FHCA 2019 Annual Conference & Trade Show

CE Session #3 – PDPM: Prepare for Success
Monday, August 5 – 8:00 to 9:30 a.m.
Celebration 5-6 – Finance/Development

Upon completion of this presentation, the learner will be able to:

- Report the five components of the newly proposed Medicare payment system
- Explain the limitations for concurrent and group therapy provided to residents under PDPM
- Explain how interrupted stays will impact the PDPM payment system

Seminar Description:

This session will walk the attendee through the basics of the upcoming Patient Driven Payment Model (PDPM). This payment system is a complete paradigm shift from the present RUG IV system. Nursing home administrators and nurse leaders need to know how to prepare for this major change in reimbursement in order to prepare their teams to be able to accurately capture all of the resident data required to complete accurate assessments. The components of PDPM, the importance of ICD-10-CM coding and MDS accuracy will be a focus of this session. Understanding the new Interim Payment Assessment option and the effect of the Interrupted stays will be critical for successful transition. Residents will continue to require therapy services to recover. Learn the limitations for concurrent and group therapy in PDPM.

Presenter Bio(s):

Carol Maher is a Board Certified Gerontological Registered Nurse with over 30 years of long term care experience working in many roles. She worked as the MDS Coordinator in large centers that had high Medicare censuses with rapid admission and discharge processes. Carol has worked as one of the Gold Standard nurses for MDS 3.0, serving on the RAP workgroup to prepare the way for the CAAs for MDS 3.0 and participating on a number of Technical Expert Panels related to MDS, Quality Measures and care planning. Carol has successfully completed the educational courses and proctored exam to become a certified professional coder. She provides ICD-10-CM training to skilled nursing center clients across the country. Carol is the Director of Education for Hansen Hunter & Co., providing MDS, Medicare and ICD-10-CM classes across the country, presenting monthly educational webinars and completing compliance audits. She is the author of Long-Term Care MDS Coordinator's Field Guide (HCPRO 2016).

Patient-Driven Payment Model (PDPM)

Carol Maher, RN-BC, RAC-MTA, RAC-MT, RAC-CT, CPC

HH

MAHER HUSTON & CO. INC.

Disclaimer

- Information presented is as accurate as possible on the date and time of presentation.
- If reviewing this information at a later date, please ensure that no changes have occurred.
- CMS changes regulations frequently, which may affect the information in this presentation.

Patient-Driven Payment Model (PDPM)

Will begin 10/1/19!

PDPM

CMS believes that relying on resident characteristics would improve the resident centeredness of the model and discourage resident care decisions predicated on service-based financial incentives.

"To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics that are patient, and not facility, centered. To that end, the proposed PDPM was developed to be a payment model which derives payment classifications almost exclusively from verifiable resident characteristics."

CMS Expected Advantages of PDPM over RUG IV

- Removes therapy minutes as the basis for therapy payment.
- Establishes separate case-mix-adjusted component for NTA services, thereby improving targeting of resources to medically complex beneficiaries and increasing payment accuracy for these services.
- Enhances payment accuracy for nursing services by making nursing payment dependent on a wide range of clinical characteristics (as originally considered for RUG-IV) rather than being primarily a function of therapy minutes and functional status.
- Improves targeting of resources to beneficiaries with diverse therapy needs by dividing single therapy component into three separate case-mix-adjusted components: P.T., O.T., and S.L.P.

FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW

CMS Expected Advantages of PDPM over RUG IV

- Provides additional resources to facilities for treating potentially vulnerable populations, including beneficiaries with the following characteristics: high NTA utilization, extensive services (ventilator, respirator, or infection isolation), dual enrollment in Medicare and Medicaid, end-stage renal disease (ESRD), longer prior inpatient stays, diabetes, wound infections, I.V. medication, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care.
- Enhances payment accuracy for all SNF services by: (1) basing payment for each component on predicted resource utilization associated with clinically-relevant resident characteristics and (2) introducing variable per-diem payment adjustments to track changes in resource use over a stay.
- Promotes consistency with other Medicare and post-acute payment settings by basing resident classification on objective clinical information while minimizing the role of service provision in determination of payment.

FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW

RUG IV vs PDPM

While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:

Effects of PDPM

By addressing each individual patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model:

Continued Adjustments for Geographical Differences

- "Under PDPM, we propose to continue to update the federal base payment rates and adjust for geographic differences in wages following the current methodology used for such updates and wage index adjustments under the SNF PPS.
- Specifically, we propose to continue the practice of using the SNF market basket, adjusted as described in section III.B. of this proposed rule to update the federal base payment rates and to adjust for geographic differences in wages as described in section III.B.4. of this proposed rule."

Reimbursement

- CMS has stated that the change to PDPM will be budget neutral plus there is a 2.5% proposed increase in to the market basket for FY2020. This should result in an overall 1.8% payment increase.
- Facilities will receive payment from each PDPM component whether the resident needed those services or not.

FY 2020 PDPM Unadjusted Rates

FY 2020 PDPM Unadjusted Federal Rate Per Diem—Urban

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

Wage Index FY2020

- Calculate your rate:
  - Labor portion of payment = 70.8% for FY2020
    A. Multiply unadjusted rates x70.8.
    B. Then multiply that figure times your wage index.
    C. Add wage index calculation to the non-labor portion of the rate. See next slide for example.

Example

Orange County, FL Wage Index=0.8675

FY 2020 PDPM Unadjusted Federal Rate Per Diem—Urban

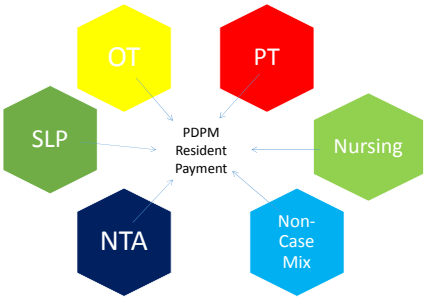
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48
Orange Co	$96.63	$72.90	$55.42	$51.59	$20.69	$86.52

Nursing base rate $106.64.
106.64 x .708 (labor portion = $75.50112
75.50112 x .8675 (OC) = $65.4972216
$65.4972216+ 31.13388 (non-labor) = $96.63

Rates Adjusted by Wage Index

- Miami-Dade County = 0.9372
- Broward County = 0.9472
- Baker, Nassau, St. Johns, Duval, Clay County= 0.8673

Components of PDPM



PDPM Proposed CMS Adjusted Payment

Therapy Components

- The set of resident characteristics from the MDS that predicted P.T. and O.T. utilization was different than the set of characteristics predicting S.L.P. utilization. Additionally, many predictors of high P.T. and O.T. costs per day predicted lower S.L.P. costs per day, and vice versa.
- For example, residents with cognitive impairments receive less Physical and Occupational Therapy but receive more Speech-Language Pathology.

