Skilled Nursing Facility

Quality Reporting Program Provider Training

Section A, I, J, and O Updates

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Acronyms in This Presentation

- ADL – Activities of Daily Living
- ARD – Assessment Reference Date
- ASAP – Assessment Submission and Processing
- CMS – Centers for Medicare & Medicaid Services
- COPD – Chronic Obstructive Pulmonary Disease
- HIPPS – Health Insurance Prospective Payment System
- ICD – International Statistical Classification of Diseases and Related Health Problems
- IPA – Interim Payment Assessment
- MDS – Minimum Data Set

Acronyms in This Presentation (cont.)

- OBRA – Omnibus Budget Reconciliation Act of 1987
- OSA – Optional State Assessment
- OT – Occupational Therapy
- PT – Physical Therapy
- PASRR – Preadmission Screening and Resident Review
- PPS – Prospective Payment System
- QIES – Quality Improvement and Evaluation System
- SNF – Skilled Nursing Facility
- SLP – Speech Language Pathologist
- SSN – Social Security Number

Objectives

- Describe the updates to Sections A, I, J, and O.
- Apply coding instructions to accurately code practice scenarios and the case study.

Section A: Identification Information

Section A. Identification Information: Intent

The intent of this section is to obtain key information to uniquely identify:

- Each resident.
- The home in which he or she resides.
- Reasons for assessment.

A0100.

Facility Provider Numbers

A0100. Facility Provider Numbers

A0100. Facility Provider Numbers	
	A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐ B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐ C. State Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- For A0100B, an instruction was added that "*if A0410 = 3 (Federal required submission), then A0100B (facility CCN) must not be blank.*"
- In A0100C, the term "*State survey agency*" was added to the instruction to clarify that the State Provider Number is actually assigned by this entity.

A0300.

Optional State Assessment (OSA)

A0300. Optional State Assessment

Item as it appears on most items sets:

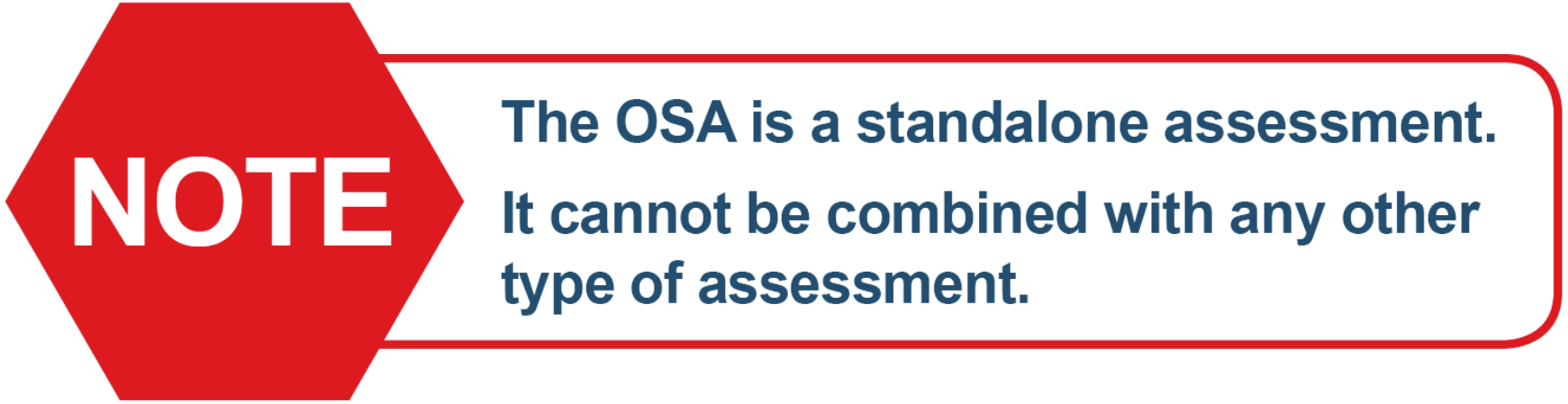
A0300. Optional State Assessment	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**

Item as it appears on the OSA:

A0300. Optional State Assessment	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment

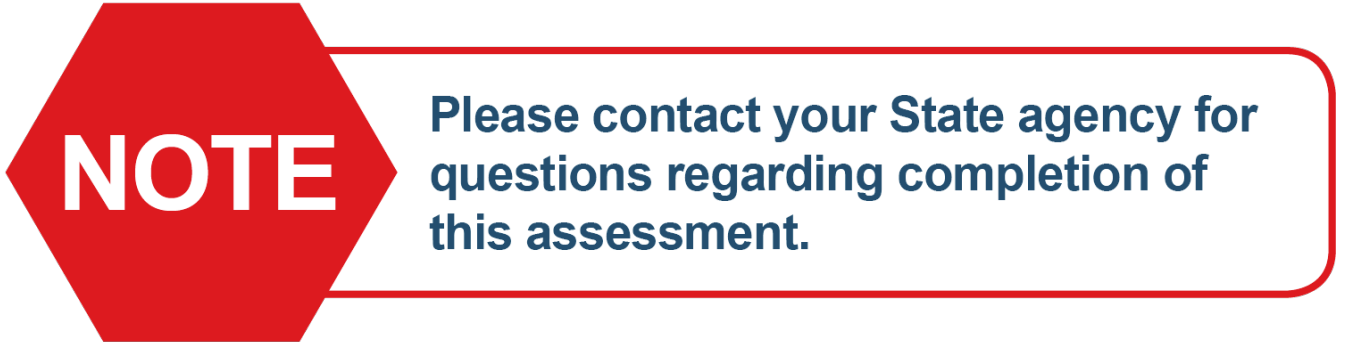
A0300. Item Rationale

Allows for collection of data required for state payment reimbursement.



A0300. Coding Instructions

- Enter the code identifying whether this is an optional payment assessment.
  - Enter **0. No**, if not required for state payment purposes, then proceed to A0310. Type of Assessment.
  - Enter **1. Yes**, if required for state payment purposes.
- These responses are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes.



A0310.

