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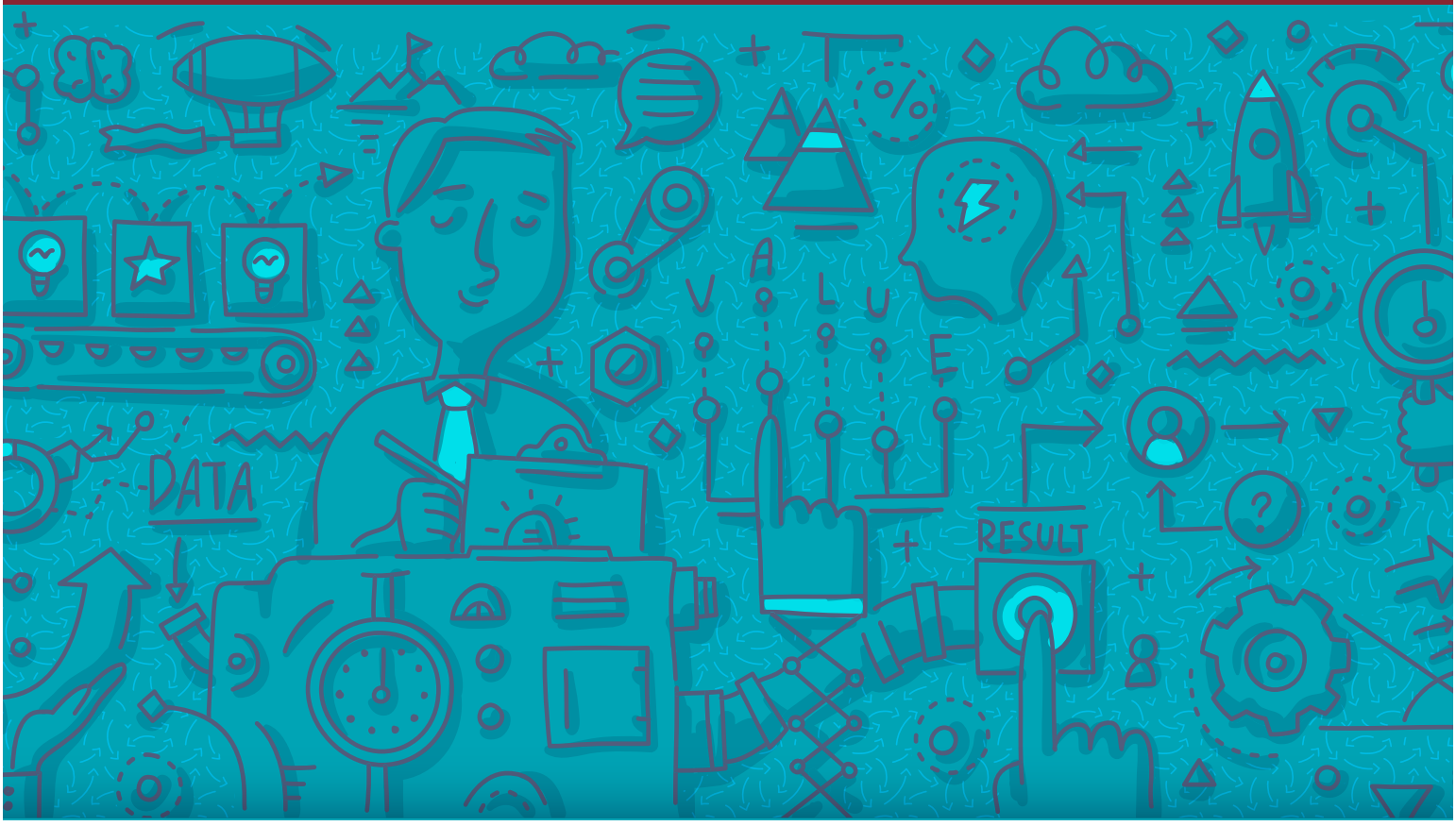
New Process Improvement Starter Kit:

The Top 5 PDPM Process Improvement Solutions



CONTENTS

IMPLEMENTATION GUIDE

PDPM success is contingent upon excellent communication. Therapy no longer drives the meeting process as all disciplines within the IDT must contribute to the collection of data to assure coding accuracy. HTS has uniquely positioned itself with a team of seasoned therapists and nurses to analyze data trends for system optimization under PDPM. The intricacies of attaining collaborative information for MDS coding can be challenging. In order to better partner with you, HTS has created several resources and meeting forms to assure communication is at the forefront of your interdisciplinary team's data collection process. This New Process Improvement Starter Kit will catapult your building's ability to tackle PDPM challenges with the use of 5 PDPM solutions.

