

Your PDPM Resource

ICD CODING AND PDPM

OVERVIEW

SNF reimbursement under PDPM is based in large part on diagnosis – and, that's a good thing! This means, however, that accurate recording of the diagnoses, and documentation <u>supporting</u> the relevance of the diagnoses chosen, becomes paramount to ensure accurate reimbursement. In fact, CMS highlights the need for accurate coding and supportive documentation in the following "warning": "Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad. For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding." (CMS: Quality Reporting Program Provider Training, May 2019)

There are two sets of official guidelines that must be considered when it comes to selecting the most appropriate ICD-10 code to represent the patient's condition:

- 1. ICD-10-CM Official Guidelines for Coding and Reporting
- 2. MDS 3.0 RAI Manual

Unfortunately, in some circumstances the two official guidelines appear to offer conflicting guidelines. This adds to confusion and may explain why there can be differences of opinion on how to correctly select ICD codes for inclusion on the MDS and on the claim submitted to the payor for reimbursement. **The guidance in the RAI manual takes precedence for completing the <u>MDS</u>, and the ICD-10 Official Guidelines takes precedence when coding the <u>claim</u>.** With that said, most of the ICD-10 Official Guidelines are to be followed on the MDS. For example:

- Diagnoses selected are to have a relationship to the patient's current status.
- Codes selected are to be as specific as possible to the patient's condition.
- Unspecified site or side codes are to be avoided, since we should know the site and side of the body involved.
- When a 7th character is required on an injury/fracture code, the rules for assigning the 7th character are to be followed. The 7th character explains the point in the episode of care from the <u>patient's</u> injury/condition perspective.

The risks of incomplete or inaccurate capture of the patient condition include:

- Incomplete or inaccurate medical record documentation
- Misguided care-planning
- Incomplete or inaccurate data on the MDS
- Incomplete or inaccurate data on the claim submitted to the payor
- Incomplete or inaccurate reporting of Quality Measures
- Claim denials
- Survey citations

The following provides MDS/PDPM patient characteristic guidance and tips. Information in *italics* are citations from the RAI Manual.



ACTIVE DIAGNOSES: 10020B

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 MDS assessment is to generate an updated, accurate picture of the resident's current health status.

10020: Indicate the resident's primary medical condition category

020. Indicate the resident's primary medical condition category					
mplete only if A0310B = 01 or 08					
Indicate the resident's primary medical condition category that best describes the primary reason for admission					
tor Code 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					
08. Amputation 09. Hip and Knee Replacement					
0. Fractures and Other Multiple Trauma					
11. Other Orthopedic Conditions					
12. Debility, Cardiorespiratory Conditions					
13. Medically Complex Conditions					
10020B. ICD Code					

MDS Guidance:

Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to 10020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.

NOTE: The primary diagnosis for the SNF setting may <u>not</u> necessarily be the same reason for the hospitalization.

- 10020B represents the resident's primary medical condition that describes the primary reason for the SNF admission.
- As is required now, the conditions for which the patient is receiving SNF care must be related to the hospital stay. Per the Medicare Benefit Policy Manual:
 - To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.
- This single ICD code directly influences reimbursement for the PT, OT and SLP casemix classification groups by placing the patient into a Clinical Category.



- Best practice is for the Interdisciplinary Team (IDT) to come together to determine the primary medical condition for the admission. *Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.*
- Be aware that many ICD codes are listed as Return to Provider (RTP) in the CMS PDPM ICD-10 Mappings. In the 8/30/19 version of the ICD mapping tool from CMS, 48% of the ICD-10 codes are listed as RTP. This means that the RTP condition likely does not represent a condition that would be a "primary reason for the admission". This does not mean that an ICD listed as RTP is not a valid diagnosis to represent a comorbidity for a SNF patient. These RTP conditions can be used to support the need for skilled services and can be present on therapy POCs and in other fields on the MDS (other than I0020B).
- It is not a Medicare requirement that all therapy disciplines utilize the same Medical Diagnosis on POCs.
- CMS expects the diagnosis in 10020B and the primary diagnosis on the SNF claim to match but there is currently no claims edit that will enforce such a requirement. However, upon medical review, auditors may consider ICD coding discrepancies in determining if coverage requirements are met.

ACTIVE DIAGNOSES: ACTIVE DIAGNOSES IN THE LAST 7 DAYS

Intent: This section identifies active diseases and infections <u>that drive the</u> <u>current plan of care</u>.

MDS Guidance:

Code diseases that have a documented diagnosis in the last 60 days and 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 during the 7-day look-back period.

There are two look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day lookback period (except for Item I2300 UTI, which does not use the active 7-day look-back period).
 - (The UTI has a look-back period of 30 days for active disease instead of 7 days.)

DEFINITIONS

ACTIVE DIAGNOSES

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

FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).