Type of Assessment

A0310. Type of Assessment

A0310. Type of Assessment

Enter Code ☐☐

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

01. **5-day** scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

08. **IPA** - Interim Payment Assessment

Not PPS Assessment

99. **None of the above**

A0310B. Prospective Payment System (PPS) Assessment

Section A	Identification Information
A0310. Type of Assessment	
Enter Code ☐☐	**A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above**
Enter Code ☐☐	**B. PPS Assessment** **PPS Scheduled Assessment for a Medicare Part A Stay** 01. **5-day** scheduled assessment **PPS Unscheduled Assessment for a Medicare Part A Stay** 08. **IPA** - Interim Payment Assessment **Not PPS Assessment** 99. **None of the above**

- A0310B, PPS Assessment.
  - **Code 01**. 5-Day Scheduled Assessment.
  - ***Code 08. IPA*** – *Interim Payment Assessment.*
  - **Code 99**. None of the above.
- For A0310A or B, enter the number corresponding to the reason for completing the assessment.

A0310B. Coding Instructions

- Coding Instructions were updated:
  - Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01 *and 08*, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded as 01 *or 08*, enter code "99."
  - PPS Unscheduled Assessment for Medicare Part A Stay.
    - ***08. IPA*** – *Interim Payment Assessment.*
  - *Not PPS Assessment.*
    - 99. None of the above.

A0310E.

Is This Assessment the First Assessment (OBRA, Scheduled PPS, or OBRA Discharge) Since the Most Recent Admission/Entry or Reentry?

A0310E. Is This Assessment the First Assessment Since the Most Recent Admission/Entry or Reentry?

Enter Code	E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
☐	0. **No** 1. **Yes**

- Coding Tips were amended as follows:
  - A0310E = 0. No, for:
    - *An Interim Payment Assessment* (A0310A = 99, A0310B = *08*, A0310F = 99, *and A0310H = 0*).
  - A0310E = 1. Yes, on the first OBRA, Scheduled PPS, or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: The first submitted assessment may not be *an OBRA* Admission assessment.

A0310G.

Type of Discharge
(Complete Only if A0310F = 10 or 11)

A0310G. Type of Discharge

Enter Code	G. **Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned**

Coding Tip was added:

- *Enter the number corresponding to the type of discharge.*

A0310G1.

Is This a SNF Part A Interrupted Stay?

A0310G1. Is This a SNF Part A Interrupted Stay?

G1. Is this a SNF Part A Interrupted Stay?

0. **No**
1. **Yes**

A0310. Type of Assessment - Continued	
Enter Code ☐	**G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned**
Enter Code ☐	**G1. Is this a SNF Part A Interrupted Stay?** 0. **No** 1. **Yes**
Enter Code ☐	**H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

A0310G1. Is This a SNF Part A Interrupted Stay? (cont. 1)

- This item allows providers to indicate whether or not an interrupted stay has occurred.
- You will code **0. No.** If the resident was discharged from SNF care but **did not** resume SNF care at the same SNF within the interruption window.
  - This means that an interrupted stay did **not** occur.
- You will code **1. Yes.** If the resident was discharged from SNF care but **did** resume SNF care at the same SNF within the interruption window.
  - This means that an interrupted stay **did** occur.

Interrupted Stay Policy

Interrupted Stay

Medicare Part A skilled nursing facility (SNF) stay in which a resident:

- Is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay), **and**
- Subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.

Interruption Window

A 3-day period starting with the calendar day of discharge from SNF care (i.e., Part A-covered stay) and including the 2 immediately following calendar days, ending at 11:59 p.m. on the third calendar day.

Resumption of SNF Care

Resident must resume SNF care (i.e., Part A-covered stay) in the same SNF or return to the **same** SNF (if physically discharged) to resume SNF care, by 11:59 p.m. of the end of the third calendar day after their Part A-covered stay ended.

Interrupted Stay Policy (cont. 1)

- In order to be considered an Interrupted Stay **both** conditions must be met:
  1. Resident discharged from Part A-covered stay **and**
  2. Resumes the Part A stay in the same SNF or returns to the same SNF to resume the Part A stay (if physically discharged) by 11:59 p.m. at the end of the third calendar day after the Part A covered stay ended.
- The subsequent stay is considered a continuation of the previous Part A stay for purposes of the:
  - Variable per diem schedule.
  - PPS assessment completion.

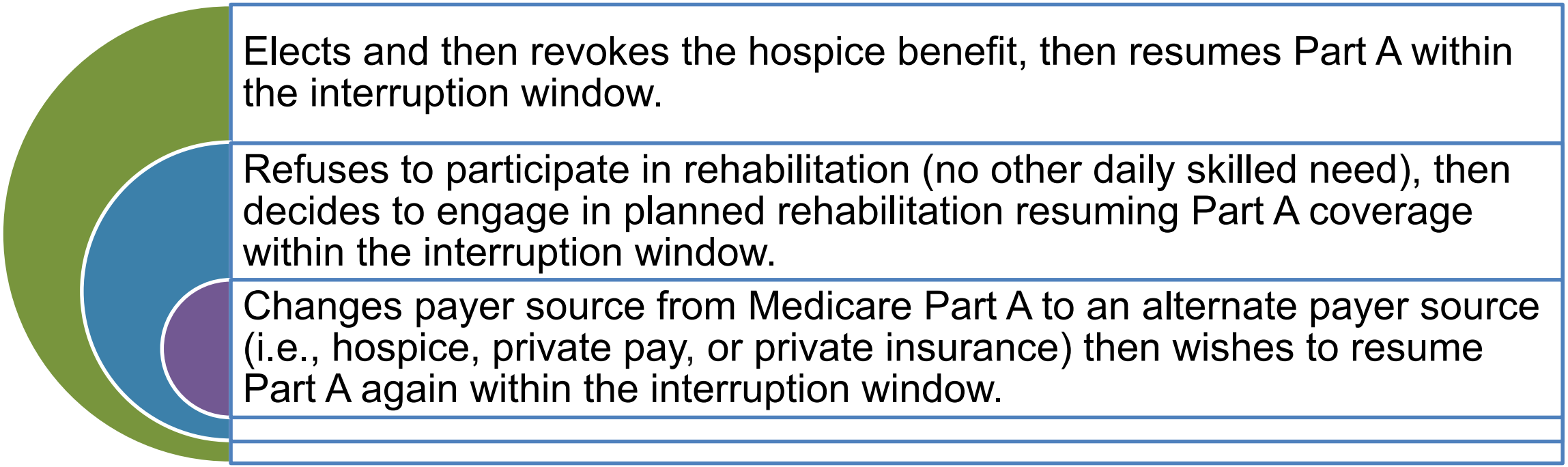
A0310G1. Coding Tips

Examples of interrupted stay where the resident leaves the SNF and returns to the same SNF to resume Part A-covered stay:

