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SNF PPS PDPM: Patient Driven Payment Model

J15 Part A Provider Outreach and Education

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Acronyms

- AIDS: Acquired Immune Deficiency Syndrome
- ARD: Assessment Reference Date
- BIMS: Brief Interview for Mental Status
- CMI: Case-mix Index
- CMS: Centers for Medicare and Medicaid Services
- COT: Change of Therapy
- CFS: Cognitive Function Scale
- CPS: Cognitive Performance Scale
- HIPPS: Health Insurance Prospective Payment System
- HIV: Human Immunodeficiency Virus
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- IPA: Interim Payment Assessment
- MDS 3.0: Minimum Data Set, Version 3
- NF: Nursing Facility
- NTA: Non-Therapy Ancillary
- OBRA: Omnibus Budget Reconciliation Act of 1987
- OMRA: Other Medicare-Required Assessment
- OSA: Optional State Assessment
- OT: Occupational Therapy
- PDPM: Patient Driven Payment Model
- PPS: Prospective Payment System
- PT: Physical Therapy
- RUG-IV: Resource Utilization Group, Version IV
- SLP: Speech Language Pathology
- SNF: Skilled Nursing Facility
- UPL: Upper Payment Limit
- VPD: Variable Per Die

PDPM Overview

J15 Part A Provider Outreach and Education

Program Overview

The Patient Driven Payment Model (PDPM), effective October 1, 2019, will improve payments made under the SNF PPS in the following ways:

- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
- Significantly reduces administrative burden on providers
- Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments

PDPM Components

PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:

- Physical Therapy
- Occupational Therapy
- Speech Language Pathology
- Nursing
- NTA

PDPM also includes a “Variable Per Diem (VPD) adjustment” that adjusts the per diem rate over the course of the stay

PDPM Snapshot

PT PT Base Rate × PT CMI × VPD Adjustment Factor

+

OT OT Base Rate × OT CMI × VPD Adjustment Factor

+

SLP SLP Base Rate × SLP CMI

+

NTA NTA Base Rate × NTA CMI × VPD Adjustment Factor

+

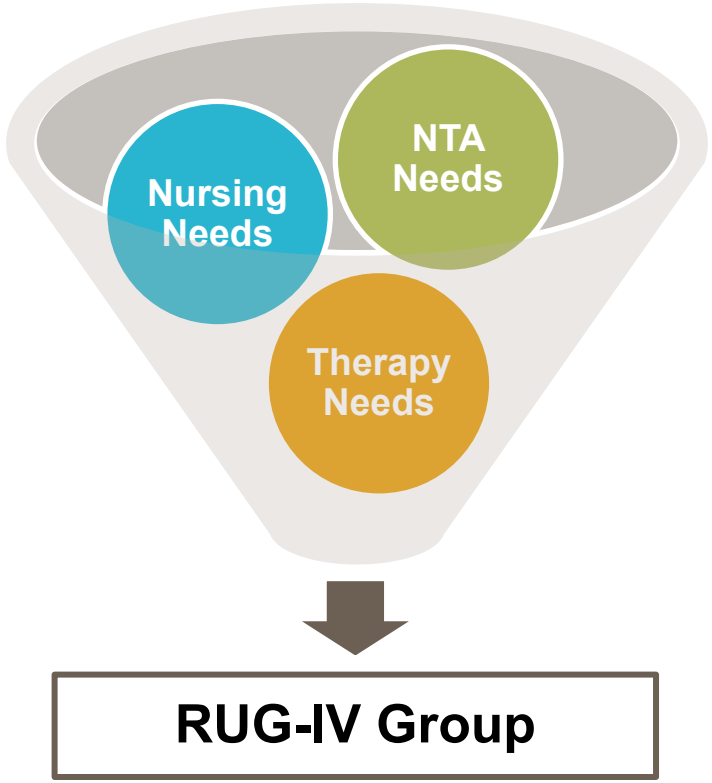
Nursing Nursing Base Rate × Nursing CMI × 18% Nursing Adjustment Factor (only for Patients with AIDS)