Therapy Components

- "We found that P.T., O.T., and S.L.P. costs correspond to 43.4 percent, 40.4 percent, and 16.2 percent of the therapy component of the federal per diem rate for urban SNFs, and 42.9 percent, 39.4 percent, and 17.7 percent of the therapy component of the federal per diem rate for rural SNFs.
- Under the proposed PDPM, the current therapy case-mix component would be separated into a Physical Therapy component, an Occupational Therapy component, and a Speech-Language Pathology component using the percentages derived above. This process would be done separately for urban and for rural facilities."

P.T. and O.T.

- The same case-mix classification model will be used for both components (P.T. and O.T.) related to the similarities in the predictors of need for therapy services.
- In practice, this means that the same resident characteristics will determine a resident's classification for P.T. and O.T. payment.
- However, each resident will be assigned separate case-mix groups for P.T. and O.T. payment, which correspond to separate case-mix indexes and payment rates.

P.T. and O.T.

- Based on our regression analyses, we found that the most relevant categories of predictors of P.T. and O.T. costs per day were the clinical reasons for the SNF stay and the resident's functional status.

ICD-10-CM Importance

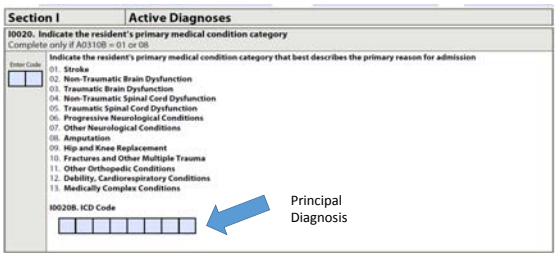
MDS Coding of ICD-10 Codes

- Providers would use MDS item I0020B to report the ICD-10-CM code that represents the primary reason for the resident's Part A SNF stay.
- The mapping between ICD-10-CM codes and the 10 clinical categories is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.
- The mapping indicates that in some cases, a single ICD-10-CM code maps to more than one clinical category because the care plan for a resident with this diagnosis may differ depending on the inpatient procedure history.
- In these cases, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the immediately preceding inpatient stay that relates to the primary reason for the Part A SNF stay and typically requires extensive post-surgical rehabilitation or nursing care.

ICD-10 Importance

- For example, certain wedge compression fractures that were treated with an invasive surgical procedure such as a fusion during the prior inpatient stay would be categorized as Major Joint Replacement or Spinal Surgery, but if these cases were not treated with a surgical procedure they would be categorized as Non-Surgical Orthopedic/Musculoskeletal.
- For residents who received a related surgical procedure during the prior inpatient stay, a provider would need to indicate the type of surgical procedure performed for the resident to be appropriately classified under PDPM. Additional items (in a checkbox format) will be added to Section J in the 10/1/19 MDS item sets to identify surgical procedures completed during the resident's hospital stay.

10/1/19 Section I0020 and I0020B



I0020B. New MDS Item 10/1/19

- To capture the patient's primary diagnosis, which is used to classify the patient into a PDPM clinical category, CMS added Item I0020B, which allows providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis.
- The item will ask "What is the main reason this person is being admitted to the SNF?" Item I0020B will be coded when Item I0020 is coded as any response 1 – 13.

Who Must Complete the ICD-10-CM Coding in the SNF?

From SNF PPS FY2019 Final Rule:

"However, we do not believe it would be appropriate for CMS, in this instance, to specifically identify the type of staff that providers must employ to ensure accurate coding, as this is a decision best left to the provider. With regard to the potential consequences of ICD-10 coding errors on RAC audits, as under the current payment system, the information reported to CMS must be accurate. Inaccuracies in the data reported to CMS, or a failure to document the basis for such data, will necessitate the same types of administrative actions as occur today."

Principal Diagnosis

From the FY 2019 SNF PPS Final Rule:

"CMS recognizes that in many cases, the primary reason for SNF care may not be the same as the primary reason for the prior inpatient stay.

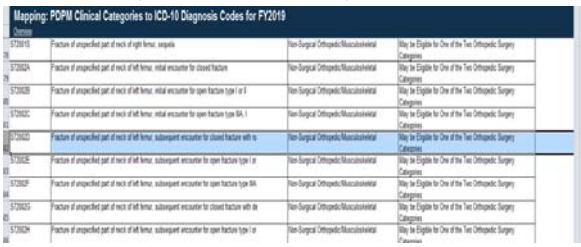
For example, a beneficiary may be treated in a SNF for a secondary condition that arose during the prior inpatient stay but that is different from the condition that precipitated the acute inpatient stay in the first place.

PDPM requires facilities to code the diagnosis that corresponds most closely to the primary reason for SNF care (in this case, the secondary condition that arose during the hospital stay) rather than the primary reason for the prior hospitalization."

CMS Mapping of ICD-10-CM

- SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay.
- ICD-10-CM codes, coded on the MDS in Item I0020B, are mapped to a PDPM clinical category. Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J.
- ICD-10 mapping available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Principal Diagnosis Mapping



Mapping: PDPM Clinical Categories to ICD-10 Diagnosis Codes for FY2019

Diagnosis			
S72001G	Fracture of unspecified part of neck of right femur, sequela	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002B	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type I or II	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002C	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type IIIA, I	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002D	Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with ro	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002E	Fracture of unspecified part of neck of left femur, subsequent encounter for open fracture type I or	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002F	Fracture of unspecified part of neck of left femur, subsequent encounter for open fracture type IIIA	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002G	Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with de	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories
S72002H	Fracture of unspecified part of neck of left femur, subsequent encounter for open fracture type I or	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories

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. Coding Tips

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

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

Surgical Procedures Continued

	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**
	Cardiopulmonary 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**
	Genitourinary Surgery

Surgical Procedures Continued

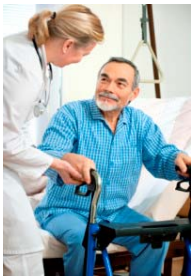
Genitourinary Surgery	
J2800.	**Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
J2810.	**Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
J2899.	**Other major genitourinary surgery**
Other Major Surgery	
J2900.	**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)
J2920.	**Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
J2930.	**Involving the breast**
J2940.	**Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
J5000.	**Other major surgery not listed above**

ADL End-Splits for PDPM

Some of the key differences between the old functional score using Section G and the new functional score using Section GG include:

- Reverse Scoring Methodology
  - Under Section G, increasing score means increasing dependence
  Under Section GG, increasing score means increasing independence.
- Non-linear relationship to payment
  - Under RUG-IV, increasing dependence, within a given RUG category, translates to higher payment.
  - Under PDPM, there is not a direct relationship between increasing dependence and increasing payment.

Therapy Components



CMS Mapping

- Given similar costs among certain clinical categories, as they relate to PT and OT costs, CMS collapsed certain clinical categories together under the PT and OT components.
- A crosswalk between the overall clinical categories and the collapsed clinical categories used under the PT and OT components may be found in the table on the next slide.
- Beware of codes designated as "Return to Provider." Return to provider codes will not map!