- Resident leaves against medical advice and returns to the same SNF to resume Part A-covered services within the interruption window.
- Acute care setting for evaluation/treatment due to a change in condition and then returning to the same SNF to resume Part A-covered services within the interruption window.
- Psychiatric facility for evaluation/treatment and then returning to the same SNF to resume Part A-covered services within the interruption window.
- Outpatient facility for a procedure/treatment and then returning to the same SNF to resume Part A-covered services within the interruption window.
- Assisted living facility or private residence with home health services and then returning to the same SNF to resume Part A-covered services within the interruption window.

A0310G1. Coding Tips (cont. 1)

Examples of interrupted stay where the resident remains in the SNF but stops being covered under the Part A PPS benefit and resumes Part A:



Examples of Interrupted Stay

- **Resident is discharged from Part A services, remains in the facility and <u>resumes</u> Part A services within the 3-day interruption window**.
  - **No** Part A PPS or OBRA Discharge required.
  - **No** Entry Tracking or 5-Day required on resumption.
- Subsequent stay is considered a <u>continuation</u> of the previous Medicare Part A covered stay.
- This **is** considered an Interrupted Stay because **both** criteria **were** met:
  - Discharge from Part A. ✔
  - Resumption of Part A within in the 3-day interruption window. ✔

Examples of Interrupted Stay (cont.)

- **Resident leaves the facility and resumes Part A services within the 3-day interruption window**.
  - **No** Part A PPS Discharge required but **OBRA Discharge is required**.
  - **Entry Tracking required,** and **OBRA Admission required on resumption** if discharge was return **not** anticipated.
  - **No** 5-Day required, and **no** OBRA Admission if discharge return anticipated.
- Subsequent stay is considered a continuation of the previous Medicare Part A covered stay.
- This **is** considered an Interrupted Stay because **both** criteria **were** met:
  - Discharge from Part A. ✓
  - Returned to the same facility to resume Part A within the 3-day interruption window. ✓

Examples of No Interrupted Stay

- **Resident is discharged from Part A services, remains in the facility, and <u>does not resume</u> Part A services within the 3-day interruption window.**
  - **Part A PPS Discharge is required.**
  - **5-Day required on resumption** if within the 30-day window allowed by Medicare.
  - OBRA schedule would continue from the beneficiary's original date of admission (item A1900).
- Subsequent stay, if there is one, is considered a **new** Part A stay.
- This is **not** considered an Interrupted Stay because **both** criteria were **not** met:
  - Discharge from Part A. ✓
  - Did **not** resume Part A services within in the 3-day interruption window. ✗

Examples of No Interrupted Stay

- **Resident is discharged from Part A services, leaves the facility, and <u>does not resume</u> Part A services within the 3-day interruption window**.
  - **Part A PPS Discharge and OBRA Discharge required** and may be combined**.**
  - **Entry Tracking Record and a 5-Day required on resumption** if within 30-day window allowed by Medicare.
  - **OBRA Admission required on resumption** if discharge was return **not** anticipated. If discharge return anticipated, no OBRA Admission required.
- Subsequent stay, if there is one, is considered a **new** Part A stay.
- This is **not** considered an interrupted stay because **both** criteria were **not** met:
  - Discharged from Part A . 
  - Did **not** return to the facility to resume Part A within in the 3-day interruption window. 

Practice Coding Scenario – Interrupted Stay

- Mr. J was receiving skilled services in a SNF 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 SNF on 4/23 at 4:00 p.m. and returned to the same SNF to resume skilled services under Part A on 4/25 at 7:00 p.m.

Q1 Is this an interrupted stay?

A. Yes

B. No

Q1 Is this an interrupted stay? (cont.)

A. Yes.

B. No.

Practice Coding Scenario – Interrupted Stay (cont. 1)

- **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 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 to the same SNF at 7:00 p.m. on the 3rd calendar day to resume Part A which is before 11:59 p.m. within the 3-day interruption window.

Q2 Which of the following assessments are required 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.

Q2 Which of the following assessments are required when Mr. J leaves the facility? (cont.)

A. OBRA Discharge.

B. Part A PPS Discharge.

C. Combined Part A PPS Discharge and OBRA Discharge

D. None of the above.

Practice Coding Scenario – Interrupted Stay (cont. 2)

- **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.

Q3 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.

Q3 Which of the following assessments/records are due when Mr. J returns to the facility to resume Part A services? (cont.)

A. 5-Day assessment.

B. OBRA Admission.

C. Entry Tracking Record

D. A and B.

Practice Coding Scenario – Interrupted Stay (cont. 3)

- **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.

A0410.

Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation: Coding Instructions

A0410. Unit Certification or Licensure Designation	
Enter Code ☐	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified

Coding Instruction for Code 1 was clarified to say that:

- "…if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and *neither CMS nor* the state has authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP."

A0600.

Social Security and Medicare Numbers

A0600A. Social Security Number

A0600. Social Security and Medicare Numbers	
	A. Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐ B. Medicare number: ☐☐☐☐☐☐☐☐☐☐☐☐

Coding Instructions amended to include a note:

- *A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.*

A0600B. Medicare Number

- Item set:
  - Parenthetical statement “or comparable railroad insurance number” was removed.
- Coding instructions updated:
  - For PPS assessments (A0310B = 01 *or 08*), the Medicare number (A0600B) must be present (i.e., may not be left blank).
  - A0600B *must* be a Medicare number.

A0700.