+

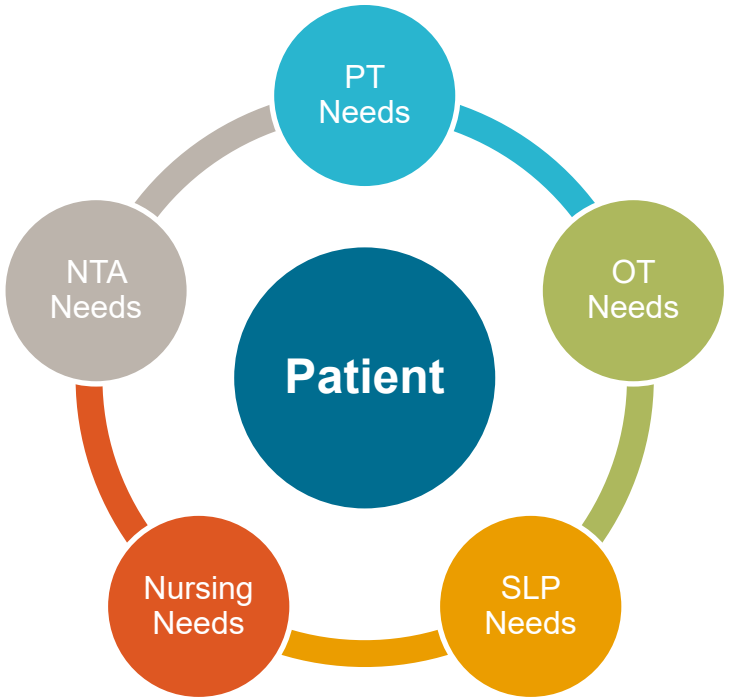
Non-Case-Mix Non-Case-Mix Base Rate

RUG –IV vs PDPM

RUV-IV reduces everything about a patient to a single, typically volume-driven, case mix group