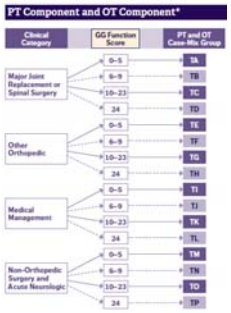
Collapsed Clinical Categories for PT and OT Classification

PDPM Clinical Category	Collapsed PT and OT Category
Major Joint Replacement or Spinal Surgery	**Major Joint Replacement or Spinal Surgery**
Non-Orthopedic Surgery	**Non-Orthopedic Surgery and Acute Neurologic**
Acute Neurological	
Non-Surgical Ortho/musculoskeletal	**Other Orthopedic**
Ortho surgery (except MJR or SS)	
Medical Management	**Medical Management**
Acute Infection	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

P.T. and O.T. Components (Mapped from I0020B)

1. Major Joint Replacement or **Spinal** Surgery.
2. Other Orthopedic (Includes other orthopedic surgery and non-surgical orthopedic/ musculoskeletal issues).
3. Medical Management (Includes acute infections, cancer, pulmonary, cardiovascular and coagulations, and other medical management).
4. Non-Orthopedic Surgery or Acute Neurologic.

P.T. and O.T. Component



Functional Score Based on Section GG

GG Code	Description	Score
05, 06	Set-up help, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88	Dependent, Refused, Not applicable, Not attempted due to medical concerns, or Cannot walk for walking items	0

Steps for Assessment (new)

- Assess the resident's self-care *performance* based on direct observation, *as well as* the resident's self-report *and* reports ***from qualified clinicians***, care staff, *or family* documented in the resident's medical record during the *three-day* assessment period.
- ***CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.***
- For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of *M*ost *R*ecent Medicare *S*tay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

Qualified Clinician

QUALIFIED CLINICIAN

- Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

GG0130 & GG0170: Steps for Assessment

- Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "*helper*" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider *only* facility staff when scoring according to *the* amount of assistance provided.

Assessment Period

Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.

- For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission.

This functional assessment **must be completed within the first three days (3 calendar days)** of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, **ending at 11:59 PM on day *3*.**

Assessment

The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions.

The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

Tips for Coding

- ***Code based on the resident's performance!***
- ***Do not record the staff's assessment of the resident's potential capability to perform the activity.***
- *What does this mean? How can your team accomplish this?*

Functional Score Based on Section GG

GG Code	Description	Score
05, 06	Set-up help, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88	Dependent, Refused, Not applicable, Not attempted due to medical concerns, or Cannot walk for walking items	0

PT and OT Functional Score

GG Item	GG Performance Score	PDPM Function Score	Total Score
Eating (GG0130A)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Individual** score
Oral Hygiene (GG0130B)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Individual** score
Toileting Hygiene (GG130C)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Individual** score
Sit to Lying (GG0170B)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Average** of Bed Mobility Items
Lying to Sitting on Side of Bed (GG0170)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	
Sit to Stand (GG0170D)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Average** of Transfer Items
Chair/Bed-to-Chair Transfer (GG0170E)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	
Toilet Transfer (GG0170F)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	
Walk 50 Feet with Two Turns (GG0170J)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	**Average** of Walking Items
Walk 150 Feet (GG0170K)	01, 02, 03, 04, 05, 06, 07, 09 10, 88	0-4	
		Total	Sum of this column

Example

- Mr. Doe was admitted from the hospital after experiencing a left femoral neck fracture which was repaired with a total hip replacement. During the first three days of his stay, before treatment was started, he was unable to walk.
- He required total assistance with sit-to-stand and chair/bed-to-chair transfers using a Hoyer lift. Toilet transfers were not attempted. He required substantial/maximal assist with toilet hygiene.
- He could brush his teeth after set-up.
- He could eat independently.
- He needed substantial/maximal help with sit to lying and lying to sitting on the edge of the bed.

Example Score

Section GG performance	Score
Self-care Eating Independent	4
Oral Hygiene: set-up	4
Toilet Hygiene: substantial/maximal	1
Sit to lying: substantial/maximal	1
Lying to sitting on side of bed: substantial/maximal	
Sit to stand: Dependent	0
Chair/bed-to-chair: Dependent	
Mobility: toilet transfer not attempted	
Walking: Not attempted	0
Total:	10

P.T. and O.T. Component

P.T. and O.T.

ADL score of 10-23 Usually Highest CMI

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

Mr. Doe

Mr. Doe Example

- Clinical Category: Major Joint Replacement with ADL score of 10.
- P.T./O.T. case-mix group = TC.
- P.T. case-mix index 1.88 x $61.16 = $114.98
- O.T. case-mix index 1.69 x $56.93 = $ 96.21

$211.19/day

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

Mr. Doe without Joint Replacement

Clinical Category: Other Orthopedic

- P.T/O.T group = T. G.
- P.T. Case Mix Index 1.67 x $61.16 = $102.14
- O.T. Case Mix Index 1.64 x $89.64= $ 93.37

$195.51

Difference of $15.68/day

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

S.L.P. Component

Presence of an Acute Neurological Condition, S.L.P. related co-morbidities, and/or cognitive impairment.

Swallowing problem and/or Mechanically altered diet

ICD-10-CM

Clinical Category will be determined from I0020B (Acute neurologic).

Examples:

- I69.352: Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
- G20: Parkinson's Disease
- G61.0: Guillain-Barre syndrome
- G80.9: Cerebral Palsy, unspecified
- R47.01: Aphasia

Proposed S.L.P.-related Comorbidities
Most from ICD-10-CM Codes in I8000

TABLE 22: Proposed SLP-related Comorbidities

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

Cognitive Impairment

PDPM Cognitive Measure
Classification Methodology

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

CPS Score When Resident Not Able to Complete the BIMS

MDS items:

- C0700: Short-term memory
- C0800: Long-term memory
- C0900: Memory/recall Ability
- C1000: Cognitive Skills for Daily Decision Making
- B0100: Comatose
- B0700: Makes self understood
- Late-loss Eating ADL

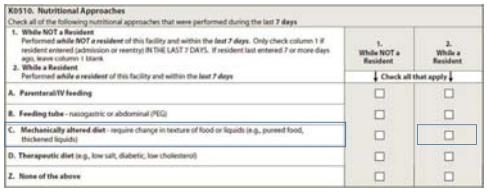
Swallowing Disorder?

Presently only 3.7% of assessments report a swallowing problem!

K0100. Swallowing Disorder 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

Any coding of A-D will trigger Swallowing Disorder for S.L.P. component.

Mechanically Altered Diet



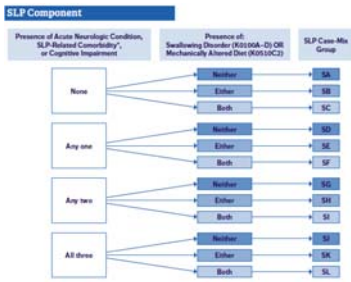
K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last 7 days

	1. While NOT a Resident	2. While a Resident
	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	☐	☐

Mechanically Altered Diet

- Diet specifically ordered to change the texture or consistency of food to facilitate intake.
- Examples:
  - Pureed
  - Soft Solids
  - Ground meat
  - Thickened liquids
- Presently 24% of the MDSs indicate that the resident has a mechanically altered diet.