Medicaid Number

A0700. Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient


Coding Instruction was updated:

- Enter one number *or letter* per box beginning in the leftmost box.

A0800.

Gender

A0800. Gender

A0800. Gender	
Enter Code ☐	1. **Male** 2. **Female**

Coding Instruction was updated:

- Resident gender on the MDS *must* match what is in the Social Security system.

A1500. & A1510.

Preadmission Screening and Resident Review (PASRR) and Level II PASRR Conditions

Old vs. New Item

Section A	Identification Information
A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code ☐	**Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status
A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ **Check all that apply**	
☐	**A. Serious mental illness**
☐	**B. Intellectual Disability ("mental retardation" in federal regulation**
☐	**C. Other related conditions**

Section A	Identification Information
A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code ☐	**Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status
A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ **Check all that apply**	
☐	**A. Serious mental illness**
☐	**B. Intellectual Disability**
☐	**C. Other related conditions**

The parenthetical statement “mental retardation in federal regulation” was removed from A1500 and A1510B.

A2400.

Medicare Stay

A2400. Medicare Stay

A2400. Medicare Stay
Complete only if A0310G1= 0

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Coding Tips

- *Completed only when A0310G1 = 0.*
- *When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.*
- *Items A2400A–A2400C are not active when the OBRA Discharge assessment indicates the resident has had an interrupted stay (A0310G1 = 1).*

Section I: Active Diagnoses

Section I. Active Diagnoses: Intent

The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

One of the important functions of the Minimum Data Set (MDS) 3.0 assessment is to generate an updated, accurate picture of the resident's current health status.

I0020.

Indicate the Resident's Primary Medical Condition Category

Revisions: I0020 and I0020B

Section I	Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission
Complete only if A0310B = 01

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**
14. **Other Medical Condition** If "Other Medical Condition," enter the IC

I0020A.

Section I	Active Diagnoses

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

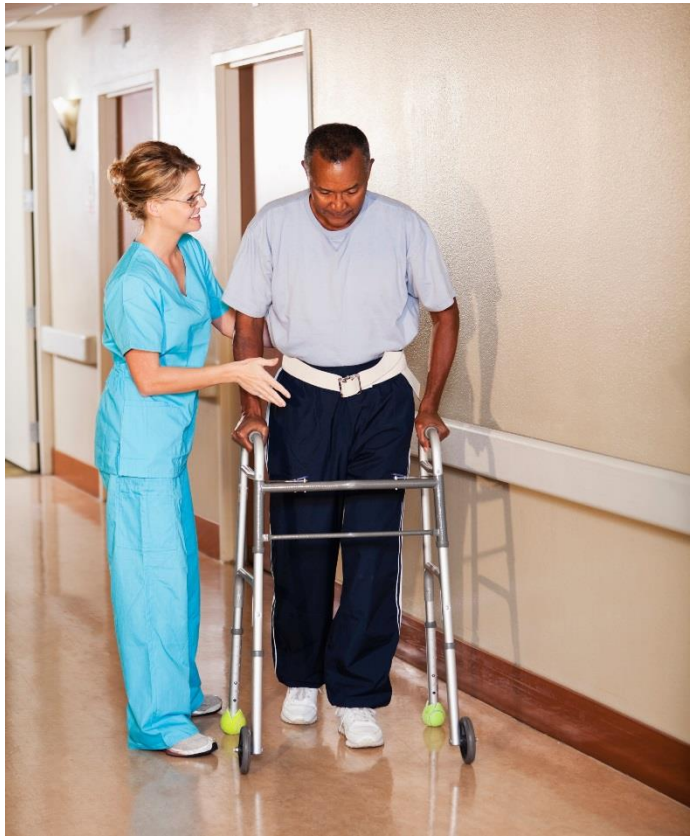
Enter Code

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

I0020. Item Rationale



- **Health-Related Quality of Life:**
  - Disease processes can have a significant adverse effect on resident's functional improvement.
- **Planning for Care:**
  - This item identifies the primary medical condition category that resulted in the resident's admission to the facility and that influences the resident's functional outcomes.

I0020. Steps for Assessment

Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the SNF facility.

I0020. Steps for Assessment (cont. 1)

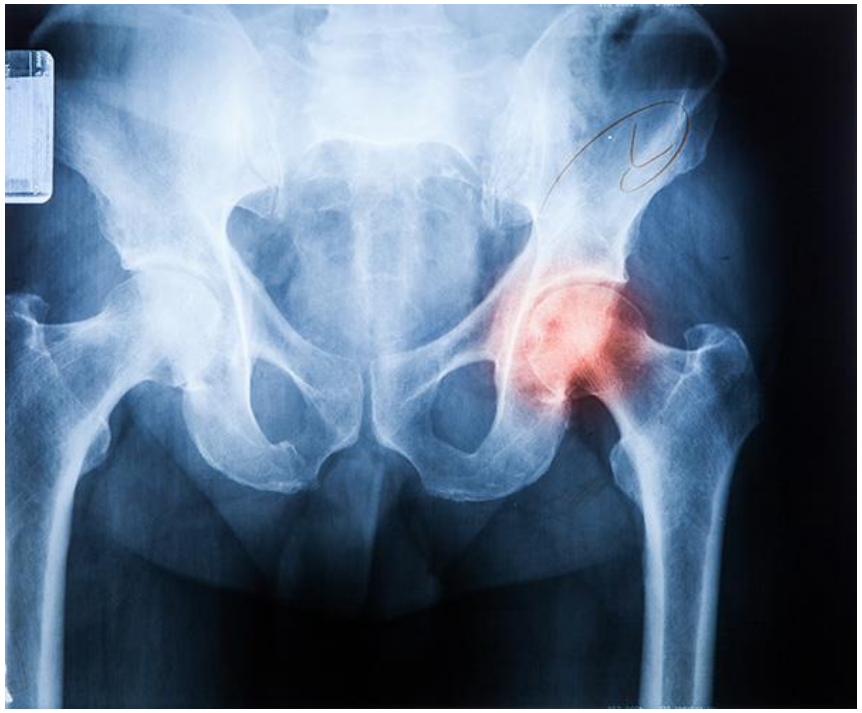
Medical Record Resources

- Transfer Documents
- Discharge Summaries
- History and Physical
- Progress Notes
- Other Resources

I0020. Steps for Assessment (cont. 2)

- There are 13 primary condition categories associated with the SNF Admission:
  1. Stroke.
  2. Non-Traumatic Brain Dysfunction.
  3. Traumatic Brain Dysfunction.
  4. Non-Traumatic Spinal Cord Dysfunction.
  5. Traumatic Spinal Cord Dysfunction.
  6. Progressive Neurological Conditions.
  7. Other Neurological Conditions.

