coding errors…

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Avoiding Common PDPM "Pitfalls" (SLP- missed Dx aphasia)

History of Present Illness:
This 85-year-old female with history o expressive aphasia secondary to stroke. Dysphagia, hypertension, breast cancer with left mastectomy and leftupper extremity lymphedema more than 15 years. She was admitted recently to the hospital of congestive heart failure mild dementia. CC of adult failure to thrive and also long-term care. For appetite. She also has known history of atrial fibrillation.Past History:
Medical History:
Past Medical History:
Diagnosis Date
• Afib 9/11/2015
• Anxiety
• Aortic stenosis
• Atrial fibrillation
• Breast cancer 2001
Left mastectomy
• CAD (coronary artery disease) 11/7/2018
• Cerebral artery occlusion with cerebral infarction 2
• CHF (congestive heart failure)
• Depression
• DVT (deep venous thrombosis)

Missed Opportunity in SLP Component (missed Aphasia dx):
Difference in SA and SD (if no other qualifiers)
Reduces SLP CMI by .78.

I0020B. ICD Code

I	5	0	.	2	3		

Attack (TIA), or Stroke
tia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia
oke, Parkinson's or Creutzfeldt-Jakob diseases)

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. ANOXIC BRAIN DAMAGE, NOT ELSEWHERE CLASSIFIED	G 9 3 . 1	
B. PAIN IN LEFT SHOULDER	M 2 5 . 5 1 2	
C. APHASIA FOLLOWING CEREBRAL INFARCTION	I 6 9 . 3 2 0	

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Avoiding Common PDPM "Pitfalls"- Nursing, Missed s/s Depression

D0300. Total Severity Score

Enter Score	
0	8

Add scores for all freque
Enter 99 if unable to co
l score must be between 00 and 27.
re items).

Missed Opportunity in Nursing Component:
Difference in HBC1 and HBC2
(also end split for Special Care Low & Clinically Complex)
Difference of 0.54 in Nursing CMI.

2.40
HBC2/2.24
1.99
HBC1/1.86

ministering PHQ-9 Resident Interview
watch?v=xXlMTt3Vj9o

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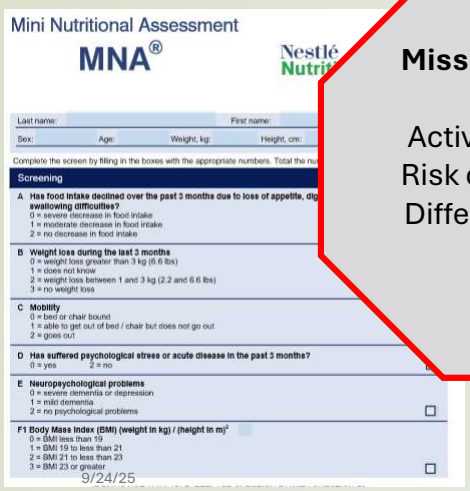
Avoiding Common PDPM "Pitfalls"-NTA, Malnutrition

- Over- Under coding of Malnutrition/At Risk for Malnutrition

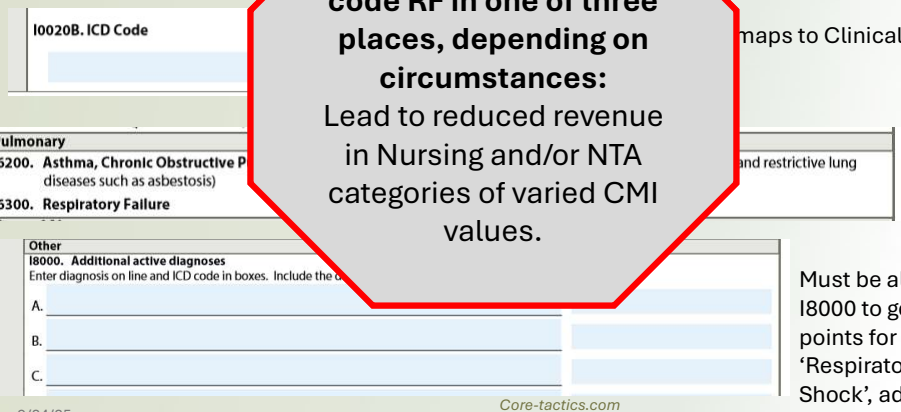


Missed Opportunity in NTA component:
Active Dx of Malnutrition or Risk of- adds one NTA point. Difference of 0.23 to 0.67 in NTA CMI.
*w/out VPD applied

Avoiding Common PDPM "Pitfalls" - Nursing and NTA, Coding of Respiratory Failure

- MDS Coding of R

Missed Opportunity to code RF in one of three places, depending on circumstances:
Lead to reduced revenue in Nursing and/or NTA categories of varied CMI values.