S.L.P. Case-Mix



S.L.P. Case-Mix Classification Groups

TABLE 23: Proposed SLP Case-Mix Classification Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51

S.L.P. Case-Mix Classification Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

Mr. Doe Example Continued

- His principal dx was major joint replacement which is non-neurological.
- He has no swallowing problem and is on a regular diet.
- He does not have any of the speech co-morbidities.
- His BIMS score was "12." (While a score of 12 would not qualify as "cognitively impaired" for the nursing component, it does qualify as a cognitive deficiency for the S.L.P. component.)

S.L.P. Case-Mix Classification Groups

TABLE 23: Proposed SLP Case-Mix Classification Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51

Mr. Doe's S.L.P. Component

FY 2020 PDPM Adjusted Rates—

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

$22.83 x 1.46 = $33.33 per day

Poll #2

- If the Physical Therapy services end, the facility will no longer receive any payment for the P.T. component of PDPM.

A. True
B. False

Poll #2 Answer

- If the Physical Therapy services end, the facility will no longer receive any payment for the P.T. component of PDPM.

A. True
B. False

Therapy Contracts

- Since the PDPM payment will not be based on therapy days and minutes, it would be appropriate to consider changing therapy contracts.
- Residents will need reasonable and necessary therapy to recover from most injuries and illnesses but most likely the majority of residents do not need 720 minutes per week as they are now routinely given.

Practice with PCC

- Some MDS software systems have included a module to assist facilities to visualize how diagnoses will map to the therapy components.
- Some MDS software systems also allow facilities to enter information in new Section J codes to determine whether the surgeries would change the mapping.
- Practice makes perfect.

Nursing Component

25 CMI Groups Compressed from 66 RUG Grouper

18% add-on HIV/AIDS

Extensive Services	Special Care High	Special Care Low
Clinically Complex	Behavior and Cognitive Impairment	Reduced Physical Function

Component Combinations

- In the Special Care High, Special Care Low, Clinically Complex, and Reduced Physical Function classification groups (RUGs beginning with H, L, C, or P), for nursing groups that were otherwise defined with the same clinical traits (for example, extensive services, medical conditions, depression, restorative nursing services received), **we propose to combine the following pairs of second characters due to their contiguous ADL score bins: (E, D) and (C, B).**
- These characters correspond to ADL score bins (15 to 16 =A, 6 to 14 BC, and 0-5 = DE respectively.

Section GG Proposed Nursing ADL Score

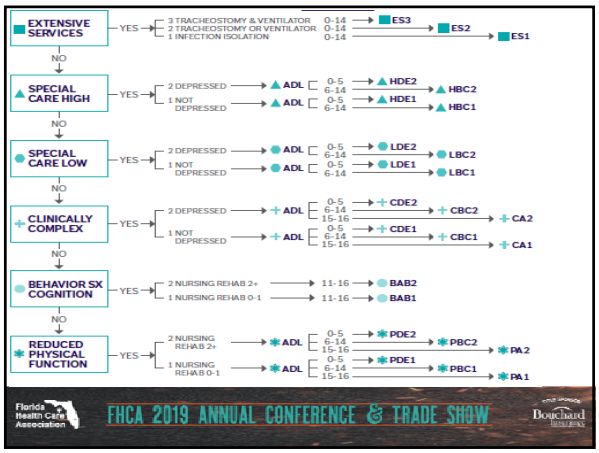
TABLE 24: Proposed Nursing Function Score Construction

Response		ADL Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

ADL Scoring Items for Nursing Component (Different items than P.T./O.T.)

TABLE 25: Section GG Items Included in Proposed Nursing Functional Measure

Section GG Item		ADL Score
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	
GG0170E1	Mobility: Chair/bed-to-chair transfer	0-4 (average of 3 items)
GG0170F1	Mobility: Toilet transfer	


EXTENSIVE SERVICES
YES
3 TRACHEOSTOMY & VENTILATOR
2 TRACHEOSTOMY OR VENTILATOR
1 INFECTION ISOLATION
0-14
ES3
ES2
ES1
NO
SPECIAL CARE HIGH
2 DEPRESSED
1 NOT DEPRESSED
ADL
0-5
6-14
HDE2
HDE1
HBC2
HBC1
SPECIAL CARE LOW
LDE2
LDE1
LBC2
LBC1
CLINICALLY COMPLEX
15-16
CDE2
CDE1
CBC2
CBC1
CA2
CA1
BEHAVIOR SX COGNITION
2 NURSING REHAB 2+
1 NURSING REHAB 0-1
11-16
BAB2
BAB1
REDUCED PHYSICAL FUNCTION
PDE2
PDE1
PBC2
PBC1
PA2
PA1
Florida Health Care Association
FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW
Boucher


CAMP FHCA
Proposed Nursing Case-Mix Groups
TABLE 26: Proposed Nursing Indexes under Proposed PDPM Classification Model
RUG-IV Nursing RUG | Extensive Services | Clinical Conditions | Depression | # of Restorative Nursing Services | GG-based Function Score | PDPM Nursing Case-Mix Group | Nursing Case-Mix Index
ES3 | Tracheostomy & Ventilator | - | - | - | 0-14 | ES3 | 4.04
ES2 | Tracheostomy or Ventilator | - | - | - | 0-14 | ES2 | 3.06
ES1 | Infection | - | - | - | 0-14 | ES1 | 2.91
HE2 HD2 | - | Serious medical | Yes | - | 0-5 | HDE2 | 2.39
Florida Health Care Association
FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW
Boucher


CAMP FHCA
Proposed Nursing Case-Mix Groups
RUG-IV Nursing RUG | Extensive Services | Clinical Conditions | Depression | # of Restorative Nursing Services | GG-based Function Score | PDPM Nursing Case-Mix Group | Nursing Case-Mix Index
conditions e.g. comatose, septicemia, respiratory therapy
HE1 HD1 | - | Serious medical conditions e.g. comatose, septicemia, respiratory therapy | No | - | 0-5 | HDE1 | 1.99
HC2 HB2 | - | Serious medical conditions e.g. comatose, septicemia, respiratory therapy | Yes | - | 6-14 | HBC2 | 2.23
HC1 HB1 | - | Serious medical conditions e.g. comatose, septicemia, respiratory therapy | No | - | 6-14 | HBC1 | 1.85
LE2 LD2 | - | Serious medical conditions e.g. radiation therapy or dialysis | Yes | - | 0-5 | LDE2 | 2.07
LE1 LD1 | - | Serious medical conditions e.g. radiation therapy or dialysis | No | - | 0-5 | LDE1 | 1.72
Florida Health Care Association
FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW
Boucher

Proposed Nursing Case-Mix Groups

LC2/LB2	-	radiation therapy or dialysis	Yes	-	6-14	LBC2	1.71
LC1/LB1	-	Serious medical conditions e.g. radiation therapy or dialysis	No	-	6-14	LBC1	1.43
CE2/CD2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	1.86
CE1/CD1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	0-5	CDE1	1.62
CC2/CB2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	1.54
CA2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	1.08
CC1/CB1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	6-14	CBC1	1.34
CA1	-	Conditions requiring complex medical care	No	-	15-16	CA1	0.94

Proposed Nursing Case-Mix Groups

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
		e.g. pneumonia, surgical wounds, burns					
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	1.04
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	0.99
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	1.57
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	1.47
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	1.21
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	0.70
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	1.13
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	0.66

HIV Adjustment (128% Add-on Removed)

- "Thus, as part of the case-mix adjustment of the nursing component, we are proposing an 18 percent increase in payment for the nursing component for residents with HIV/AIDS.