I0020. Steps for Assessment (cont. 3)



8. Amputation.
9. Hip and Knee Replacement.
10. Fractures and Other Multiple Trauma.
11. Other Orthopedic Conditions.
12. Debility, Cardiorespiratory Conditions.
13. Medically Complex Conditions.

I0020. Coding Instructions

- Complete only if A0310B = 01 (Start of Part A Prospective Payment System (PPS) stay) or A0310B = 08 (Interim Payment Assessment).
- Enter the code that represents the primary medical condition that resulted in the resident's admission to the SNF and proceed to I0020B to enter the ICD Code (with decimal).
- Include the primary medical condition coded in Item I0020 in Section I0100 through I8000: Active Diagnoses in the Last 7 Days.

I0020. Coding Instructions (cont. 1)

- **Code 01, Stroke.**
  - Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
- **Code 02, Non-Traumatic Brain Dysfunction.**
  - Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.
- **Code 03, Traumatic Brain Dysfunction.**
  - Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

I0020. Coding Instructions (cont. 2)

- **Code 04, Non-Traumatic Spinal Cord Dysfunction.**
  - Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
- **Code 05, Traumatic Spinal Cord Dysfunction.**
  - Examples include paraplegia and quadriplegia following trauma.
- **Code 06, Progressive Neurological Conditions.**
  - Examples include multiple sclerosis and Parkinson's disease.

I0020. Coding Instructions (cont. 3)

- **Code 07, Other Neurological Conditions.**
  - Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
- **Code 08, Amputation.**
  - For example, acquired absence of limb.
- **Code 09, Hip and Knee Replacement.**
  - For example, total knee replacement.
  - If hip replacement is secondary to hip fracture, code as a fracture.
- **Code 10, Fractures and Other Multiple Trauma.**
  - Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

I0020. Coding Instructions (cont. 4)

- **Code 11, Other Orthopedic Conditions.**
  - For example, unspecified disorders of joint.
- **Code 12, Debility, Cardiorespiratory Conditions.**
  - Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
- **Code 13, Medically Complex Conditions.**
  - Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

I0020. Practice Coding Scenarios

I0020. Practice Coding Scenario 1

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.

Q4 How would you code I0020?

Indicate the resident's primary medical condition category for the Part A stay:

A. Code **01**, Stroke.

B. Code **06**, Progressive Neurological Conditions.

C. Code **12**, Debility, Cardiorespiratory Conditions.

D. Code **13**, Medically Complex Conditions.

Q4 How would you code I0020? (cont.)

Indicate the resident's primary medical condition category for the Part A stay:

A. **Code 01, Stroke.**

B. Code 06, Progressive Neurological Conditions.

C. Code 12, Debility, Cardiorespiratory Conditions.

D. Code 13, Medically Complex Conditions.

I0020. Practice Coding Scenario 1 (cont.)

- **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 (cont. 1)

- 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 diagnosis of pancreatitis was incorporated into Mrs. H's Part A SNF medical record.

Q5 How would you code I0020?

Indicate the resident's primary medical condition category for the Part A stay:

A. Code **09**, Hip and Knee Replacement.

B. Code **10**, Fracture and Other Trauma.

C. Code **11**, Other Orthopedic Conditions.

D. Code **13**, Medically Complex Conditions.

Q5 How would you code I0020? (cont.)

Indicate the resident's primary medical condition category for the Part A stay:

A. Code 09, Hip and Knee Replacement.

B. Code 10, Fracture and Other Trauma.

C. Code 11, Other Orthopedic Conditions.

D. Code 13, Medically Complex Conditions.

I0020. Practice Coding Scenario 2 (cont. 2)

- **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.)

I5900. Bipolar Disorder

I5900, manic-depression (bipolar disease) was changed to *bipolar disorder*.

Section I	Active Diagnoses
	Psychiatric/Mood Disorder
☐	**I5700. Anxiety Disorder**
☐	**I5800. Depression** (other than bipolar)
☐	**I5900. Manic Depression** (bipolar disease)
☐	**I5950. Psychotic Disorder** (other than schizophrenia)
☐	**I6000. Schizophrenia** (e.g.,
☐	**I6100. Post Traumatic Stre**

Section I	Active Diagnoses
	Psychiatric/Mood Disorder
☐	**I5700. Anxiety Disorder**
☐	**I5800. Depression** (other than bipolar)
☐	**I5900. Bipolar Disorder**
☐	**I5950. Psychotic Disorder** (other than schizophrenia)
☐	**I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
☐	**I6100. Post Traumatic Stress Disorder (PTSD)**

Section J: Health Conditions

Section J. Health Conditions: Intent

The last sentence of the Intent statement was updated to reflect the new items in this section:

- Prior Surgery.
- Recent Surgery Requiring Active SNF Care.
- Surgical Procedures.

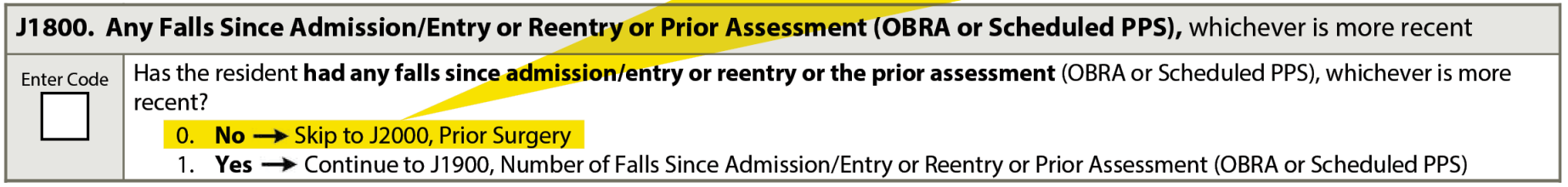
J1800.

Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), Whichever Is More Recent

J1800. Coding Instructions

- Coding Instructions were updated to allow for a new skip pattern:
- **Code 0. No**, if the resident has not had any fall since the last assessment:
  - If the assessment being completed is an OBRA assessment, skip to Swallowing Disorder item (K0100).
  - If the assessment being completed is a Scheduled PPS assessment, skip to Prior Surgery item (J2000).

0. **No** → Skip to J2000, Prior Surgery



J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent	
Enter Code ☐	Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent? 0. **No** → Skip to J2000, Prior Surgery 1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

J1900.

Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), Whichever Is More Recent

J1900. Number of Falls Since Admission/Entry or Prior Assessment (OBRA or Scheduled PPS), Whichever Is More Recent

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		
Coding: 0. **None** 1. **One** 2. **Two or more**	↓ **Enter Codes in Boxes**	
	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900. Examples Clarified

- Two examples were clarified:
  - Example 1.
    - A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, a *range of motion* assessment was completed that indicated no injury. *A skin assessment conducted shortly after the fall also revealed no injury.*
    - **Coding:** J1900A, No injury would be **coded 1, one**.
    - **Rationale:** Slipping to the floor is a fall. No injury was noted.

J1900. Examples Clarified (cont. 1)

- Example 5.
  - Mr. R. fell on his right hip in the facility on the Assessment Reference Date (ARD) of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly Assessment and coded the assessment to reflect this information. The assessment was submitted to Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP). Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly Assessment.

J1900. Examples Clarified (cont. 2)

- **Original Coding:**
  - J1900B, Injury (except major) *is* **coded 1, one** *and J1900C, Major Injury is* ***coded 0, none***.
- **Rationale:**
  - Mr. R. had a fall-related injury that caused him to complain of pain.
- **Modification of Quarterly Assessment:**
  - J1900B, Injury (except major), is coded 0, none; and J1900C, Major Injury, is coded 1, one.

J1900. Examples Clarified (cont. 3)

- **Rationale:**
  - The extent of the injury did not present right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly Assessment.
  - Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was not found to be different based on a repeat x-ray of the resident's hip, the Quarterly Assessment needed to be modified to accurately reflect the injury sustained during that fall.

J2100.

Recent Surgery Requiring Active SNF Care

J2100. Recent Surgery Requiring Active SNF Care

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**

- J2100 is completed only if A0310B = 01 (5-Day PPS) or 08 (Interim Payment Assessment).
- Complete J2300 through J5000 if J2100 is coded as 1, Yes.

J2100. Item Rationale

- **Health-Related Quality of Life:**
  - A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.
- **Planning for Care:**
  - This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

J2100. Steps for Assessment

1. Ask the resident and his or her family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident's Part A admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

J2100. Steps for Assessment (cont.)

Medical Record Resources

- Transfer Documents
- Discharge Summaries
- History and Physical
- Progress Notes
- Other Resources

J2100. Coding Instructions

- **Code 0, No:** If the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 1, Yes:** If the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 8, Unknown:** If it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

J2100. Coding Tips

Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:

- The resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
- The surgery carried some degree of risk to the resident's life or the potential for severe disability.

J2300. – J5000.

Surgical Procedures

J2300. – J5000. Surgical Procedures

Surgical Procedures - Complete only if J2100 = 1	
↓ **Check all that apply**	
	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) **or arm** (but not hand)
☐	**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** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**

J2300. – J5000. Item Rationale

- **Health-Related Quality of Life:**
  - A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.
- **Planning for Care:**
  - This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

J2300. – J5000. Steps for Assessment

1. **Identify recent surgeries:** The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.

J2300. – J5000. Steps for Assessment (cont. 1)

2. **Determine whether the surgeries require active care during the SNF stay:** Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay.

Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B.

Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period.

Check information sources in the medical record for the last 30 days to identify "active" surgeries.

J2300. – J5000. Steps for Assessment (cont. 2)

Medical Record Resources

- Transfer Documents
- Discharge Summaries
- History and Physical
- Progress Notes
- Other Resources

J2300. – J5000. Steps for Assessment (cont. 3)

- How do you determine whether a surgery should be coded as requiring active care during the SNF stay?
  - Specific documentation in the medical record indicates that the SNF stay is for treatment related to the surgical intervention.
  - No specific documentation exists, but complexity of services prescribed can only be performed safely/effectively by or under general supervision of skilled nursing and/or rehabilitation, such as:
    - Surgical wound care.
    - Daily skilled rehabilitative therapies.
    - Administration of medication and skilled monitoring.

J2300. – J5000. Coding Instructions

Key Points:

- Complete J2300 through J5000 only if J2100 is coded as 1, Yes.
- Check all surgeries that:
  - Are documented to have occurred in the last 30 days.
  - Occurred during the inpatient stay that immediately preceded the resident's Part A admission.
  - Have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.
  - Drive the resident's plan of care during the 7-day look-back period.

J2100. Practice Coding Scenarios

J2100. Practice Coding Scenario 1

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.

Q6 How would you code J2100?

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code **0**, No.

B. Code **1**, Yes.

C. Code **8**, Unknown.

Q6 How would you code J2100? (cont.)

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code 0, No.

B. Code 1, Yes.

C. Code 8, Unknown.

J2100. Practice Coding Scenario 1 (cont.)

- **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**, and the **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

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.

Q7 How would you code J2100?

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code **0**, No.

B. Code **1**, Yes.

C. Code **8**, Unknown.

Q7 How would you code J2100? (cont.)

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code 0, No.

B. Code 1, Yes.

C. Code 8, Unknown.

J2100. Practice Coding Scenario 2 (cont.)

- **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

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.

Q8 How would you code J2100?

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code **0**, No.

B. Code **1**, Yes.

C. Code **8**, Unknown.

Q8 How would you code J2100? (cont.)