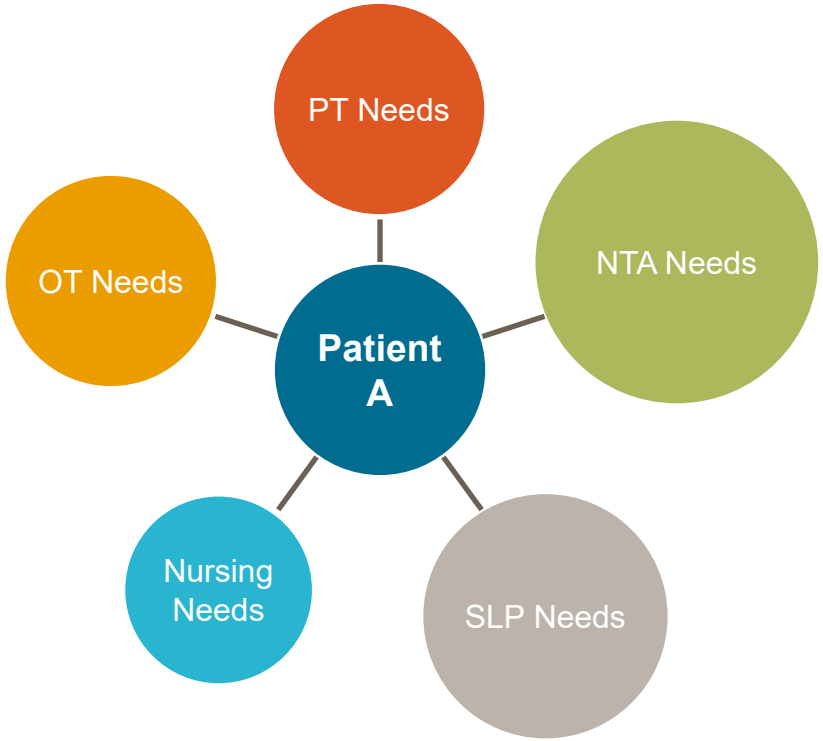


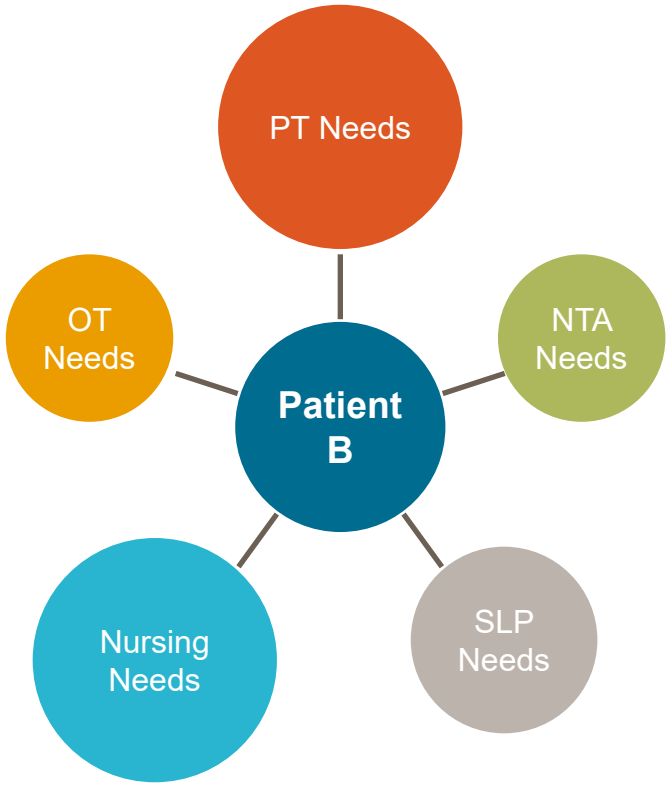
PDPM focuses on the unique, individualized needs, characteristics, and goals of each patient.



Outcome of PDPM

By addressing each individual patient's unique needs separately, PDPM improves payment accuracy and helps establish a more patient specific care model.





PDPM Patient Classification

- Under PDPM each patient is classified into a group for each of the five case-mix adjusted components: PT, OT. SLP, Nursing, and NTA
- Each component utilizes different criterial as the basis for classification:
  - PT: Clinical Category, Functional Score
  - OT: Clinical Category, Functional Score
  - SLP: Presence of Acute Neurologic Condition, SLP Related Comorbidity or Cognitive Impairment, Mechanically altered Diet, Swallowing Disorder
  - Nursing: Same characteristics as under RUG-IV
  - NTA: NTA Comorbidity Score

PT & OT Components: RUG-IV & PDPM

- Under RUG-IV, the number of PT, OT, and SLP therapy treatment minutes are combined for a total number of treatment minutes that is used to classify a given patient into a given therapy RUG
- Under PDPM, patient characteristics will be used to predict the therapy costs associated with a given patient, rather than rely on service use
- For the PT & OT components, tow classifications are used:
  - Clinical Category
  - Functional Status

PDPM Clinical Categories

- SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, coded on the Minimum Data Set (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 on the PDPM Web page https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
  - Clinical Categories available on next page

PDPM Clinical Categories

- Major Joint Replacement or Spinal Surgery
- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic – Surgical Extremities not Major Joint
- Acute Infections
- Medical Management
- Cancer
- Pulmonary
- Cardiovascular and Coagulations
- Acute Neurologic
- Non-Orthopedic Surgery

PT & OT Clinical Categories

Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification:

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non- Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	Non- Orthopedic Surgery & Acute Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic – Surgical Extremities Not Major Joint	Other Orthopedic
Medical Management	Medical Management
Cancer	Medical Management
Pulmonary	Medical Management
Cardiovascular & Coagulations	Medical Management
Acute Infections	Medical Management

PT & OT Functional Score

- PDPM advances CMS' goal of using standardized assessment items across payment settings by using items in Section GG of the MDS as the basis for patient functional assessments
- The functional score for the PT & OT components is calculated as the sum of the scores on ten Section GG items:
  - Two bed mobility items
  - Three transfer items
  - One eating item
  - One toileting item
  - One oral hygiene item
  - Two walking items

PT & OT Functional Score: GG Items

Section GG Items included in the PT & OT Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-Care: Eating	0-4
GG0130B1 – Self Care: Oral Hygiene	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	0-4 (average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0-4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	0-4 (average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	0-4 (average of 3 items)
GG0170J1 – Mobility: Walk 50 fee with 2 turns	0-4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	0-4 (average of 2 items)

Nurse Functional Score: GG Items

Section GG items included in the Nurse Functional Score:

Section GG Item	Functional Score Range
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	0-4 (average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0-4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	0-4 (average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	0-4 (average of 3 items)

Functional Score: Item Response Crosswalk (1)

PT & OT and Nursing Functional Score Construction (Non-walking Items)

Item Response	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, 10, 88, missing – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns	0

Functional Score: Item Response Crosswalk (2)

PT & OT Functional Score Construction (Walking Items)

Item Response	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, 10, 88, missing – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns, Resident Cannot Walk (Coded based on response to GG0170I1)	0

RUG-IV & PDPM Functional Score Differences

Notable differences between G and GG scoring methodologies:

- Reverse Score 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
    - Example: For the PT & OT component, payment for three clinical categories is lower for the most and least dependent patients (who are less likely to require high therapy amounts of therapy), compared to those in between (who are more likely to require high amounts of therapy)

PT & OT Components: Payment Group

PDPM Clinical Categories	PT & OT Function Score	PT & OT Case Mix Group	PT CMI	OT CMI
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

SLP Component

For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:

- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of swallowing disorder

SLP-Related Comorbidities

Twelve SLP comorbidities were identified as predictive of higher SLP costs:

- Conditions and services combined into a single SLP-related comorbidity flag
- Patient qualifies if any of the conditions/services is present
- A mapping between ICD-10 codes and the SLP comorbidities is available on the PDPM Web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM)

SLP Comorbidities:

- Aphasia
- CVA, TIA, or Stroke
- Hemiplegia or Hemiparesis
- Traumatic Brain Injury
- Tracheostomy (while Resident)
- Ventilator (while Resident)
- Laryngeal Cancer
- Apraxia
- Dysphagia
- ALS
- Oral Cancers
- Speech & Language Deficits

PDPM Cognitive Scoring

- Under RUG-IV, a patient's cognitive status is assessed using the Brief Interview for Mental Status (BIMS):
  - In cases where the BIMS cannot be completed, providers are required to perform a staff assessment for mental status
  - The Cognitive Performance Scale (CPS) is then used to score the patient's cognitive status based on the results of the staff assessment
- Under PDPM, a patient's cognitive status is assessed in exactly the same way as under RUG-IV (i.e., via the BIMS or staff assessment):
  - Scoring the patient's cognitive status, for purposes of classification, is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment

PDPM Cognitive Score: Methodology

PDPM Cognitive Measure Classification Methodology

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

SLP Component: Payment 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
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

Nursing Component

- RUG-IV classifies patients into a therapy RUG, based on how much therapy the patient receives, and a non-therapy RUG, based on certain patient characteristics:
  - Only one of these RUGs is used for payment purposes
  - Therapy RUGs are used to bill for over 90% of Part A days
- Therapy RUGs use a consistent nursing case-mix adjustment, which obscures clinically meaningful differences in nursing characteristics between patients in the same therapy RUG
- PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:
  - Function score based on Section GG of the MDS 3.0
  - Collapsed functional groups, reducing the number of nursing groups from 43 to 25

Nursing Component: Payment Groups (1)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
ES3	Tracheostomy & Ventilator				0-14	ES3	4.04
ES2	Tracheostomy & Ventilator				0-14	ES2	3.06
ES1	Infection Isolation				0-14	ES1	2.91
HE2/HD2		Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes			HDE2	2.39
HE1/HD1		Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No			HDE1	1.99
HC2/HB2		Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes			HBC2	2.23
HC1/HB1		Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No			HBC1	1.85

Nursing Component: Payment Groups (2)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
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
LC2/LB2		Serious medical conditions e.g., 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

Nursing Component: Payment Groups (3)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
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 e.g., pneumonia, surgical wounds, burns	No		15-16	CA1	0.94
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	0.7
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

NTA Component

- NTA classification is based on the presence of certain comorbidities or use of certain extensive services
- We considered various options to incorporate comorbidities into payment:
  - Total number of comorbidities is linked to NTA costs, but a simple count of conditions overlooks differences in relative costliness
  - A tier system accounts for differences in relative costliness but does not account for the number of comorbidities
- Comorbidity score is a weighted count of comorbidities:
  - Comorbidities associated with high increases in NTA costs grouped into various point tiers
  - Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