- This adjustment would be applied based on the presence of ICD-10-CM code B20 on the SNF claim. In cases where a resident is coded as having this diagnosis, the nursing component per diem rate for this resident would be multiplied by 1.18, to account for the 18 percent increase in nursing costs for residents with this diagnosis."

Mr. Doe Example

- Mr. Doe required dressing changes to his surgical wound from the hip replacement surgery. He also has an active diagnosis of Type II diabetes and requires daily insulin. He has diabetic retinopathy.
- He qualified for the Clinically Complex category related to his surgical wound and surgical wound care.
- His PHQ-9 score was "10."

Mr. Doe's ADL Score

Section GG performance	Score
Self-care Eating Independent	4
Toilet Hygiene: substantial/maximal	1
Sit to lying: substantial/maximal	1
Lying to sitting on side of bed: substantial/maximal	
Sit to stand: Dependent	0
Chair/bed-to-chair: Dependent	
Mobility: toilet transfer not attempted	
Total:	6

Mr. Doe's Nursing Component Payment

- Mr. Doe qualified for the Clinically Complex category of CBC2 (ADL score of BC, PHQ-9 score provided end split of 2).
- CBC2 CMI = 1.54
- Nursing base rate component = $106.64
  - $106.64 x 1.54 = $164.23/day

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

Mr. Doe with Higher Nursing Needs

- If the resident had an infection requiring isolation, the nursing component score would change to ES1 when completing an IPA (more later).

ES1 Case mix 2.91 x $106.64= $310.32/day

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$106.64	$80.45	$61.16	$56.93	$22.83	$95.48

Non-Therapy Ancillary Component

Non-Therapy Ancillary Component

- Non-therapy ancillary costs include drugs, laboratory services, respiratory therapy, and medical supplies.
- Prescription drugs or medication therapy were frequently noted areas of concern due to their potentially high cost for particular residents.
- In order to predict the NTA costs, CMS proposes to use clinical co-morbidities (ICD-10 and Section I), Medication costs, and extensive services.

NTA Score

- Points have been assigned to the identified items where the NTA cost was assumed to be increased.
- The scores are totaled to find the final NTA score.
- Note how many of the NTA qualifiers will be based upon ICD-10-CM coding.

Proposed Conditions and Services for NTA Classification

Condition/Service	Source	Points
HIV/AIDs	SNF Claim	8
Parenteral/IV feeding-High level	K0510A2, K0710A2	7
IV medications Post admit	O0100H2	5
Ventilator/Respirator	O0100F2	4
Parenteral/IV feeding-Low level	K0510A2, K0710A2/B2	3
Lung Transplant status	I8000*	3
Transfusion Post Admit	O0100I2	2

Proposed Conditions and Services for NTA Classification

Condition/Service	Source	Points
Major organ transplant-except lung	I8000*	2
Multiple Sclerosis	I5200	2
Opportunistic Infections	I8000*	2
COPD, Asthma, Chronic Lung disease	I6200	2
Bone/Joint/Muscle Infections/Necrosis - except aseptic necrosis of bone	I8000*	2
Chronic Myeloid Leukemia	I8000	2
Wound infection code	I2500	2
Diabetes Mellitus	I2900	2
Endocarditis	I8000*	1

Proposed Conditions and Services for NTA Classification

Condition/Service	Source	Points
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other foot skin problems-Diabetic Foot Ulcer	M1040B	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Tracheostomy Post Admit	O0100E2	1
Multi-Drug Resistant Organism	I1700	1
Isolation Post Admit	O0100M2	1
Specified Heredity Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Radiation Post Admit	O0100B2	1

Proposed Conditions and Services for NTA Classification

Condition/Service	Source	Points
Highest stage unhealed pressure ulcer-Stg 4	M0300D1	1
Psoriatic Arthropathy and System Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other open lesion on foot exc Diabetic foot ulcer code	M1040A, M1040B, M1040C	1
Complication of Specified Implanted Device or Graft	I8000	1
Intermittent Catheterization	H0100D	1

Proposed Conditions and Services for NTA Classification

Condition/Extensive Service	Source	Points
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Suctioning Post-Admit	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
Tube Feeding	K0510B2	1

Proposed Conditions and Services for NTA Classification

Condition/Extensive Service	Source	Points
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Malnutrition	I5600	1
Disorders of Immunity Except RxCC97: Immune Disorders	I8000	1
Cirrhosis of the Liver	I8000	1
Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

Calculation of NTA Case-Mix Group

TABLE 28: Proposed NTA Case-Mix Classification Groups

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

Mr. Doe

- Qualifies for:
- Active Diagnosis: Diabetes Mellitus = 2 points
- Active Diagnosis: Diabetic Retinopathy = 1 point

Total = 3 points

TABLE 28: Proposed NTA Case-Mix Classification Groups

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

NTA Base rate $80.45 X 1.34 = $107.80

Mr. Doe's Final Payment

- P.T. = $114.98
- O.T. = $96.21
- S.L.P. = $33.33
- NSG. = $164.23
- NTA = $107.80
- Non-CMI= $95.48

- Total = $612.03/day

P.T. and O.T. Adjustment Factors
(2% decrease every 7 days beginning day 21)

TABLE 30: Proposed Variable Per-diem Adjustment Factors and Schedule – PT and OT

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Example: Mr. Doe's P.T. and O.T. combined rate on day one was $211.19/day, by day 35 his daily rate would be $198.52/day and by 56 it would be down to $185.85/day. By day 98 the rate would be $160.50/day

NTA Adjustment Factor

TABLE 31: Proposed Variable Per-diem Adjustment Factors and Schedule – NTA

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

Mr. Doe's NTA base rate is $107.80/day.

On days 1-3, the facility would receive $323.40/day (base rate x 3).

On day 4, the NTA would drop back to the base rate of $107.80/day.

Mr. Doe's Payment Days 1-3

- P.T. = $114.98
- O.T. = $96.21
- S.L.P. = $33.33
- NSG. = $164.23
- NTA = $107.80 x 3 = $323.40
- Non-CMI= $95.48

- Total = $827.63/day

MDS

PDPM Effects on MDS

- PDPM does not have any effect on the OBRA schedule.
- PDPM does not change the requirements for OBRA Discharge Assessments and tracking forms.