Must be check box'd In I6300 to get nursing Category of Special Care Low

Must be also listed in I8000 to get the NTA points for 'Respiratory Failure and Shock', adds one NTA point

Avoiding Common PDPM "Pitfalls"-NTA, Morbid Obesity

- MDS Coding of Morbid Obesity

Missed Opportunity in NTA component:
Active Dx of Morbid Obesity- adds one NTA point. Difference of 0.23 to 0.67 in NTA CMI.

*w/out VPD applied

- **Z68.42** (BMI 45 to 49.9)
- **Z68.43** (BMI 50 to 59.9)
- **Z68.44** (BMI 60 to 69.9)
- **Z68.55** (BMI ≥ 70)

DEFINITIONS

ACTIVE DIAGNOSES
Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

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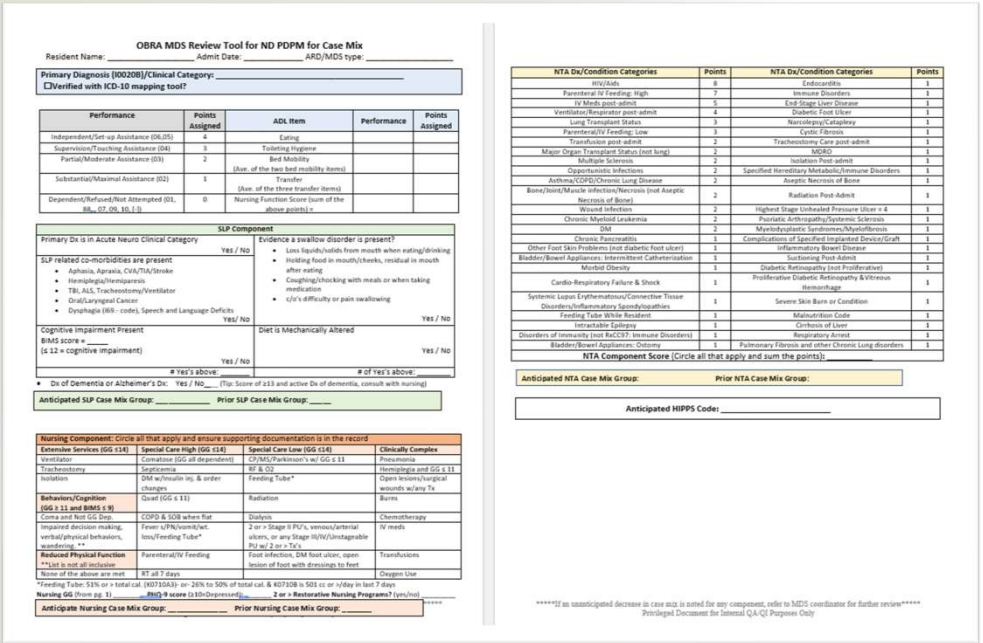
Utilize Tools to Anticipate Case Mix Potential



OBRA MDS Review Tool for ND PDPM for Case Mix

Resident Name: _____ Admit Date: _____ ARD/MDS type: _____

Primary Diagnosis (I0020B)/Clinical Category: _____
☐Verified with ICD-10 mapping tool?

Performance	Points Assigned	ADL Item	Performance	Points Assigned
Independent/Set-up Assistance (06,05)	4	Eating		
Supervision/Touching Assistance (04)	3	Toileting Hygiene		
Partial/Moderate Assistance (03)	2	Bed Mobility (Ave. of the two bed mobility items)		
Substantial/Maximal Assistance (02)	1	Transfer (Ave. of the three transfer items)		
Dependent/Refused/Not Attempted (01, 88,, 07, 09, 10, [-])	0	Nursing Function Score (sum of the above points) =		

SLP Component

Primary Dx is in Acute Neuro Clinical Category — Yes / No

SLP related co-morbidities are present
- Aphasia, Apraxia, CVA/TIA/Stroke
- Hemiplegia/Hemiparesis
- TBI, ALS, Tracheostomy/Ventilator
- Oral/Laryngeal Cancer
- Dysphagia (I69- code), Speech and Language Deficits

Yes/ No

Cognitive Impairment Present
BIMS score = ____
(≤ 12 = cognitive impairment)
Yes / No
Yes's above: ____