Suggested Training Format:

The administrator or another facility staff member selected is to facilitate new process improvement meetings or tools. The meeting date and time for necessary facility staff to be present is recommended to be specified.

How to Use These Tools:

These tools are to be used as a guide for process improvement related to PDPM components to improve interdisciplinary communication, thorough collection of patient data, and accuracy of coding.

Practical Applications:

Consider your building's process for attaining PDPM coding. You may implement one or more of:

- Improvement process tools to attain the most accurate clinical picture for optimal PDPM coding
- HTS Meeting forms and discussion guides to structure the communication process in your building
- Observations as part of an ongoing competency monitoring plan related to PDPM processes

The HTS Top 5 PDPM Solutions

1) Initial Medicare Meeting Tool & Discussion Guide

The Initial Medicare Meeting is recommended to facilitate interdisciplinary communication related to coding on the MDS. Accurate coding results in the PDPM case mix groups that are representative of the patients' clinical status and promote a patient-centered care delivery model. The Initial Medicare Assessment Meeting Form is a structured tool for communication and documentation system to achieve optimal coding in your building. A discussion guide was also created to detail each item present on the meeting form.

2) Physician Query Process

HTS is committed to advocating for proper documentation practices. The Initial Medicare Meeting Tool may identify a query opportunity. Such queries are made in situations such as:

- Clinical indicators of a diagnosis are present, but there is no documentation of the condition
- Clinical evidence is present to support a higher degree of specificity or severity
- Uncertainty of a cause-and-effect relationship between two conditions or organisms
- An underlying cause when admitted with symptoms
- Only the treatment is documented (without a diagnosis documented)
- Clinical validation of a diagnosis

In order to facilitate the physician query process, a policy and template have been provided in this toolkit. It is recommended for the administrator or another designated facility staff member to champion this process improvement implementation.

3) SLP Component Communication Tool

Clinically indicated coding to support SLP PDPM Components is an opportunity across the industry. HTS created the "SLP Component Communication Tool" to effectively communicate the SLP's (or OT's) clinical perspective on related MDS items. Once completed, this tool is to be brought to the Initial Medicare Meeting for discussion by the interdisciplinary team so that the MDS Coordinator is aware of all the data available prior to coding in MDS sections B, C, I, and K. Please note this tool is completed when there is therapy involvement with the case.

4) NTA Case-Mix Group Classification Guide & NTA Quick Tips

This reference tool provides at-a-glance information that is useful in understanding and implementing strategies for coding for the NTA component of PDPM. Use the NTA Quick Tips Reference to familiarize staff with the NTA component and process improvement ideas. Additionally, this one-page reference allows your team to review the 5 most commonly missed NTA coding opportunities!

5) Nursing Classification Guide

This one-page guide offers a quick solution to assure nursing classification is clinically indicated. Nursing function score, PHQ-9 score, and classification requirements are all available for your team's review to assure the Nursing Case Mix Group is reflective of the patients' needs and the nursing care delivered.

Other Recommended Tools Available to HTS Partners:

- BIMs Toolkit
- Triple Check Toolkit
- Infection Control Toolkit
- Function Score Quick Tips
- Section GG Daily Documentation Form

Get Started Today!

HTS Partners have instant access to all of the tools and resources mentioned above by logging into the PartnerHQ Web Portal. If you have trouble accessing your login credentials, please contact HTS Marketing at marketing@htstherapy.com.

