

# Skilled Nursing Facilities

## Quality Reporting Program Provider Training



**SKILLED  
NURSING  
FACILITY**

**QUALITY REPORTING  
PROGRAM**

## Section I and Section J Updates

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# Acronyms in This Presentation

- Cerebral vascular accident (CVA)
- Chronic obstructive pulmonary disease (COPD)
- Inpatient Rehabilitation Facility (IRF)
- International Classification of Diseases (ICD)
- Intravenous (IV)
- Minimum Data Set 3.0 (MDS)
- National Quality Forum (NQF)
- Prospective Payment System (PPS)
- Quality Reporting Program (QRP)
- Skilled Nursing Facility (SNF)
- Total hip replacement (THR)



# Overview

- Explain the intent of Sections I and J
- Define Item I0020: Indicate the Resident's Primary Medical Condition Category and Item J2000: Prior Surgery: Did the resident have major surgery during the 100 days prior to admission?
- Discuss coding instructions for Items I0020 and J2000
- Review practice coding scenarios



# Objectives

- Identify the intent of Sections I and J
- Practice the coding instructions for Item I0020: Indicate the Resident's Primary Medical Condition Category
- Apply the coding instructions for Item J2000: Prior Surgery: Did the resident have major surgery during the 100 days prior to admission?



# 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 3.0 (MDS) assessment is to generate an updated, accurate picture of the resident's current health status



# **Item I0020. Indicate the Resident's Primary Medical Condition Category**



# I0020. Indicate the Resident's Primary Medical Condition Category

Section I	Active Diagnoses								
<b>I0020. Indicate the resident's primary medical condition category</b>									
<b>Enter Code</b> <input type="text"/> <input type="text"/>	<p><b>Indicate the resident's primary medical condition category that best describes the primary reason for admission</b> Complete only if A0310B = 01</p> <ul style="list-style-type: none"><li>01. Stroke</li><li>02. Non-Traumatic Brain Dysfunction</li><li>03. Traumatic Brain Dysfunction</li><li>04. Non-Traumatic Spinal Cord Dysfunction</li><li>05. Traumatic Spinal Cord Dysfunction</li><li>06. Progressive Neurological Conditions</li><li>07. Other Neurological Conditions</li><li>08. Amputation</li><li>09. Hip and Knee Replacement</li><li>10. Fractures and Other Multiple Trauma</li><li>11. Other Orthopedic Conditions</li><li>12. Debility, Cardiorespiratory Conditions</li><li>13. Medically Complex Conditions</li><li>14. Other Medical Condition If "Other Medical Condition," enter the ICD code in the boxes</li></ul> <p><b>I0020A.</b></p> <table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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# 10020 Item Rationale



- Health-related quality of life
  - Disease processes can have a significant adverse effect on residents' 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 Item Rationale (cont.)

- Item I0020 is used as a risk adjustor for new skilled nursing facility (SNF) quality reporting program (QRP) functional outcome quality measures
  - Application of Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (National Quality Forum (NQF) #2633)
  - Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
  - Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
  - Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)



# 10020

## Steps for Assessment

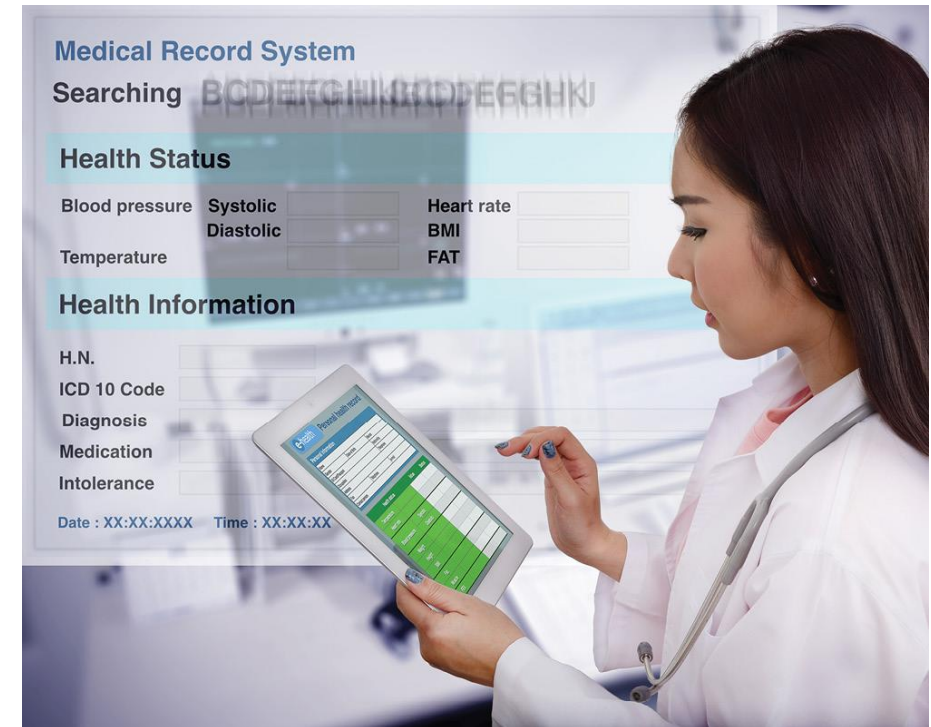
1. Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the facility