MDS Current PPS Schedule

TABLE 32: Current PPS Assessment Schedule

Scheduled PPS assessments			
Medicare MDS assessment schedule type	**Assessment reference date**	**Assessment reference date grace days**	**Applicable standard Medicare payment days**
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled PPS assessments			
Start of Therapy OMRA	5-7 days after the start of therapy		Date of the first day of therapy through the end of the standard payment period.
End of Therapy OMRA	1-3 days after all therapy has ended		First non-therapy day through the end of the standard payment period.
Change of Therapy OMRA	Day 7 (last day) of the COT observation period		The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment.
Significant Change in Status Assessment	No later than 14 days after significant change identified		ARD of Assessment through the end of the standard payment period.

Proposed MDS Schedule PDPM

Medicare MDS Assessment Type	Assessment Reference Date	Applicable standard Medicare Payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge unless IPA completed
Interim Payment Assessments (IPA)	Now optional. Used to change the RUG during Medicare A stay	ARD of the IPA through the Part A discharge unless a subsequent IPA is completed.
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of Most Recent Medicare A stay (A2400C)	N/A

Interim Payment Assessment

- Resets rate if substantial change occurs.
- Will not reset variable per diem rate.
- The IPA is meant to capture substantial changes to a resident's clinical condition and not everyday, frequent changes.

Monitoring Need for IPA

- There are many "changes" that could occur that could make the completion of an IPA financially beneficial.
- Monitoring for these changes will require vigilance and frequent record review.
- This is different that an SCSA, but an SCSA could be clinically required.

Monitoring for IPA

From the FY2019 SNF PPS Final Rule:

"It is our expectation that the optional nature of the IPA will allow facilities to capture all of these changes as they occur during a SNF stay. Facilities will determine when IPAs should be completed, and we expect them to pay special attention to clinical and functional changes. It should be noted that, even absent an IPA requirement, we expect SNFs to constantly evaluate, capture, document and treat clinical and functional changes that occur in patients throughout a SNF stay."

Monitoring for IPA

"…rather than making the IPA a required assessment as we proposed, this assessment will be optional, and providers may determine whether and when an IPA is completed.

In addition, because the IPA is an optional assessment and providers can determine their own criteria for when an IPA is completed, we are revising the ARD criteria such that the ARD will be the date the facility chooses to complete the IPA relative to the triggering event that causes the facility to choose to complete the IPA."

MDS Combinations

- 5-day PPS MDSs will continue to be able to be combined with any OBRA assessments that may be required if the rules for the ARD apply.
- IPA MDS assessments cannot be combined with any other assessment.

Transition from RUG-IV to PDPM

The transition between RUG-IV and PDPM will be a "hard" transition, meaning that the two systems will not run concurrently at any point. RUG-IV billing will end on September 30, 2019 and PDPM billing will begin on October 1, 2019.

MDS During Transition

- **14.2 How will I get a PDPM payment code to bill starting October 1, 2019?**
- To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A patients.
- October 1, 2019 will be considered Day 1 of the variable per diem schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
- Any "transitional IPAs" with an ARD after October 7, 2019 will be considered late and the late assessment penalty would apply.

Late September 2019 Medicare Start Dates

- A PPS MDS must be completed with ARD no later than 9/30/19 in order to obtain a RUG for September 2019 payment.
- Short-stay assessments must follow all Short-stay rules. If Medicare does not end on or before 9/30/19, a short-stay assessment cannot be completed in order to obtain a Rehab RUG for late September Medicare starts.
- An IPA must also be completed with the ARD for days 10/1 to 10/7 in order to obtain PDPM payment.

Transition from RUG-IV to PDPM

- As part of the changeover from RUG-IV to PDPM, all current SNF residents who were admitted prior to the PDPM effective date (October 1, 2019) are to receive a new Interim Payment Assessment (IPA) under the PDPM, even though they may have been assessed already under the previous RUG-IV model.
- However, this changeover IPA would not entitle such current residents to a new presumption of coverage under the PDPM, as the presumption has always been tied to the *5-day* assessment that is performed at the *outset* of a resident's SNF stay.

Transition Critical Processes

- IPA assessments must be opened and ARDs set between 10/1/19 and 10/7/19 for all residents on Medicare from September to October.
- The team must determine the principal diagnosis for skilled care in the 7-day look-back which may be different than the original primary diagnosis chosen if the resident has been on skilled care for a while.
- Section GG assessments must be completed for each IPA during that first week of October along with those required for new admissions on or after 10/1/19 (Remember the 3 day assessment window includes the ARD and the 2 preceding days).
- BIMS and PHQ9 Interviews must be completed for each ARD.

New MDS Item Sets: IPA and OSA

There are two new item sets that have been created as a result of PDPM.

- First, the IPA has its own IPA item set. This item set contains merely payment items and demographic items, as necessary to attain a billing code under PDPM.
- Second, for states that rely on the RUG-IV assessment schedule for calculating case mix group for NF patients, CMS has created an optional assessment so that Medicaid payments are not adversely impacted when PDPM is implemented as of October 1, 2019. States will have the ability to determine the policy associated with this assessment to meet your Medicaid payment needs. The optional assessment will be in place from October 1, 2019 through September 30, 2020.

Therapy

Concurrent and Group Therapy Limits in PDPM

- Under RUG-IV, no more than 25% of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy
- •Definitions:
  - Concurrent Therapy: One therapist with two patients doing different activities
  - Group Therapy: One therapist with four patients doing the same or similar activities
- Under PDPM, we use a combined limit both concurrent and group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline

Therapy Items Added to NPE

- CMS is concerned that residents will not receive necessary therapy services with PDPM, because the therapy days/minutes will not factor into the payment system.
- In order to measure whether residents are receiving therapy, CMS is adding the therapy MDS items to the NPE.

Items Added to Part A PPS Discharge MDS
Since start date of Medicare A Stay

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)

C. Physical Therapy

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)

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

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)

Therapy Limits

- CMS is limiting the total percentage of therapy provided by a combination of concurrent or group to 25% for each therapy discipline.
- This means that at least 75% of the therapy provided by each therapy discipline must be provided as individual therapy.

Warning Message

When the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, that providers would receive a non-fatal warning edit on the validation report that the provider receives when submitting an assessment which would alert the provider that the therapy provided to that resident exceeded the threshold.

Reporting Concurrent and Group Therapy

Under PDPM, providers will be required to complete the PPS Discharge Assessment (Item Set Code = NPE) at the end of a SNF stay for all SNF Part A beneficiaries. As part of this assessment, providers will complete a new section of the MDS, section O0425, where providers will report the total amount of therapy, broken down by therapy mode (individual, concurrent and group) and by therapy discipline (Physical Therapy, Occupational Therapy, Speech-Language Pathology) the patient received during the entire Part A stay.

Reporting Concurrent and Group Therapy

- The look back for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay. Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each patient, by discipline, as a percentage of all therapies provided to that patient. If the amount of therapy provided exceeds 25 percent, then this would be deemed as non-compliance.

Flags for Review

- CMS would monitor group and concurrent therapy utilization under the proposed PDPM and will consider making future proposals to address abuses of this proposed policy or flag providers for additional review should an individual provider be found to consistently exceed the proposed threshold after the implementation of the proposed PDPM.