Initial Medicare Assessment Meeting Tool

Patient Name: Date:

Suggested Items for IDT to bring to meeting to guide discussion:

- ☐ Hospital H&P and DC Summary (NSG)
- ☐ Proof of Supportive Doc. for Coding (NSG)
- ☐ MDS Observations for GG Coding (MDS)
- ☐ Medication/Treatment List (NSG)
- ☐ Therapy Treatment ICD.10 Codes (TX)
- ☐ PLOF Form (SS)
- ☐ Preadmission Form (SS)
- ☐ Observations for Section GG (NSG)
- ☐ List of Skilled Nursing Opportunities (NSG)
- ☐ Therapy Function Scores (GG) (TX)
- ☐ 5-Day Assessment Tool (TX)
- ☐ Confirmation of Payor Source (BOM)
- ☐ BIMS Score (MDS)
- ☐ Therapy Skilled Intervention Plan - inc. frequency/duration, ST/LTGs, est. LOS (TX)

Administrator or another member of leadership runs the meeting & guides the discussion:

Y	N	Item	Comments
		Confirm a Qualifying Hospital Stay Occurred	
		Confirm Payor Source	Days Remaining: _____ Days Used: _____
		Review Pre-admission Paperwork	
		Review Hospital DC Paperwork to Assure Dx Codes and Treatments are Captured	
		Primary ICD.10 Diagnosis is Selected and Distributed to the IDT (Therapy, Billing, MDS, etc.)	Primary ICD.10 Code: _____
		Review List of NTA Comorbidities to be Coded	
		Discuss Sequencing of Top 8 ICD.10 Codes on Line H of UB04. Assure Primary ICD.10 Code is 1st; most Supportive Codes Following.	List ICD.10 Code Sequence:
		Physician Documentation Supports All ICD.10 Codes Captured on MDS	
		Functional Scores (Sec GG) from 1st Three Days of Admission Documented	
		Discuss Medications/Treatments to Capture All Active Treatments (Active within Last 7 Days)	
		Discuss Skilled Nursing Opportunities	
		Discuss Depression Evaluation	PHQ9 Score: _____ Documentation of Interventions:
		Review Cognitive Status / BIMS Score	
		Discuss Sec K Coding with Input from SLP, Dietitian, NSG, MDS - Reference 5-Day Assessment Tool	
		Discuss & Document DC Plan Across Disciplines	If Returning Home, List Resource / Equipment Needs:
		Review Restorative Nursing Program(s) Implemented	
		Discuss any New Issues Related to QMs / Review Reports	

Initial Medicare Assessment (IMA)
Meeting Discussion Guide

Administrator: Ensures all attendees are present, timely, and prepared with suggested items:

- ☐ Hospital H&P and DC Summary (NSG)
- ☐ Proof of Supportive Doc. for Coding (NSG)
- ☐ MDS Observations for GG Coding (MDS)
- ☐ Medication/Treatment List (NSG)
- ☐ Therapy Treatment ICD.10 Codes (TX)
- ☐ PLOF Form (SS)
- ☐ Preadmission Form (SS)
- ☐ Observations for Section GG (NSG)
- ☐ List of Skilled Nursing Opportunities (NSG)
- ☐ Therapy Function Scores (GG) (TX)
- ☐ 5-Day Assessment Tool (TX)
- ☐ Confirmation of Payor Source; available days (BOM)
- ☐ BIMS Score (MDS)
- ☐ Therapy Skilled Intervention Plan - include frequency/duration, ST/LTGs, estimated LOS (TX)

Recommended Meeting Timeframe: Day 4, 5 or 6 – after section GG coding has been gathered

Following the Medicare A census, the administrator leads/directs the meeting using this guide to facilitate team discussion:

- Administrator verifies the following for each new admission:
    - Confirm the qualifying hospital stay
    - Confirm documentation is present to support the stay
    - Assure the MD Cert/Recert is complete and accurate
- BOM confirms the payor source and the days remaining; days used are noted in the comments section of the meeting form
- Review Pre-admission paperwork
    - Discuss potential diagnoses that are presumably active and coded on the MDS
        - » MDS and IDT to confirm coding as active and supported via documentation
        - » Discuss querying the physician for supportive documentation if indicated, or
        - » Confirm the diagnosis is no longer active and assure coding is accurate on the MDS
- Nursing presents hospital DC paperwork and the team assures dx codes and treatments are captured as clinically indicated
- MDS Coordinator selects/presents the primary ICD.10 diagnosis
    - IDT discusses the code selected
    - The primary code is communicated to therapy, billing, etc
    - The codes match on the UB04 (line H) and MDS Section I0020B
- IDT reviews the list of NTA comorbidities to be coded
    - Confirm the codes are active and supported by documentation
    - Discuss the need for physician query for any identified diagnoses
    - Recommend Resource: NTA Quick Tips
- Discuss the top 8 ICD.10 Codes that will be positioned on line H of the UB04
    - Assure the primary ICD.10 code is 1st on line H
    - Assure the most supportive codes are following the primary code on line h
        - » Discuss sequencing during the meeting
    - *Business office manager to utilize details of this discussion for sequencing on UB04*
- Review physician documentation to assure the ICD.10 codes on the MDS are supported

- Discuss the function scores (section GG) from the 1st three days of admission (usual performance before therapeutic intervention)
    - Assure there is collaborative documentation to support coding choices and such documentation is available within the medical record
    - Document any inconsistencies and reasoning
    - If there isn't consistency
        - » Determine the problem
        - » Consider observation of ADLs and review coding process
        - » Provide additional education if warranted
- Discuss Medications/Treatments to capture all active treatments (active within the last 7 days)
- Discuss any skilled nursing opportunities
    - Recommended: *HTS Nursing Classification Guides* to assure opportunities are not missed
        - » Ex: COPD is diagnosis & SOB is present and documented, nursing group is Special Care High
- Discussion depression capture
    - PHQ9 score
        - » Was this completed at a time of day that is representative of the patient's typical clinical presentation?
        - » Review RAI guidelines for administration as indicated
        - » Recommended: *Therapists to use HTS Impacting Depression Clinical Protocol* when indicated
- Review Cognitive Status
    - Discuss the BIMs Score
        - » Was this completed at a time of day that is representative of the patient's typical clinical presentation?
        - » Review RAI guidelines for administration as indicated
        - » Recommended Resource: *HTS BIMS Toolkit*
        - » Cross reference with the SLP Communication Component Tool and SLP evaluation (if completed) to document any inconsistencies across the record or more in-depth testing completed
        - » Discuss ACL score if performed by OT
        - » Discuss and document any modified approaches to care due to cognition
- Discuss Section K Coding with input from the SLP, Dietician, Nursing, and MDS
    - Use the SLP Communication Component Tool for therapy input on section K coding
    - Dysphagia evaluations (if applicable) serve as support for section K coding
    - Recommended Resource: *Section K Quick Reference: Optimize Coding in Section K*
- Discuss and document DC Plan Across Disciplines
    - If returning home, social services to list resource/equipment needs
- If the facility offers restorative services as an adjunct to skilled therapy, discuss the details
    - Frequency and duration
    - Patient response to services
    - On-going need to progress programming based on advancements in therapy

***All HTS recommended resources are available on PartnerHQ Web Portal. HTS Partners have instant access to all of the tools and resources mentioned above by logging into the PartnerHQ Web Portal. If you have trouble accessing your login credentials, please contact HTS Marketing at marketing@htstherapy.com.**

Updated 3/2021

Physician Query Process, Policy & Procedure

POLICY STATEMENT & PURPOSE

The facility is committed to advocating proper documentation practices. This policy describes the expectation for the use of a query process to enhance the facility's compliance with billing/coding rules and to serve as an educational tool for providers and facility staff.