# 10020

## Steps for Assessment (cont.)

- Medical record sources for physician diagnoses include:
  - The most recent history and physical
  - Transfer documents
  - Discharge summaries
  - Progress notes
  - Other resources, as available



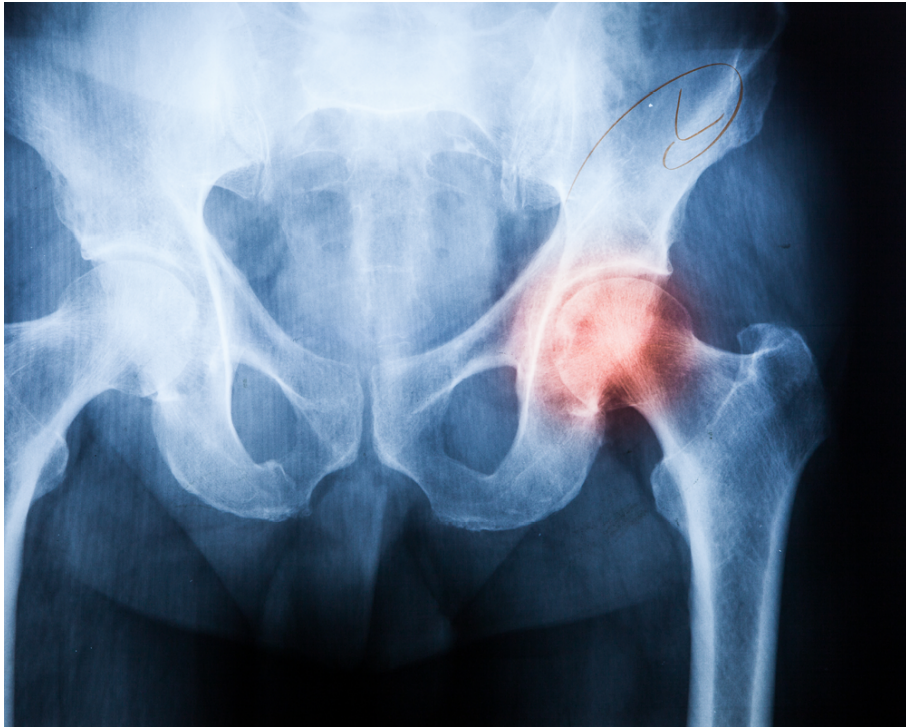
# Fourteen Primary Condition Categories Associated With the SNF Admission

- Stroke
- Non-traumatic Brain Dysfunction
- Traumatic Brain Dysfunction
- Non-traumatic Spinal Cord Dysfunction
- Traumatic Spinal Cord Dysfunction
- Progressive Neurological Conditions
- Other Neurological Conditions





# Fourteen Primary Condition Categories Associated With the SNF Admission (cont.)



- Amputation
- Hip and Knee Replacement
- Fractures and Other Multiple Trauma
- Other Orthopedic Conditions
- Debility, Cardiorespiratory Conditions
- Medically Complex Conditions
- Other Medical Condition
  - Used when no other condition category applies

# I0020

## Coding Instructions

- Complete only if A0310B = 01 (Start of Part A Prospective Payment System (PPS) stay)
- Enter the code that represents the primary medical condition that resulted in the resident's admission
- If codes 1 through 13 do not apply, enter code 14, "Other Medical Condition," for I0020 and proceed to I0020A
- Include the primary medical condition coded in Item I0020 in Section I0100 through I8000: Active Diagnoses in the Last 7 Days





## 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



# 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



## 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 fracture



## Coding Instructions (cont. 4)

- **Code 10, Fractures and Other Multiple Trauma**
  - Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula
- **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

# I0020

## Coding Instructions (cont. 5)

- **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
- **Code 14, Other Medical Condition**
  - If the resident's primary medical condition category is not one of the listed categories, enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A
    - If Item I0020 is coded 1 through 13, do not complete I0020A