Calculating Compliance with the Concurrent and Group Therapy Limit

Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

- Step 1: Total Therapy Minutes, by discipline [O0425X1(I) + O0425X2(C) + O0425X3(G)]
- Step 2: Total Concurrent and Group Therapy Minutes, by discipline [O0425X2(C)+O0425X3(G)]
- Step 3: C/G Ratio (Step 2 result/Step 1 result)
- Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.

Example

- Total PT Individual Minutes (O0425C1): 2,000
- Total PT Concurrent Minutes (O0425C2): 600
- Total PT Group Minutes (O0425C3): 1,000

Compliance Calculations

- Step 1: Total PT Minutes (O0425C1 + O0425C2 + O0425C3): 3,600
- Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 +O0425C3): 1,600
- Step 3: C/G Ratio (Step 2 result/Step 1 result): 0.44
- Step 4: 0.44 is greater than 0.25, therefore this is non-compliant.

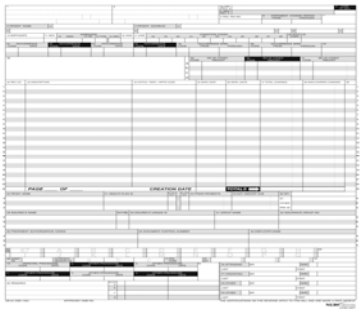
Non-compliance

- There will be no penalty for exceeding the 25% combined concurrent and group therapy limit. However, providers will receive a warning edit on their assessment validation report that will inform them that they have exceeded the 25% limit.
- The warning edit will read as follows: "The total number of group and/or concurrent minutes for one or more therapy disciplines exceeds the 25 percent limit on concurrent and group therapy. Consistent violation of this limit may result in your facility being flagged for additional medical review."
- CMS will also monitor therapy provision under PDPM to identify facilities that exceed the limit, in order to determine if additional administrative or policy action would be necessary.

Therapy

- Consider reviewing therapy contracts. Paying by RUGS or by minute no longer seems in the best interest of the SNF.
- Provide oversight of therapy weekly to ensure that no more than 25% of therapy is provided by combination of concurrent or group per discipline.
- Can software assist with this oversight?

HIPPS Codes for PDPM



PDPM HIPPS Coding

- Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character HIPPS code

The current RUG-IV HIPPS code follows a prescribed algorithm:

- Character 1-3: RUG Code
- Character 4-5: Assessment Indicator

In order to accommodate the new payment groups, the PDPM HIPPS algorithm is revised as follows:

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator

FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW

PDPM HIPPS Coding Crosswalk PT, OT, NTA Components

PT/OT component	SLP Component	NTA	HIPPS
TA	SA	NA	A
TB	SB	NB	B
TC	SC	NC	C
TD	SD	ND	D
TE	SE	NE	E
TF	SF	NF	F
TG	SG		G
TH	SH		H
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L

FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW

PT/OT Component HIPPS

PT/OT Component	HIPPS
TM	M
TN	N
TO	O
TP	P

Nursing HIPPS

Nursing	HIPPS	Nursing	HIPPS
ES3	A	CDE1	M
ES2	B	CBC2	N
ES1	C	CA2	O
HDE2	D	CBC1	P
HDE1	E	CA1	Q
HBC2	F	BAB2	R
HBC1	G	BAB1	S
LDE2	H	PDE2	T
LDE1	I	PDE1	U
LBC2	J	PBC2	V
LBC1	K	PA2	W
CDE2	L	PBC1	X
		PA1	Y

Assessment Type HIPPS

HIPPS	Assessment Type
0	IPA
1	5-day PPS

Danger Zone!

Must be sure of payer on admission! The Admission MDS will not be able to provide a PDPM HIPPS code. If the PPS MDS had not be completed, there would be no payer for stays greater than 8 days.

Example 1

- PT/OT Payment Group: TN
- SLP Payment Group: SH
- Nursing Payment Group: CBC2
- NTA Payment Group: NC
- Assessment Type: 5-day PPS Assessment

- HIPPS Code: NHNC1

Example 2

- PT/OT Payment Group: TC
- SLP Payment Group: SD
- Nursing Payment Group: PBC1
- NTA Payment Group: NE
- Assessment Type: 5-day PPS Assessment

- HIPPS Code:CDXE1

Default Rate Coding

- As under RUG-IV, there may be instances in which providers may bill the "default" rate on a SNF claim (e.g., when an MDS assessment is considered late).The default rate refers to the lowest possible per diem rate.
- The default code under **PDPM is ZZZZZ**, as compared to the default code under RUG-IV of AAA00.
- Billing the default code under PDPM represents the equivalent of billing the following PDPM groups:
  - PT Payment Group: TP
  - OT Payment Group: TP
  - SLP Payment Group: SA
  - Nursing Payment Group: PA1
  - NTA Payment Group: NF

Interrupted Stays

Interrupted Stay

- CMS defines an "interrupted" SNF stay as one in which a patient is discharged from SNF care and subsequently readmitted to the *same* SNF (not a different SNF) *within 3 days or less* after the discharge (the "interruption window").
- Consistent with the interrupted stay policies used in the Inpatient Rehabilitation Facility (IRF) and Inpatient Hospital settings, the interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF *by 12:00 am at the end of the third calendar day*.

Interrupted Stay

- If both conditions are met, the subsequent stay is considered a continuation of the previous "interrupted" stay for the purposes of both the variable per diem schedule and the assessment schedule.
- The variable per diem schedule continues from the day of the previous discharge.
- For example, if the patient was discharged on Day 17, payment rates resume at Day 17 upon readmission.
- The assessment schedule also continues from the day of the previous discharge.
- Thus, no new 5-day assessment is required upon the subsequent readmission, although the optional Interim Payment Assessment (IPA) may be completed at the provider's discretion.

New Stay

- If the patient is readmitted to the same SNF *more than 3 consecutive calendar days after discharge*, OR in *any* instance when the patient is *admitted to a different SNF* (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay.
- In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating a new 5-day assessment required.

Interrupted Stay Policy Examples

Example 1

Patient A is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to the same SNF on 11/25/19 – **New stay**

- – Assessment Schedule: Reset; stay begins with new 5-day assessment
- – Variable Per Diem: Reset: stay begins on Day 1 of variable per diem schedule

Example 2

Patient B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to a different SNF on 11/22/19 – New stay

- – Assessment Schedule: Reset; stay begins with new 5-day assessment
- – Variable Per Diem: Reset; stay begins on Day 1 of variable per diem schedule

Example 3

Patient C is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to the same SNF on 11/22/19 – **Continuation of previous stay**

- – Assessment Schedule: No PPS assessments required, IPA optional
- – Variable Per Diem: Continues from Day 14 (Day of Discharge)

Example A:

- A beneficiary is discharged from a SNF on day three of the stay. **Four days** after the date of discharge, the beneficiary is then re-admitted (as explained above, this re-admission would be in the same benefit period) to the same SNF.
- The SNF would conduct **a new 5-day assessment** at the start of the second admission and re-classify the beneficiary accordingly.
- In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to day one payment rates for the beneficiary's new case-mix classification.