Did the resident have a major surgical procedure during the prior inpatient stay that requires care during the SNF stay?

A. Code 0, No.

B. Code 1, Yes.

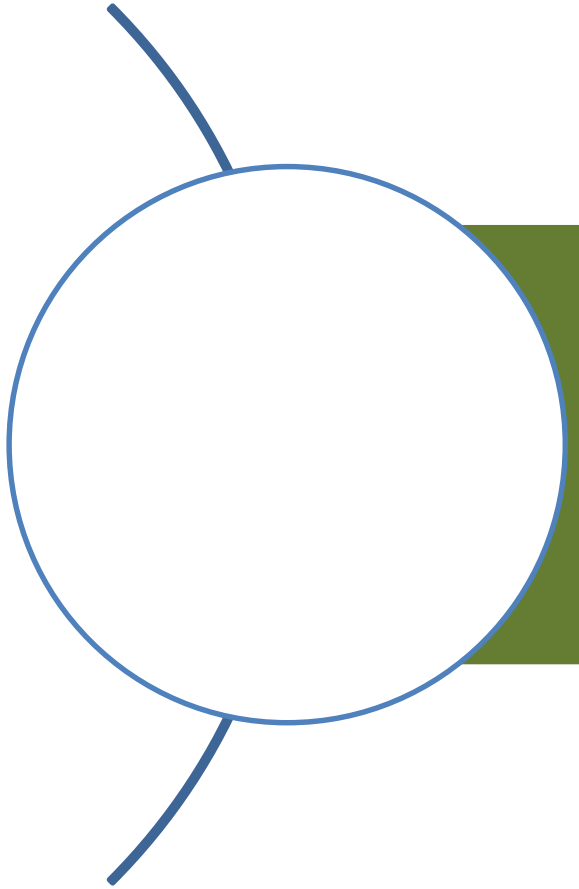
C. Code 8, Unknown.

J2100. Practice Coding Scenario 3 (cont.)

- **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

Section O. Special Treatments, Procedures, and Programs: Intent



The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

O0425.

Part A Therapies

O0425. Part A Therapies

O0425. Part A Therapies

Complete only if A0310H = 1

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes [ ][ ][ ][ ]

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes [ ][ ][ ][ ]

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes [ ][ ][ ][ ]

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

Enter Number of Minutes [ ][ ][ ][ ]

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days [ ][ ][ ]

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425. Part A Therapies

O0425. Part A Therapies

Complete only if A0310H = 1

B. Occupational Therapy

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Days [ ][ ][ ]

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425. Part A Therapies

O0425. Part A Therapies

Complete only if A0310H = 1

C. Physical Therapy

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425. Item Rationale

- **Health-Related Quality of Life:**
  - Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people.
  - Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility— such as incontinence and pressure ulcers/injuries—which contribute to diminished quality of life.

O0425. Item Rationale (cont. 1)

- The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents attain or maintain their highest level of well-being and improve their quality of life.

O0425. Item Rationale (cont. 2)

- **Planning for Care:**
  - Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
    1. Ordered by a physician based on a qualified therapist's assessment and treatment plan.
    2. Documented in the resident's medical record.
    3. Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
    4. Therapy treatment may occur either inside or outside of the facility.

O0425. Steps for Assessment

1. Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1. Yes.
2. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes) and consult with each of the qualified care providers to collect the information required for this item.

O0425. Modes of Therapy

- A resident may receive therapy via different modes during the same day or even treatment session. These modes are:
  - Individual,
  - Concurrent, and
  - Group therapy.
- When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately.

O0425. Modes of Therapy (cont.)

- The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy.
- For any therapy that does not meet one of the therapy mode definitions, those minutes may not be counted on the MDS.

O0425. Coding Tips and Special Populations

For detailed descriptions of how to code minutes of therapy and an explanation of skilled versus nonskilled therapy services, co-treatment, therapy aides, and students, please refer to these topic headings in the discussion of item O0400 in Section O of the RAI Manual.

O0425. Coding Instructions: Part A Therapy Minutes

Individual Therapy

- Treatment provided by one therapist or assistant to one resident at a time.

Individual Minutes

- Enter the total number of minutes of therapy that were provided on an individual basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if none were provided.

O0425. Coding Instructions: Part A Therapy Minutes (cont. 1)

Concurrent Therapy

- Treatment of two residents at the same time when the residents are **not** performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

Concurrent Minutes

- Enter the total number of minutes of therapy that were provided on a concurrent basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if none were provided.

O0425. Coding Instructions: Part A Therapy Minutes (cont. 2)

Group Therapy

- Treatment of four residents, regardless of payer source, who are performing the same or similar activities and are supervised by a therapist or an assistant who is not supervising any other individuals.

Group Minutes

- Enter the total number of minutes of therapy that were provided in a group during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if none were provided.

O0425. Coding Instructions: Part A Therapy Minutes (cont. 3)

Co-Treatment

- When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments.

Co-Treatment Minutes

- Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Skip the item if none were provided.

O0425. Coding Instructions: Therapy Days

- Remember: A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual, plus concurrent, plus group), without any adjustment to determine if the day is counted.
- If the resident receives more than one therapy discipline on a given calendar day, this may only count for 1 calendar day for the purposes of coding this item.

O0425. Coding Instructions: Therapy Days (cont. 1)

Speech-Language Pathology Days

- Enter the number of days speech-language pathology therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
- If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.

O0425. Coding Instructions: Therapy Days (cont. 2)

Occupational Therapy Days

- Enter the number of days occupational therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
- If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.

O0425. Coding Instructions: Therapy Days (cont. 3)

Physical Therapy Days

- Enter the number of days physical therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
- If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.

O0425. Practice Coding Scenario

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.

O0425. Practice Coding Scenario (cont. 1)

- 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.

O0425. Practice Coding Scenario (cont. 2)

- 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.

O0425. Practice Coding Scenario (cont. 3)

- 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.

O0425. Practice Coding Scenario (cont. 4)

- 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 23 minutes, 18 minutes, and 12 minutes.
  - Concurrent therapeutic exercises Monday through Friday for 20 minutes each day.
  - Discharged from PT services on 10/19/19.