PROCEDURES

1. Providers will be educated about the need for the provider query process to generate their constructive communication and promoting regulatory agency compliance.
2. Queries will be initiated as a result of variation in documentation practices by providers. Queries may be made in situations such as:
    - Clinical indicators of a diagnosis present, but no documentation of the condition
    - Clinical evidence present to support a higher degree of specificity or severity
    - Uncertainty of a cause-and-effect relationship between two conditions or organisms
    - An underlying cause when admitted with symptoms
    - Only the treatment is documented (without a diagnosis documented)
    - Clinical validation of a diagnosis
3. It may be appropriate to generate a provider query when documentation in the patient's record fails to meet one of the following criteria:
    a. Legibility
    b. Completeness
    c. Clarity
    d. Consistency
    e. Precision
    f. Reliability
    g. Timeliness
4. Provider documentation entries in the medical record should:
    a. Address clinical significance of abnormal test results
    b. Support the intensity of patient evaluation and treatment and describe the thought process and complexity of medical decision making
    c. Include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed in addition to the results
    d. Include any changes in the patient's condition, including psychological and physical symptoms
    e. Include all conditions that coexist at the time of the admission, that subsequently develop, or that affect the treatment received and the patient's length of stay
5. Queries may be either verbal or written, verbal queries will follow same format as written
6. Written and e-mail queries will be made utilizing compliant query templates

7. Query templates may only be edited as follows:
    a. Deletion of any part of the query form not pertinent to the query
    b. Add any pertinent clinical findings as documented in the health record
8. All queries will:
    a. Be clear, concise, and non-leading
    b. Be simple and direct
    c. Indicate the clinical indicators or clues (example: documentation found in nursing documentation, but not mentioned in the primary providers documentation, lab findings, radiological findings) in the medical record
9. The query should contain all of the patient's identifying information such as name, date of admission, room number, etc. as well as clear concise itemization of the clinical findings with supporting documentation resulting in a specific question for the provider
10. Queries may be initiated by either health information management or MDS staff
11. All queries will be logged for follow-up, to track responses and to trend for any documentation issues that may indicate additional documentation improvement educational opportunities for providers or over use of queries by facility staff

APPROVALS	**Printed Name**	**Signature**	**Date**
Executive Leadership			
Chief Compliance Officer			
General Counsel			
REVIEW and REVISIONS			
Version #: Date:			
Summary of changes:			
Version #: Date:			
Summary of changes:			

Instructions for Physician Query
(located on next page)

Use the following steps to assist in completing the following query template(s).

1. Review the record and identify your query opportunity.
2. Select the query template that best fits your query need.
3. Fill in each section of the query to add the specificity needed for each patient. You may addfree text in the open response boxes provided; each query should include all the clinicalindicators used to support the query. Click on the free text or drop down box to insert the queryspecific information. Use the Check Boxes next to selections to indicate your appropriateresponse.
    a. Insert the Provider's name in the first open response box.
    b. Describe the opportunity
    c. Enter the date/ location in regards to the reference document.
    d. Fill out the following table with the drop-box selections provided, if there are anyadditional indicators that are not included in the list or if there are more than four,describe or list them below the table in the "Other Indicators" open response field.
    e. Use the check boxes to select one question to be asked of the provider.
    f. Select one or both of the first two check boxes to insert an open response diagnosticoption, or select from the remaining three options (If "Other explanation of clinicalfindings" is selected, please identify the findings using the open response box provided).

Physician Query

Provider name(s):_____

Opportunity: _____

Reference document date/location(s): _____

Signs & Symptoms	Treatments	Risk Factors

Other Indicators: _____

Select a question to be asked of the provider:

- ◯ Can this diagnosis be further specified?
- ◯ Can this relationship between these two diagnoses be further specified?
- ◯ Can this diagnosis be further specified as present on admission or developed after admission?
- ◯ Can an associated diagnosis be documented?

Please either enter a diagnostic option(s) or select one of the provided options below.