Example B:

- A beneficiary is discharged from a SNF stay on day seven and is re-admitted to the same SNF within the 3-day interruption window.
- For the purposes of classification and payment, this would be considered a continuation of the previous stay (an interrupted stay).
- The SNF would not conduct a new 5-day assessment to re-classify the patient and for purposes of the variable per diem adjustment schedule, the payment schedule would continue where it left off; in this case, the first day of the second stay would be paid at the day eight per diem rates under that schedule.

Example C:

- A beneficiary is discharged from an SNF stay on day seven and is re-admitted to a different SNF within the 3-day interruption window.
- The SNF would conduct a new 5-day assessment at the start of the second admission and classify the beneficiary accordingly.
- In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to day one payment rates for the beneficiary's new case-mix.

MDS with Interrupted Stays

- As is the current policy, SNFs would be expected to complete the OBRA discharge assessment upon any discharge and within currently established timeframes, regardless of any expectation as to whether or not a patient might be readmitted and/or whether the readmission would be considered an interrupted stay. However, the Part A PPS Discharge MDS will not be completed if the discharge is an interrupted stay.

MDS with Interruption

- OBRA Discharge assessments will be required when a resident discharges to the hospital regardless of whether the resident returned to the SNF within 3 days of the discharge.
- The Interrupted stay policy does not change the requirements the OBRA Discharge MDS assessments, but does affect the rules for the Part A PPS Discharge.

Discharge to/Readmit from

13.15 Is the source of the readmission (e.g. from the community, from an intervening hospital stay, or from another type of facility) a relevant factor to the Interrupted Stay policy?

- No, the source of the readmission is not a relevant factor. The beneficiary may be readmitted to the SNF from the community, from an intervening hospital stay, or from a different kind of facility, and the interrupted stay policy would operate in the same manner. The only relevant factors to the determination of whether a stay is considered "interrupted" under the Interrupted Stay Policy are the length of time between stays, and whether the patient is admitted to the same or a different SNF.

Do Denial Notices Affect Interrupted Stay Determinations?

13.16 Would the issuance of a denial notice, such as a NOMNC or SNFABN, prior to the patient's departure have any effect on the Interrupted Stay Policy?

- No, the policy would be the same in this situation. The basic purpose of the interrupted stay policy is to ensure that when two segments of a patient's stay in the facility are separated by only a brief absence, the variable per diem payment adjustment is not inappropriately reset to Day 1 upon the patient's return. The issuance of a denial notice such as a NOMNC or SNFABN prior to the patient's departure would not, in itself, have any effect on the nature of the care needed by the patient upon subsequent resumption of SNF care, the costs of readmission, or the way in which providers would be paid under the PDPM.

Discharge with Return NOT Anticipated

13.17 Would the issuance of an OBRA Discharge Return Not Anticipated assessment have any effect on the Interrupted Stay Policy?

- No, the policy would be the same in this situation. While the provider may have prepared a discharge plan for this patient based on the notion that the patient would not return, the patient's return to the SNF within that 3-day window would suggest that either the patient was not adequately prepared for discharge or may have been discharged too early from the facility. Further, providers should consider the possibility that a patient may return before finalizing the precise discharge type coded on the MDS. Finally, we believe that exempting such discharges from the interrupted stay policy could incentivize providers to merely code discharges in this manner only for this purpose and without sufficient basis.

How Will Interrupted Stays Affect SNF QRP?

- We are aware that admissions and discharges are currently coded for purposes of the SNF QRP in a way that might conflict with how stays will be captured under the new PDPM. CMS is revising the codes so that a hospital admission and return to the SNF does not trigger a new Medicare stay for purposes of the SNF QRP. We are revising the codes so that a Medicare stay is captured the same way for purposes of the SNF QRP and the PDPM.

FAQ 13.22 How does the interrupted stay policy affect Medicare physician certification?

- The existing requirements governing level of care certification and recertification timeframes are tied to a beneficiary's SNF admission.
- If a beneficiary is discharged from the SNF (or from the covered Part A stay) and then resumes covered SNF care within the interruption window, the subsequent resumption would not be considered a new admission and, thus, would not trigger a new certification/recertification schedule.

FAQ 13.23 Will the interrupted stay impact the Leave of Absence policy?

- No. When a beneficiary leaves the SNF, the commencement of the day count for an interrupted stay under the PDPM would be triggered by the beneficiary's discharge from the SNF; by contrast, a leave of absence involves a temporary departure from the SNF in which there is no formal discharge.
- Accordingly, the interrupted stay and leave of absence scenarios are mutually exclusive. Moreover, because the beneficiary's return from a leave of absence would not represent a new "admission" to the SNF in this context, it would not reset the variable per diem payment schedule to Day 1.

MDS Examples for PDPM

- Admit 10/1/19.
- Admission/5-day PPS MDS completed with ARD of 10/8/19.
- Resident discharged to hospital on 10/15/19.
- OBRA Discharge with return anticipated completed with ARD of 10/15/19 (No NPE!).
- Resident returned on 10/17/19.
- Reentry tracking form completed –no new 5-day PPS, no new Admission MDS.
- Assess for SCSA and for IPA.

MDS Example #2 PDPM

- Admit date 10/1/19.
- ARD of Admission/5-day 10/8/19.
- Discharge to the hospital 10/15/19.
- Resident returned from the hospital on 10/19/19.
- OBRA Discharge With return anticipated/Part A PPS Discharge completed with ARD of 10/15/19.
- Reentry tracking form 10/19/19.
- 5-day PPS MDS with ARD of 10/19/19 to 10/26/19 completed. Assess for SCSA.

ICD-10-CM Changes Affecting IPA Decisions

- Resident's original principal diagnosis urinary tract infection (Medical Management). ADL score 20. Not neuro, no co-morbidities, no swallow or mechanically altered diet. NTA diabetic with diabetic retinopathy. $432.37/day
- Interrupted stay for fractured ankle (new principal dx in Other ortho), episode of endocarditis requiring IV antibiotics, some difficulty swallowing noted and BIMS declined to 12. ADL score = 10. **Payment changes to $670.01/day with IPA!**

Points to Ponder

- There will be a 2.5 market basket increase for FY2020. CMS expects urban SNFs to have an overall increase in Medicare payments of 1.8% with PDPM over RUGS IV for FY2020.
- ICD-10-CM processes need to be strong. Teams should begin choosing principal diagnoses together right after admission. SLP comorbidity diagnoses and NTA diagnoses should become a focus. Redo ICD-10-CM coding class.
- Section GG systems should be strengthened.
- Review therapy contracts and consider in-house therapy.
- Develop audits for GG, Diagnosis codes, therapy percentages of concurrent/group therapy.
- MDS Coordinators must develop skills to watch for opportunity for IPAs. AANAC time study showed that more MDS Coordinators would be needed with PDPM than with RUGS IV. Accuracy in each payment item will be critical.

Resources

- **Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program.**
- **SNF PPS Proposed Rule for FY2020.**

Questions?

cmaher@hhc-cpa.com