Sec	tion I Active Diagnoses
Activ	e Diagnoses in the last 7 days - Check all that apply
Diagn	oses listed in parentheses are provided as examples and should not be considered as all-inclusive lists
_	Cancer
	10100. Cancer (with or without metastasis)
	Heart/Circulation
	10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
	10400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
	10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
	10700. Hypertension
	10800. Orthostatic Hypotension
	10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
	Gastrointestinal
	11300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
	Genitourinary
	11500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
	11550. Neurogenic Bladder
	11650. Obstructive Uropathy
	Infections
	11700. Multidrug-Resistant Organism (MDRO)
	12000. Pneumonia
	I2100. Septicemia
	12200. Tuberculosis
	12300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
	12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
	12500. Wound Infection (other than foot)
	Metabolic
	12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
	I3100. Hyponatremia
	13200. Hyperkalemia
	13300. Hyperlipidemia (e.g., hypercholesterolemia)
_	Musculoskeletal
	13900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and
	fractures of the trochanter and femoral neck)
	14000. Other Fracture
	Neurological
	14200. Alzheimer's Disease
	14300. Aphasia
	14400. Cerebral Palsy
	14500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
	14800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
	14900. Hemiplegia or Hemiparesis
	15000. Paraplegia
	I5100. Quadriplegia
	15200. Multiple Sclerosis (MS)
	I5250. Huntington's Disease
	15300. Parkinson's Disease
	IS350. Tourette's Syndrome
	15400. Seizure Disorder or Epilepsy
	IS500. Traumatic Brain Injury (TBI)



Nutritional					
15600. Malnutrition (protein or calorie) or at risk for malnutrition					
Psychiatric/Mood Disorder					
15700. Anxiety Disorder					
15800. Depression (other than bipolar)					
15900. Bipolar Disorder					
15950. Psychotic Disorder (other than schizophrenia)					
16000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)					
16100. Post Traumatic Stress Disorder (PTSD)					
Pulmonary					
I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., ch diseases such as asbestosis)	ronic	bronchitis	and res	trictive l	ung
16300. Respiratory Failure					
Other					
18000. Additional active diagnoses					
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.					
A					
B					
6					
L			<u> </u>		
D.					
E					
					
F					
G					
н.					
н					
L					
				<u> </u>	
Υ					

- The disease conditions in this section **require a 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**
- Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
- Only include <u>active</u> diagnoses. 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.
- If an individual is receiving aftercare following a hospitalization, a Z code ("aftercare" Z code) may be assigned. Aftercare Z codes are represented by ICD-10 codes starting with the letter Z, or by using the Subsequent Encounter 7th digit on the injury or fracture ICD-10 code when the aftercare is for an injury or fracture. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z



codes are used, another diagnosis for the related primary medical condition should be checked in items 10100–17900 or entered in 18000.

- In 18000, list codes that support the need for skilled services. Best practice is for the Interdisciplinary Team (IDT) to review pertinent diagnoses for 18000.
- Ensure inclusion of all conditions that qualify for an NTA or SLP comorbidity.
- Codes listed as Return to Provider (RTP) in the CMS PDPM ICD-10 Mappings can be coded in 18000.

SURGICAL PROCEDURES

Intent: 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.

MDS Guidance:

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.

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

- 1. 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
- 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

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.



Surgi	cal Proc	cedures - Complete only if J2100 = 1
¥	Check a	ll that apply
	Major J	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
		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)
		Other major orthopedic surgery
		ogical Surgery
		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
	Cardio	pulmonary Surgery
	J2700.	Involving the heart or major blood vessels - open or percutaneous procedures
	J2710.	Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic
	J2799.	Other major cardiopulmonary surgery
	Genito	urinary Surgery
	J2800.	Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
	J2810.	Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of
		nephrostomies or urostomies)
	J2899.	Other major genitourinary surgery
		Major Surgery
		Involving tendons, ligaments, or muscles
	J2910.	Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver,
		pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
		Involving the endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus - open
		Involving the breast
		Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
	J5000.	Other major surgery not listed above

- The physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) may specifically indicate that the SNF stay is for treatment related to the surgical intervention.
- In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:
 - The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:
 - The management of a surgical wound that requires skilled care (e.g., managing



potential infection or drainage).

- Daily skilled therapy to restore functional loss after surgical procedures.
- Administration of medication and monitoring that requires skilled nursing.
- Major surgery during the preceding hospital stay may make the resident eligible for a different clinical category and may influence the PT and OT case-mix classification.
- If there is no qualifying major surgical procedure during the preceding hospital stay, the resident will remain in their default primary clinical category as noted in 10020B.