O0425. Practice Coding Scenario Debrief

- **SLP Coding:**
  - O0425A1 would be **coded 270**, O0425A2 would be **coded 0**, O0425A3 would be **coded 0**, O0425A4 would be **coded 0**, and 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.

O0425. Practice Coding Scenario Debrief (cont. 1)

- **OT Coding:**
  - O0425B1 would be **coded 413**, O0425B2 would be **coded 0**, O0425B3 would be **coded 200**, O0425B4 would be **coded 53**, and 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.

O0425. Practice Coding Scenario Debrief (cont. 2)

- **PT Coding:**
  - O0425C1 would be **coded 638**, O0425C2 would be **coded 200**, O0425C3 would be **coded 180**, O0425C4 would be **coded 47**, and O0425C5 would be **coded 13**.
- **Rationale:**
  - Individual minutes (including 53 co-treatment minutes) totaled 632 over the stay [(45 × 13) + (23 + 18 + 12) = 638].
  - 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.

NEW

O0430.

Distinct Calendar Days of Part A Therapy

O0430. Distinct Calendar Days of Part A Therapy

O0430. Distinct Calendar Days of Part A Therapy Complete only if A0310H = 1	
Enter Number of Days ☐☐☐	Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

This item is completed only on a Part A PPS Discharge Assessment (A0310H = 1).

O0430. Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, OT, or PT for at least 15 minutes during the Part A SNF stay.

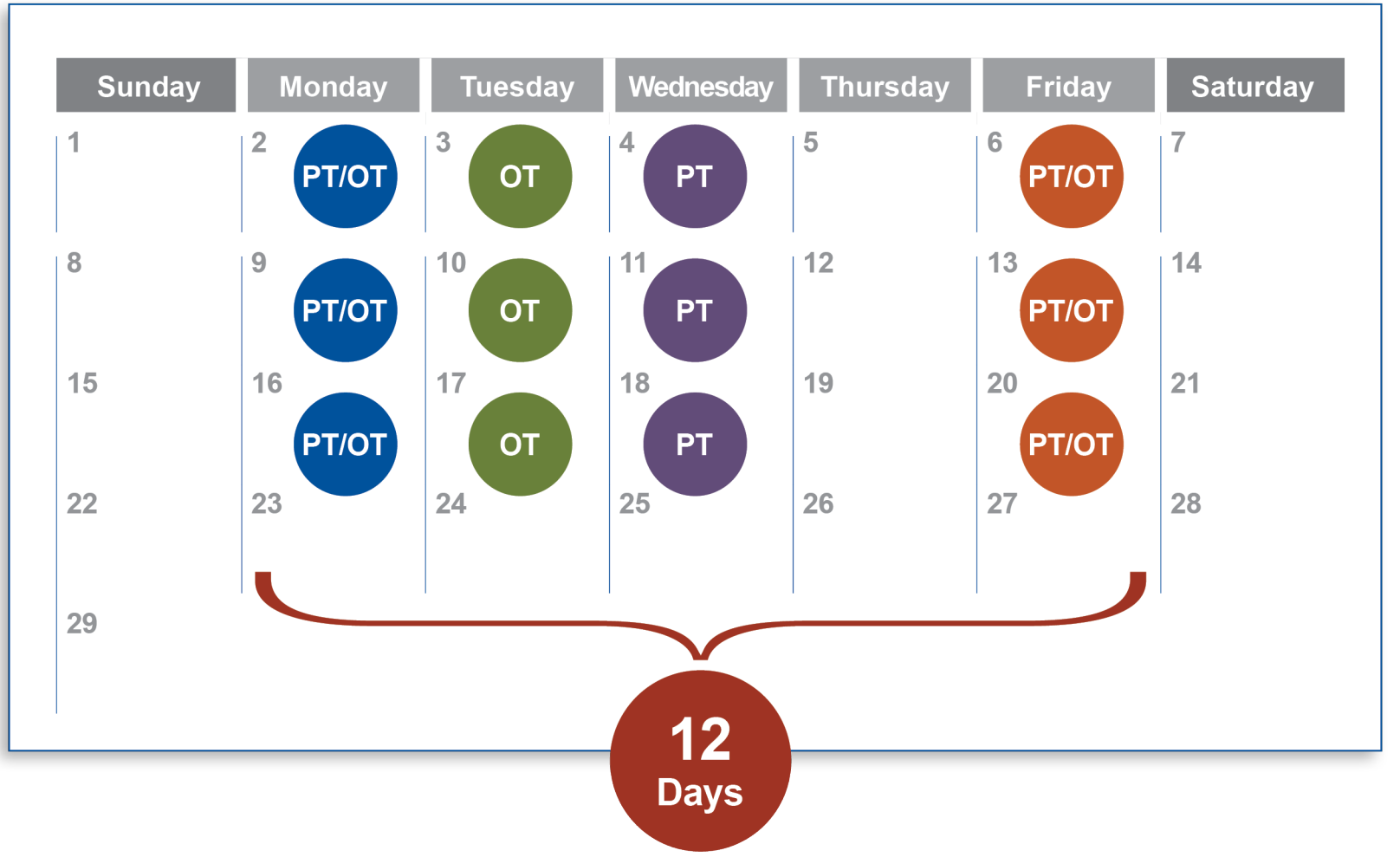
O0430. Coding Instructions

- Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, OT, or PT for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C).
- If a resident receives more than one therapy discipline on a given calendar day, this may only count for 1 calendar day for the purposes of coding item O0430.

O0430. Coding Instructions (cont. 1)

- Example: Mrs. T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18.
  - She received a total of 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay.
  - Mrs. T also received a total of 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay.

O0430. Coding Instructions (cont. 2)



O0450.

Resumption of Therapy

O0450. Resumption of Therapy

O0450. Resumption of Therapy	
Enter Code ☐	A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline? 0. No 1. Yes

This item is no longer required by CMS; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

Summary

Summary

In this lesson, you learned:

- About the updates in Sections A, I, J and O.
- How to apply coding instructions to accurately code practice scenarios and the case study.

Record Your Action Plan Ideas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Questions?