# Practice Coding Scenario 1

- Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke
- The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician



# How would you code I0020?

Indicate the patient's primary medical condition category:

- A. Code **01**, Stroke
- B. Code **02**, Non-traumatic Brain Dysfunction
- C. Code **13**, Medically Complex Conditions





# Practice Coding Scenario 2

- Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis
- The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician's discharge summary from the acute care hospital and are incorporated into Mrs. H's medical record



# How would you code I0020?

Indicate the patient's primary medical condition category:

- A. Code **12**, Debility, Cardiorespiratory Conditions
- B. Code **13**, Medically Complex Conditions
- C. Code **14**, Other Medical Conditions



# Practice Coding Scenario 3

- Mr. T is an active 83-year-old male who fell from a ladder while changing a ceiling lightbulb at home and sustained a left intracapsular hip fracture with subsequent total hip replacement (THR)
- The discharge diagnoses of status post-hip fracture with THR are documented in the physician's discharge summary from the acute care hospital and are incorporated into Mr. T's medical record
- He is admitted to the SNF for rehabilitation



# How would you code I0020?

Indicate the patient's primary medical condition category:

- A. Code **09**, Hip and Knee Replacement
- B. Code **10**, Fractures and Other Multiple Trauma
- C. Code **11**, Other Orthopedic Conditions



# Section J. Health Conditions

# Section J. Health Conditions: Intent

- The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life
- The items include an assessment of pain that uses an interview with the resident or with staff if the resident is unable to participate
- The pain items assess the presence of pain, pain frequency, effect on function, intensity, management, and control
- Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls



# Item J2000. Prior Surgery



# J2000. Prior Surgery

J2000. Prior Surgery	
Enter Code <input type="checkbox"/>	Did the resident have major surgery during the <b>100 days prior to admission</b> ? 0. <b>No</b> 1. <b>Yes</b> 8. <b>Unknown</b>



# J2000 Item Rationale

- Health-related quality of life
  - A recent history of major surgery during the 100 days prior to admission can affect a resident's recovery
- Planning for care
  - This item identifies whether the resident had major surgery during the 100 days prior to admission. A recent history of major surgery can affect a resident's recovery



# J2000 Item Rationale (cont.)

- Item J2000 data is used as a risk adjustor for new SNF QRP functional outcome quality measures
  - Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
  - Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
  - Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
  - Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)



# J2000 Steps for Assessment

1. Ask the resident and family or significant other about any surgical procedures in 100 days prior to admission
2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days before admission



# J2000 Steps for Assessment (cont.)

- Medical record sources include:
  - Medical records received from facilities where the resident received health care during the previous 100 days
  - The most recent history and physical
  - Transfer documents
  - Discharge summaries
  - Progress notes
  - Other resources, as available



# J2000 Coding Instructions

- **Code 0, No**, if the resident did not have major surgery during the 100 days prior to admission
- **Code 1, Yes**, if the resident had major surgery during the 100 days prior to admission
- **Code 8, Unknown**, if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission



# J2000 Coding Tips

- Generally, a major surgery for Item J2000 refers to a procedure that meets **all** the following criteria:
  1. The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the SNF
  2. The resident had general anesthesia during the procedure
  3. The surgery carried some degree of risk to the resident's life or the potential for severe disability





# Practice Coding Scenario 4

- Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago
- She had the procedure as an outpatient
- She reports no other surgeries in the past 100 days



# How would you code J2000?

Did the resident have major surgery during the 100 days prior to admission?

- A. Code **0**, No
- B. Code **1**, Yes
- C. Code **8**, Unknown



# Practice Coding Scenario 5

- Mr. A's wife informs his nurse that 6 months ago, he was admitted to the hospital for 5 days following a bowel resection (partial colectomy) for diverticulitis
- Mr. A's wife reports that Mr. A has had no other surgeries since the time of his bowel resection



# How would you code J2000?

Did the resident have major surgery during the 100 days prior to admission?

- A. Code **0**, No
- B. Code **1**, Yes
- C. Code **8**, Unknown



# Practice Coding Scenario 6

- Mrs. G. was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy for which she received general anesthesia
- The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record
- She was transferred to the facility immediately following a 4-day hospitalization



# How would you code J2000?

Did the resident have major surgery during the 100 days prior to admission?

- A. Code **0**, No
- B. Code **1**, Yes
- C. Code **8**, Unknown



# Summary



In this presentation, you learned:

- The intent of Sections I and J
- Coding instructions for Items I0020 and J2000
- How to apply coding instructions to accurately code practice scenarios

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# Questions?