Evidence a swallow disorder is present?
- Loss liquids/solids from mouth when eating/drinking
- Holding food in mouth/cheeks, residual in mouth after eating
- Coughing/chocking with meals or when taking medication
- c/o's difficulty or pain swallowing

Yes / No

Diet is Mechanically Altered
Yes / No
# of Yes's above: ____

- Dx of Dementia or Alzheimer's Dx: Yes / No__ (Tip: Score of ≥13 and active Dx of dementia, consult with nursing)

Anticipated SLP Case Mix Group: _____ **Prior SLP Case Mix Group:** ____

Nursing Component: Circle all that apply and ensure supporting documentation is in the record

Extensive Services (GG ≤14)	Special Care High (GG ≤14)	Special Care Low (GG ≤14)	Clinically Complex
Ventilator	Comatose (GG all dependent)	CP/MS/Parkinson's w/ GG ≤ 11	Pneumonia
Tracheostomy	Septicemia	RF & O2	Hemiplegia and GG ≤ 11
Isolation	DM w/insulin inj. & order changes	Feeding Tube*	Open lesions/surgical wounds w/any Tx
Behaviors/Cognition (GG ≥ 11 and BIMS ≤ 9)	Quad (GG ≤ 11)	Radiation	Burns
Coma and Not GG Dep.	COPD & SOB when flat	Dialysis	Chemotherapy
Impaired decision making, verbal/physical behaviors, wandering. **	Fever: s/Pn/vomit/wt loss/Feeding Tube*	2 or > Stage II PU's, venous/arterial ulcers, or any Stage III/IV/Unstageable PU w/ 2 or > Tx's	IV meds
Reduced Physical Function **List is not all inclusive	Parenteral/IV Feeding	Foot infection, DM foot ulcer, open lesion of foot with dressings to feet	Transfusions
None of the above are met	RT all 7 days		Oxygen Use

*Feeding Tube: 51% or > total cal. (K0710A3)- or- 26% to 50% of total cal. & K0710B is 501 cc or >/day in last 7 days
Nursing GG (from pg. 1) _____ **PHQ-9 score** (≥10=Depressed)_____ **2 or > Restorative Nursing Programs?** (yes/no) _____
Anticipate Nursing Case Mix Group: _____ **Prior Nursing Case Mix Group:** _____

NTA Dx/Condition Categories	Points	NTA Dx/Condition Categories	Points
HIV/Aids	8	Endocarditis	1
Parenteral IV Feeding: High	7	Immune Disorders	1
IV Meds post-admit	5	End-Stage Liver Disease	1
Ventilator/Respirator post-admit	4	Diabetic Foot Ulcer	1
Lung Transplant Status	3	Narcolepsy/Cataplexy	1
Parenteral/IV Feeding: Low	3	Cystic Fibrosis	1
Transfusion post-admit	2	Tracheostomy Care post-admit	1
Major Organ Transplant Status (not lung)	2	MDRO	1
Multiple Sclerosis	2	Isolation Post-admit	1
Opportunistic Infections	2	Specified Hereditary Metabolic/Immune Disorders	1
Asthma/COPD/Chronic Lung Disease	2	Aseptic Necrosis of Bone	1
Bone/Joint/Muscle infection/Necrosis (not Aseptic Necrosis of Bone)	2	Radiation Post-Admit	1
Wound Infection	2	Highest Stage Unhealed Pressure Ulcer = 4	1
Chronic Myeloid Leukemia	2	Psoriatic Arthropathy/Systemic Sclerosis	1
DM	2	Myelodysplastic Syndromes/Myelofibrosis	1
Chronic Pancreatitis	1	Complications of Specified Implanted Device/Graft	1
Other Foot Skin Problems (not diabetic foot ulcer)	1	Inflammatory Bowel Disease	1
Bladder/Bowel Appliances: Intermittent Catheterization	1	Suctioning Post-Admit	1
Morbid Obesity	1	Diabetic Retinopathy (not Proliferative)	1
Cardio-Respiratory Failure & Shock	1	Proliferative Diabetic Retinopathy & Vitreous Hemorrhage	1
Systemic Lupus Erythematosus/Connective Tissue Disorders/Inflammatory Spondylopathies	1	Severe Skin Burn or Condition	1
Feeding Tube While Resident	1	Malnutrition Code	1
Intractable Epilepsy	1	Cirrhosis of Liver	1
Disorders of Immunity (not ReCC97: Immune Disorders)	1	Respiratory Arrest	1
Bladder/Bowel Appliances: Ostomy	1	Pulmonary Fibrosis and other Chronic Lung disorders	1