- ◯ _____

  _____
- ◯ Other explanation of clinical findings: _____

  _____
- ◯ Unable to determine.
- ◯ No further clarification needed.

SLP Component Communication Tool – Page 1 of 2

IMA ARD: _____

MDS Item	Item Description	Therapy PDPM Component	Scoring Method	Comments
Section B				
B0700	Makes Self-Understood	**SLP Component**	☐ Yes ☐ No	
Section C				
C0500	BIMS Summary Score	**SLP Component**	Nursing to complete BIMS	Consider using BIMS score within documentation/compare BIMS results with therapy cognitive and/or communicative testing for consistency.
C0700	Short-term Memory OK	**SLP Component**	☐ Memory OK ☐ Memory Problem	Memory considered OK if the resident recalled information after 5 minutes.
C1000	Cognitive Skills for Daily Decision Making	**SLP Component**	☐ Independent ☐ Modified Independent ☐ Moderately Impaired ☐ Severely Impaired	
Section I				**Must be an active diagnosis in the last 7 days**
I4300	Aphasia	**SLP Comorbidity**	☐ Yes ☐ No	
I4500	CVA, TIA, or Stroke	**SLP Comorbidity**	☐ Yes ☐ No	
I4900	Hemiplegia or Hemiparesis	**SLP Comorbidity**	☐ Yes ☐ No	
I5500	Traumatic Brain Injury *(TBI)*	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	Laryngeal Cancer* C32.-	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	Apraxia* I69.990	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	Dysphagia* I69.991	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	ALS* G12.21	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	Oral Cancers* C00.- C04.- C05.- C06.- C01.-C09.- C02.- C10.- C03.- C14.0-	**SLP Comorbidity**	☐ Yes ☐ No	
I8000	Speech and Language Deficits* I69.92-	**SLP Comorbidity**	☐ Yes ☐ No	
Section K				
K0100A	Loss of liquids/solids from mouth when eating or drinking	**SLP Component**	☐ Yes ☐ No	
K0100B	Holding food in mouth/cheeks or residual food in mouth after meals	**SLP Component**	☐ Yes ☐ No	
K0100C	Coughing or choking during meals or when swallowing medications	**SLP Component**	☐ Yes ☐ No	
K0100D	Complaints of difficulty or pain with swallowing	**SLP Component**	☐ Yes ☐ No	
K0100Z	None of the above	**SLP Component**	☐ Yes ☐ No	
K0510C2	Mechanically Altered Diet While a Resident	**SLP Component**	☐ Yes ☐ No	

**See CMS PDPM Calculation Worksheet for SNFs for a list of qualifying diagnoses*

***See "Care Items Section GG Items Specification" Tool for MDS Section GG Coding Specifications*

****This tool is not to be used as supportive documentation. All supportive documentation must be located in the medical record. Use this tool to promote consistency and accuracy of information.*

Coding Reference

MDS Item B0700 – Makes Self Understood

- Code 0, understood: if the resident expresses requests and ideas clearly
- Code 1, usually understood: if the resident has difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood
- Code 2, sometimes understood: if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet)
- Code 3, rarely or never understood: if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet)

MDS Items C0700 and C1000 are portions of staff assessment when the resident is not interviewable and the BIMS cannot be completed.

- To determine memory OK or memory problem the following must occur:
  - Code 0, memory OK: if the resident recalled information after 5 minutes
  - Code 1, memory problem: if the most representative level of function shows the absence of recall after 5 minutes

- C1000 cognitive skills for daily decision making
  - Code 0, independent: if the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values
  - Code 1, modified independence: if the resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations
  - Code 2, moderately impaired: if the resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines
  - Code 3, severely impaired: if the resident's decision making was severely impaired; the resident never (or rarely) made decisions

I4300; I4500; I4900; I5500; I8000 must be an active diagnosis within the last 7 days:

Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. 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, as these would be considered inactive diagnoses.

NTA Classification Guide

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	SNF Claim ICD-10 B20	8
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator Post-admit Code	O0100F2	4
Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes (DM)	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Post-admit Code	O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1

Condition/Extensive Service	MDS Item	Points
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A M1040B M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

NTA Comorbidity Score	NTA Case Mix Group	CMI
12+	NA	3.24
9-11	NB	2.53
6-8	NC	1.84
3-5	ND	1.33
1-2	NE	0.96
0	NF	0.72

SNF PDPM ICD-10 Mappings: *crosswalk between the listed condition and the ICD-10-CM codes which must be coded to qualify that condition to serve as part of the resident's NTA classification*

Version 6/2020

Non-Therapy Ancillary (NTA) Quick Tips

NTA Component

- Non-Therapy Ancillary (NTA) comprise 50 conditions and extensive services, 34 related to diagnosis.
- The NTA comorbidity score is the result of a weighted count of a patient's comorbidities, rather than using a simple count of comorbidities.
- In order to determine the patient's NTA comorbidity score, a provider would identify all comorbidities for which a patient would qualify and then add the points for each comorbidity together. The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA component classification group.
- Payment Adjustment; days 1-3 CMI 3x higher
- Over 1,500 ICD-10-CM codes can be used to report presence of NTA items
- Non-Therapy Ancillary (NTA) requires the following for an active diagnosis:
    1. Physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last **60 days**.
    2. Diagnosis 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 in the past 7 days (except UTI-last 30 days) (RAI, p. I-7).