SWALLOWING DISORDER AND MECHANICALLY ALTERED DIET

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

K0100. S	K0100. Swallowing Disorder				
Signs and	Signs and symptoms of possible swallowing disorder				
↓ Check all that apply					
	A. Loss of liquids/solids from mouth when eating or drinking				
	B. Holding food in mouth/cheeks or residual food in mouth after meals				
	C. Coughing or choking during meals or when swallowing medications				
	D. Complaints of difficulty or pain with swallowing				
	Z. None of the above				

MDS Guidance:

- 1. Ask the resident if he or she has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D. Observe the resident during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
- 2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period.
- 3. Review the medical record, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.
- 4. Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- 5. Code even if the symptom occurred only once in the 7-day look-back period.

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last 7 days		
 While NOT a Resident Performed while NOT a resident of this facility and within the last 7 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank While a Resident 	1. While NOT a Resident	2. While a Resident
Performed while a resident of this facility and within the last 7 days	↓ Check all that apply ↓	
A. Parenteral/IV feeding		
B. Feeding tube - nasogastric or abdominal (PEG)		
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		
Z. None of the above		

Intent: Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating. The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

MDS Guidance:

Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

Tips:

- When dysphagia is related to a cerebrovascular accident or cerebrovascular disease, be sure to include the relevant dysphagia ICD code from the I69.- series of the ICD-10 coding manual. The manual instructions advise to also use an <u>additional</u> ICD code from the R13.1- family to identify the type of dysphagia, if known (e.g., oral, pharyngeal, etc.).
- The presence of a swallowing disorder and/or a mechanically altered diet will influence reimbursement for the SLP case-mix classification.

COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

MDS Guidance:

Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should

DEFINITIONS

MECHANICALLY

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET

A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).



enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

In cases where neither the BIMS nor the staff assessment is completed, the patient will be considered "cognitively intact" for classification purposes under PDPM.

The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance. The final determination of the level of impairment should be made by the resident's physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance.

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

PDPM Cognitive Score Classification Methodology

The new PDPM Cognitive Score is based on the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all patients.

Tips:

- For the presence of a cognitive impairment, any level of cognitive impairment (mild or above) is sufficient to qualify the patient for this aspect of the SLP component classification criteria.
- The BIMS provides very specific instructions for accurately capturing the patient's cognitive function. Only therapists trained in carrying out the BIMS and that have passed a related competency test should administer the BIMs.

SLP COMORBIDITIES

The ICD-10 codes that are included in the PDPM SLP Component can be found in the PDPM ICD-10 Mappings file on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

With regard to the presence of an SLP-related comorbidity, CMS identified twelve comorbidities that were directly correlated with increased SLP costs. Rather than separately accounting for each of these twelve conditions, the presence of any one of these conditions is sufficient to qualify the patient under this aspect of the SLP component classification criteria. The twelve SLP-related comorbidities that will be used under the SLP component may be found in the table below.



SLP-Related Comorbidities MDS Item	Description
14300	Aphasia*
14500	CVA, TIA, or Stroke
14900	Hemiplegia or Hemiparesis
15500	Traumatic Brain Injury
18000	Laryngeal Cancer
18000	Apraxia*
18000	Dysphagia*
18000	ALS
18000	Oral Cancers
18000	Speech and Language Deficits*
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

- The treatment diagnoses that are denoted with the * will be identified **by a trained Speech Language Pathologist.** The SLP must then identify the condition, describe the extent, outline the proper plan of care, and provide supportive documentation.
- Accurately coding all of the appropriate SLP related comorbidities will help the Interdisciplinary Team (IDT) understand the needs of the resident.
- When apraxia, aphasia, dysarthria, fluency disorder or other speech language deficit is related to a cerebrovascular accident or cerebrovascular disease, be sure to include the relevant ICD code from the I69.- series of the ICD-10 coding manual.
- These comorbidities, when captured appropriately on the MDS, will directly influence reimbursement for the SLP case-mix classification.



NTA (Non-therapy Ancillary) COMORBIDITIES

Intent: NTA classification is determined by the presence of certain conditions or the use of certain extensive services that were found to be correlated with increases in NTA costs for SNF patients. CMS identified a list of 50 conditions and extensive services that were associated with increases in NTA costs. The presence of these conditions and extensive services is reported by providers on the MDS 3.0, with some of these conditions being identified by ICD-10-CM codes that are coded in Item 18000 of the MDS.

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

Conditions and Extensive Services Used for NTA Classification



Condition/Extensive Service	Source	Points
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion	MDS Item M1040A,	1
on Foot Code, Except Diabetic Foot Ulcer Code	M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue	MDS Item I8000	1
Disorders, and Inflammatory Spondylopathies	WID'S Item 18000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy	MDS Item 18000	1
and Vitreous Hemorrhage		1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

• As part of the Interdisciplinary Team (IDT), therapists should be knowledgeable of conditions that qualify for an NTA comorbidity score and ensure that the IDT is aware when a resident qualifies to ensure appropriate capture on the MDS.

Questions about this information? Contact PDPM@AegisTherapies.com or visit our Resource Center for more information at AegisTherapies.com/Resources.

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