NTA Component Score (Circle all that apply and sum the points)= _____

Anticipated NTA Case Mix Group: **Prior NTA Case Mix Group:**

Anticipated HIPPS Code: _____

*****If an unanticipated decrease in case mix is noted for any component, refer to MDS coordinator for further review*****
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Utilize Tools to Anticipate Case Mix Potential

Resident:	John Doe			Entry Date:	12/28/25
Payor Source:	ND Medicaid				
Primary Dx:	HTN				
SLP Component:	SE (cognitionBIMS = 6, and puree diet)				
Nursing Component:	CBC1 (O2 use and func score 10, PHQ 0)				
NTA Component:	ND (4 points, DM and COPD)				
	Minimum ARD	Maximum ARD	ARD	Expected Score	Actual Score
Admission	1/3/26	1/10/26	1/3/2026	EPD	EPD
1st OBRA	3/21/26	3/28/26	3/21/2026	EPD	EPE
2nd OBRA	6/21/26	6/28/26			
3rd OBRA	9/21/26	9/28/26			
4th OBRA	12/21/26	12/28/26			
5th OBRA	3/21/27	3/28/27			
6th OBRA	6/21/27	6/28/27			
7th OBRA	9/21/27	9/28/27			
8th OBRA	12/21/27	12/28/27			
9th OBRA	3/21/28	3/28/28			
10th OBRA	6/21/28	6/28/28			
11th OBRA	9/21/28	9/28/28			

NTA Score Range	NTA Case-Mix Group	CMI
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0	NF	0.68

What was missed?
-NTA dropped from 4, to 2 pts. -
-This is a reduction in NTA CMI of 0.35.
-On review, COPD was not coded on 6/21/26 MDS.
-What are the next steps?

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Utilize Tools to Anticipate Case Mix Potential

Resident:	John Doe			Entry Date:	12/28/25
Payor Source:	ND Medicaid				
Primary Dx:	HTN				
SLP Component:	SE (cognitionBIMS = 6, and puree diet)				
Nursing Component:	CBC1 (O2 use and func score 10, PHQ 0)				
NTA Component:	ND (4 points, DM and COPD)				
	Minimum ARD	Maximum ARD	ARD	Expected Score	Actual Score
Admission	1/3/26	1/10/26	1/3/2026	EPD	EPD
1st OBRA	3/21/26	3/28/26	3/21/2026	EPD	EPB
2nd OBRA	6/21/26	6/28/26			
3rd OBRA	9/21/26	9/28/26			
4th OBRA	12/21/26	12/28/26			
5th OBRA	3/21/27	3/28/27			
6th OBRA	6/21/27	6/28/27			
7th OBRA	9/21/27	9/28/27			
8th OBRA	12/21/27	12/28/27			
9th OBRA	3/21/28	3/28/28			
10th OBRA	6/21/28	6/28/28			
11th OBRA	9/21/28	9/28/28			

NTA Score Range	NTA Case-Mix Group	CMI
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0	NF	0.68

Scenario…
-Mr. Doe starts IV Antibiotic on 3/25/26 for UTI
-Moving ARD to 3/25 will increase NTA score by 5 points, raising total NTA score to 9 (NB).
-This is an increase in NTA CMI score of 1.13.

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Final Thoughts…

- Pre-assessment PDPM review tool
  - Take a pro-active approach
  - Anticipate case mix groups, validate the score, if there are discrepancies, review for coding inaccuracy
- Use your IDT, not just your MDS staff
- Communicate and document key events:
  - ED visits
  - IV fluids/med
  - New dx… infections
  - Wounds
- Significant Change/IPA opportunities
- Use CMS tools- PDPM resources web page
- Pull into QAPI: results of any ADR's can shed light on non-compliance, apply these concepts to all payer types

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Resources

- Five Star Quality Rating System: Technical Users' Guide
  - https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf
- Skilled Nursing Facility Quality Reporting Program Measures and Technical Information
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information
- CDC, COVID-19 Vaccination Guidelines
  - https://www.cdc.gov/covid/vaccines/stay-up-to-date.html
- Patient Driven Payment Model, Overview
  - https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model
- NDHHS, Long Term Care Providers
  - https://www.hhs.nd.gov/healthcare/medicaid/provider/long-term-care

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Corporate Compliance
Claims Appeals & Denials
Medicare / Medicaid Audits
Pre-Billing Audits
MDS Accuracy
9/24/25
Thank You for Joining us Today!
Any Questions?
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