Refer to the ICD-10 NTA Comorbidity Crosswalk for I8000-derived comorbidities with acceptable ICD-10 codes that map to the NTA component and to the NTA item listing for a complete list of NTA conditions/services

NTA Component Tips

- Clinical Meeting
    - Review new orders daily
    - Discuss changes in conditions daily; wound care, need for IV medications, intermittent catheterizations, suctioning, etc.
- Review resident's needs and diagnosis prior to admission and at weekly Medicare meetings.
- Ensure supportive documentation is in place during assessment look-back periods for conditions being managed or services being provided
- Consider a system for maintaining an active diagnosis list. Active diagnosis includes:
    - Recent onset or acute exacerbation of the disease or condition indicated by a positive test, study, or procedure.
    - Hospitalization for acute symptoms and/or recent change in therapy in the last 7 days.
    - Symptoms & abnormal signs indicating ongoing or decompensated disease in last 7 days.
    - Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in last 7 days
- Monitor for significant changes in the resident's condition and care needs after completion of the 5-day assessment; this may warrant completion of the IPA.
- Focus on the most common comorbidities; Diabetes Mellitus, COPD/Asthma/Chronic Lung Disease, IV medication use in the facility, Feeding tubes, Intermittent catheterizations, Ostomy needs.
- Be sure to query the physician if a diagnosis is not clear or is suspected. Example; resident admits with a diagnosis of obesity. However, the weight meets the definition for morbid obesity. Don't be afraid to ask!
- Common missed NTA's include:
    - Wound infection
    - Multi-Drug Resistant Organism (MDRO)
    - Opportunistic Infections- 37 different ICD-10 codes can be coded in I8000 to qualify for the NTA comorbidity
    - Cardio-Respiratory Failure & Shock
    - Malnutrition or Morbid Obesity

Center for Medicare and Medicaid Services. (2019). MDS 3.0 RAI Manual. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

PDPM NURSING CLASSIFICATION GUIDE

EXTENSIVE SERVICES

Total Nursing Function Score (NFS) = 0 - 14	NFS	Nursing Classification
• Tracheostomy care **AND** ventilator/respirator *(while a resident)*	0 – 14	ES3
• Tracheostomy care **OR** ventilator/respirator *(while a resident)*	0 – 14	ES2
• Isolation or quarantine for active infectious disease *(while a resident)*	0 – 14	ES1

SPECIAL CARE HIGH

Total Nursing Function Score (NFS) = 0 - 14	NFS	PHQ-9 Score	Nursing Class.
• Comatose **and** completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all = 01, 09, or 88)	0 – 5	10 or greater	HDE2
	0 – 5	Less than 10	HDE1
	6 – 14	10 or greater	HBC2
	6 – 14	Less than 10	HBC1
• Septicemia			
• Diabetes with **both** of the following: ✓ Insulin injections for all 7 days ✓ Insulin order changes on 2 or more days			
• Quadriplegia **with** NFS Score <=11			
• COPD **and** SOB when lying flat			
• Fever with **one** of the following: ✓ Pneumonia ✓ Vomiting ✓ Weight loss ✓ Feeding tube **with** requirements[1]			
• Parenteral/IV feedings			
• Respiratory Therapy for all 7 days			

