## Section A: Identification Information

A0310G1 Practice Coding Scenario 1

- **Is this a SNF Part A Interrupted Stay?**
  - Mr. J was receiving skilled services under Medicare Part A for rehabilitation. Mr. J fell and was sent to the acute care hospital for an evaluation. Since staff expect Mr. J to return to the facility, he was discharged return anticipated.
  - Mr. J left the facility on 4/23 at 4:00 p.m. and returned to resume skilled services under Part A on 4/25 at 7:00 p.m.
- **Coding: Yes,** would be coded.
- **Rationale:**
  - The interrupted stay policy applies to residents who leave the facility, are discharged from Part A and return to the same SNF, resuming Part A services within the 3-day interruption window. Transfer to an acute care hospital for evaluation is allowed under this policy.
  - Additionally, the two criteria for Interrupted Stay were met:
  - Mr. J was on skilled services under Part A when he was transferred to the acute care hospital, and he returned before 11:59 p.m. on the 3rd calendar day to resume Part A services, which is within the 3-day interruption window.

- **Which of the following assessments are due when Mr. J leaves the facility?**
  - A. OBRA Discharge.
  - B. Part A PPS Discharge.
  - C. Combined Part A PPS Discharge and OBRA Discharge.
  - D. None of the above.
- **Answer:** A. **OBRA Discharge**
- **Rationale:**
  - Although the resident is in an interrupted stay, his Part A PPS stay does not end. Therefore, the Part A PPS Discharge is not required. However, because Mr. J was physically discharged, the OBRA Discharge is required.

- **Which of the following assessments/records are due when Mr. J returns to the facility to resume Part A services?**
  - A. 5-Day assessment.
  - B. OBRA Admission.
  - C. Entry Tracking Record.
  - D. A and B.
- **Answer:** C**. Entry Tracking Record**
- **Rationale:**

- An Entry Tracking Record is required on return to the facility because it is required when a resident was previously in the facility, was discharged and returned to the facility within 30 days.
- An OBRA Admission is not required because Mr. J was discharged return anticipated. Had he been discharged return not anticipated, a new OBRA Admission assessment would be required.
- Remember that an interrupted stay does not affect the OBRA schedule. The OBRA rules still apply when a resident is physically discharged from the facility, even though under the interrupted stay policy, the Part A PPS stay does not end.
- A 5-Day PPS would not be required on resumption because Mr. J's Part A PPS Stay did not end. Payment resumes on the Variable Per Diem (VPD) Schedule from the day of discharge.

**Section I: Active Diagnoses**

I0020. Practice Coding Scenario 1

- **Indicate the Resident's Primary Medical Condition Category:**
  - Mr. K is a 67-year-old male with a history of Alzheimer's dementia and diabetes who is admitted for a Part A stay after a stroke (ICD I63.411). The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Mr. K's history and physical by the admitting physician.
- **Coding:** I0020 would be coded **01, Stroke**.
  - I0020B would be coded as I63.411 (Cerebral infarction due to embolism of the right middle cerebral artery)
- **Rationale:**
  - The physician's history and physical documents the diagnosis stroke as the reason for Mr. K's admission. (The International Statistical Classification of Diseases and Related Health Problems (ICD)-10 code provided in I0020B above is only an example of an appropriate code for this condition category.)

I0020. Practice Coding Scenario 2

- **Indicate the Resident's Primary Medical Condition Category:**
  - Mrs. H is a 78-year old female who had an extended hospitalization for pancreatitis (ICD K85.00).
  - She had a central line placed during the acute care stay to receive total parenteral nutrition (TPN).
  - During her Part A SNF stay, Mrs. H is being transitioned from taking nothing by mouth (NPO), with the goal of being able to tolerate oral nutrition.
  - The hospital discharge diagnoses of pancreatitis was incorporated into Mrs. H's Part A SNF medical record.
- **Coding:** I0020 would be coded **13, Medically Complex Conditions**.

- I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).

- **Rationale:**
  - Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of her central line does not change her care to a surgical category because it is not considered to be a major surgery. (The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

**Section J: Health Conditions**

J2100. Practice Coding Scenario 1

- **Recent Surgery Requiring Active SNF Care:**
  - Mrs. V was hospitalized for gram-negative pneumonia. Since this was her second episode of pneumonia in the past 6 months, a diagnostic bronchoscopy was performed while in the hospital. She also has Parkinson's disease and rheumatoid arthritis. She was discharged to a SNF for continuing care.
- **Coding: J2100 is coded 0, No**. Because there is no documentation that indicates the resident had major surgery.
  - **I0020A** is coded as **13, Medically Complex Conditions**
  - **I0020B** SNF ICD-10 code is **J15.6**, **(**Pneumonia due to other aerobic gram-negative bacteria).
- **Rationale:**
  - Mrs. V did not receive any major surgery during the prior inpatient stay and she was admitted to the SNF for continued care due to pneumonia.

J2100. Practice Coding Scenario 2

- **Recent Surgery Requiring Active SNF Care**:
  - Mr. O is a diabetic who was hospitalized for sepsis from an infection that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. He was discharged to a SNF for continued antibiotic treatment and monitoring.
- **Coding: J2100 is coded 0, No** because there is no documentation that indicates the resident had major surgery.
  - **I0200A** is coded as **13, Medically Complex Conditions, and the**
  - **I0020B** SNF ICD-10 code is **A41.01** (Sepsis due to methicillin susceptible staphylococcus aureus).
- **Rationale:**

- Neither the placement of a central line nor the outpatient bunion surgery is considered to be major surgery, but the resident was admitted to the SNF for continued antibiotic treatment and monitoring.

J2100. Practice Coding Scenario 3

- **Recent Surgery Requiring Active SNF Care:**
  - Mrs. J had a craniotomy to drain a subdural hematoma after suffering a fall at home (ICD S06.5X2D). She has COPD and uses oxygen at night. In addition, she has moderate congestive heart failure, is moderately overweight, and has hypothyroidism. After a 6-day hospital stay, she was discharged to a SNF for continuing care.

- **Coding: J2100 would be coded 1, Yes** because there is documentation indicating the resident had major surgery.
  - **I0020A** is coded as **07, Other Neurological Conditions.**
  - The **I0020B** SNF ICD-10 code is **S06.5X2D** (Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter). **J2600, Neuro surgery** – brain, surrounding tissue or blood vessels, would be checked.
- **Rationale:**
  - The craniotomy surgery during the inpatient stay immediately preceding the SNF stay requires continued skilled care and skilled monitoring for wound care as well as therapies to address any deficits that led to her fall or any functional deficits resulting from her fall. (The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category).

**Section O: Special Treatments, Procedures, and Programs**

O0425 Practice Coding Scenario

- **Part A Therapy:**
  - Following a bilateral knee replacement, Mrs. G., while still in the hospital, exhibited some short-term memory difficulties specifically affecting orientation. She was non-weight bearing, had reduced range of motion, and had difficulty with Activities of Daily Living (ADLs). She was referred to Speech Language Pathologist (SLP), occupational therapy (OT), and physical therapy (PT), with the long-term goal of returning home with her husband.
  - Mrs. G was admitted to the SNF in stable condition for rehabilitation therapy on Sunday 10/06/19 under Part A SNF coverage.
  - Her initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. She was also referred to recreational therapy.
  - She was in the SNF for 14 days and was discharged home on 10/19/2019.
  - Mrs. G received the following rehabilitation services during her stay in the SNF:
  - Speech-language pathology services that were provided over the SNF stay:

        - Individual cognitive training; six sessions for 45 minutes each day.
        - Discharged from SLP services on 10/14/2019.
    - OT services that were provided over the SNF stay:
        - Individual ADL activities daily for 30 minutes each, starting 10/08/19.
        - Co-treatment: Seating and transferring with PT:
        - Three sessions for the following times: 23 minutes, 18 minutes, and 12 minutes.
        - Balance/coordination activities: 10 sessions for 20 minutes each session in a group.
        - Discharged from OT services on 10/19/19.
    - PT services that were provided over the stay:
        - Individual mobility training daily for 45 minutes per session starting 10/07/19.
        - Group mobility training for 30 minutes on Tuesdays, Wednesdays, and Fridays.
        - Co-treatment seating and transferring for three sessions with OT for 7 minutes, 22 minutes, and 18 minutes.
        - Concurrent therapeutic exercises Monday through Friday for 20 minutes each day.
        - Discharged from PT services on 10/19/19.

- **SLP Coding:**
    - O0425A1 would be coded **270,**
    - O0425A2 would be coded **0,**
    - O0425A3 would be coded **0,**
    - O0425A4 would be code**d 0,**
    - O0425A5 would be coded **6.**
- **Rationale:**
    - Individual minutes totaled 270 over the stay (45 minutes × 6 days).
    - Concurrent minutes totaled 0 over the stay (0 × 0 = 0).
    - Group minutes totaled 0 over the stay (0 × 0 = 0).
    - Therapy was provided 6 days of the stay.

- **OT Coding:**
    - O0425B1 would be **coded 413**
    - O0425B2 would be **coded 0**
    - O0425B3 would be **coded 200**
    - O0425B4 would be **coded 53**
    - O0425B5 would be **coded 12**.
- **Rationale:**
    - Individual minutes (including 53 co-treatment minutes) totaled 413 over the stay [(30 × 12) + 53 = 413].
    - Concurrent minutes totaled 0 over the stay (0 × 0 = 0).
    - Group minutes totaled 200 over the stay (20 × 10 = 200).

- Therapy was provided 12 days of the stay.

- **PT Coding:**
  - O0425C1 would be **coded 632**
  - O0425C2 would be **coded 200**
  - O0425C3 would be **coded 180**
  - O0425C4 would be **coded 47**
  - O0425C5 would be **coded 13**.
- **Rationale:**
  - Individual minutes (including 47 co-treatment minutes) totaled 632 over the stay [(45 × 13) + (7 + 22 + 18) = 632].
  - Concurrent minutes totaled 200 over the stay (20 × 10 = 200).
  - Group minutes totaled 180 over the stay (30 × 6 = 180).
  - Therapy was provided 13 days of the stay.