SPECIAL CARE LOW

Total Nursing Function Score (NFS) = 0 - 14	NFS	PHQ-9 Score	Nursing Class.
• Cerebral palsy **with** NFS <=11	0 – 5	10 or greater	LDE2
• Multiple sclerosis **with** NFS <=11	0 – 5	Less than 10	LDE1
• Parkinson's disease **with** NFS <=11	6 – 14	10 or greater	LBC2
• Respiratory failure **and** oxygen therapy *(while a resident)*	6 – 14	Less than 10	LBC1
• Feeding tube **with** requirements[1]			
• Two or more stage 2 pressure ulcers **with** two or more selected skin treatments[2]			
• Any stage 3 or 4 pressure ulcer **with** two or more selected skin treatments[2]			
• One stage 2 pressure ulcer **and** one venous/arterial ulcer **with** two or more selected skin treatments[2]			
• Foot infection **or** diabetic foot ulcer **or** other open lesion of foot **with** application of dressings to the feet			
• Radiation treatment *(while a resident)*			
• Dialysis treatment *(while a resident)*			

[1]Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories **OR**
(2) K0710A3 is 26% to 50% of total calories **AND** K0710B3 is 501 cc or more per day fluid intake in last 7 days

[2]Selected skin treatments:

M1200 A or B – Pressure relieving device to chair and/or bed
M1200C – Turning/repositioning program
M1200D – Nutrition or hydration intervention
M1200E – Pressure ulcer care
M1200G – Application of dressing (other than to feet)
M1200H – Application of ointments/medications (other than to feet)

[3]Selected skin treatments:

M1200F – Surgical wound care
M1200G – Application of dressing (other than to feet)
M1200H – Application of ointments/medications (other than to feet)

CLINICALLY COMPLEX

Total Nursing Function Score (NFS) = 0 - 16	NFS	PHQ-9 Score	Nursing Class.
• Pneumonia	0 – 5	10 or greater	CDE2
• Hemiplegia/hemiparesis with NFS <=11	0 – 5	Less than 10	CDE1
• Open lesions (other than ulcers, rashes, and cuts) **with** any selected skin treatment[3] **or** surgical wounds	6 – 14	10 or greater	CBC2
	6 – 14	Less than 10	CBC1
• Burns			
• Chemotherapy *(while a resident)*	15 – 16	10 or greater	CA2
• Oxygen therapy *(while a resident)*	15 – 16	Less than 10	CA1
• IV medications *(while a resident)*			
• Transfusions *(while a resident)*			

BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Total Nursing Function Score (NFS) = 11 – 16	NFS	Restorative Programs	Nursing Class.
• BIMS Summary Score <=9 **OR** CPS >=3	11 – 16	2 or more	BAB2
• Hallucinations	11 – 16	0 or 1	BAB1
• Delusions			
• Physical behavioral symptoms directed toward others *(4 or more days)*			
• Verbal behavioral symptoms directed toward others *(4 or more days)*			
• Other behavioral symptoms not directed toward others *(4 or more days)*			
• Rejection of care *(4 or more days)*			
• Wandering *(4 or more days)*			

REDUCED PHYSICAL FUNCTION

Total Nursing Function Score (NFS) = 0 – 16	NFS	Restorative Programs	Nursing Class.
• Behavioral Symptoms and Cognitive Performance with NFS <11	0 – 5	2 or more	PDE2
	0 – 5	0 or 1	PDE1
• Residents who do not meet the conditions in any of the previous categories	6 – 14	2 or more	PBC2
	6 – 14	0 or 1	PBC1
• Restorative Nursing Services administered for 6 or more days	15 – 16	2 or more	PA2
	15 - 16	0 or 1	PA1

FUNCTION SCORE FOR NURSING CLASSIFICATION:

GG Item	Admission Performance Code =	Function Score =
Eating (GG0130A1) Toileting Hygiene (GG0130C1)	05, 06	4
Sit to Lying (GG0170B1) Lying to Sitting on Side of Bed (GG0170C1)	04	3
Sit to Stand (GG0170D1) Chair/Bed-to-Chair Transfer (GG0170E1)	03	2
Toilet Transfer (GG0170F1)	02	1
	01, 07, 09, 88	0

Eating
Eating Function Score: _____ +

Toileting
Toileting Hygiene Function Score: _____ +

Bed Mobility
Sit to Lying Function Score: _____
Lying to Sitting on Side of Bed Function Score: _____ > Average +

Transfer
Sit to Stand Function Score: _____
Chair/Bed-to-Chair Function Score: _____ > Average =
Toilet Transfer Function Score: _____

Total Nursing Function Score: _____