NTA Component: Comorbidity Coding

- Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000
- A mapping between ICD-10-CM codes and NTA comorbidities used for NTA classification is available on the PDPM Web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM)
- One comorbidity Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV:
  - The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS

NTA Component Condition Listing (1)

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral Intravenous (IV) Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Asthma Chronic obstructive pulmonary disease (COPD) Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis – Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Diabetes Mellitus (DM) Code	MDS Item I2900	2

NTA Component Condition Listing (2)

Condition/Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Live Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer – Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1

NTA Component Condition Listing (3)

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

NTA Component Condition Listing (4)

Condition/Extensive Service	Source	Points
Disorders of Immunity – Except: RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

NTA Component: Payment 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

Variable Per Diem Adjustments

- The Social Security Act requires the SNF PPS to pay on a per-diem basis
- Constant per diem rates do not accurately track changes in resource utilization throughout the stay and may allocate too few resources for providers at beginning of stay
- To account more accurately for the variability in patient costs over the course of a stay, under PDPM, an adjustment factor is applied (for certain components) and changes the per diem rate over the course of the stay:
  - Similar to what exists under the Inpatient Psychiatric Facility PPS
- For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay

Variable Per Diem Adjustment Schedules

PT & OT Components

Day in Stay	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

NTA Component

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

Additional PDPM Policies

- In addition to the case-mix refinements, PDPM also includes policy changes to the SNF PPS to be effective concurrent with implementation of PDPM
- Areas discussed include:
  - MDS Related Changes
  - Concurrent & Group Therapy Limit
  - Interrupted Stay Policy
  - Administrative Presumption
  - Payment for Patients with AIDS
  - Revised Health Insurance Prospective Payment Systems (HIPPS) Coding
  - RUG-IV – PDPM Transition

MDS Related Changes: Assessment Schedule

- Both RUG-IV and PDPM utilize the MDS 3.0 as the basis for patient assessment and classification
- The assessment schedule for RUG-IV includes both scheduled and unscheduled assessments with a variety of rules governing timing, interaction among assessments, combining assessments, etc.:
  - Frequent assessments are necessary, due to the focus of RUG-IV on such highly variable characteristics as service utilization
- The assessment schedule under PDPM is significantly more streamlined and simpler to understand than the assessment schedule under RUG-IV
- The changes to the assessment schedule under PDPM have no effect on any Omnibus Budget Reconciliation Act of 1987 (OBRA)-related assessment requirements

RUG-IV Assessment Schedule

RUG-IV Assessment Schedule

Scheduled Assessment			
Medicare DMS 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 Assessment			
Start of Therapy Other Medicare-Required Assessment (OMRA)	5-7 days after	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	End of therapy	First non-therapy day through the end of the standard payment period
Change of Therapy OMRA	Day 7 (last day) of	Change of Therapy (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	Assessment Reference Date (ARD) of Assessment through the end of the standard payment period

PDPM Assessment Schedule

Medicare MDS Assessment Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Five-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

MDS Changes: New Item Sets

- Interim Payment Assessment (IPA):
  - Optional Assessment: May be completed by providers in order to report a change in the patient's PDPM classification
    - Does not impact the variable per diem schedule
  - ARD: Determined by the provider
  - Payment Impact: Changes payment beginning on the ARD and continues until the end of the Part A stay or until another IPA is completed
- Optional State Assessment (OSA):
  - Solely to be used by providers to report on Medicaid-covered stays, per requirements set forth by their state
  - Allows providers in states using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until September 30, 2020, at which point CMS support for legacy payment models will end

MDS Changes: New and Revises Items

SNF Primary Diagnosis:

- Item I0020B (New Item)
- This item is for providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis
- "What is the main reason this person is being admitted to the SNF?"
- Coded when I0020 is coded as any response 1 – 13

MDS Changes: New and Revised Items (1)

Patient Surgical History

- Items J2100 – J5000 (New Items)
- These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission (i.e., the qualifying hospital stay)
- Similar to the active diagnoses captured in Section I, these Section J items will be in the form of checkboxes

MDS Changes: Patient Surgical Categories

Item	Surgical Procedure Category
J2100	Recent Surgery Requiring Active SNF Care
J2300	Knee Replacement – partial or total
J2310	Hip Replacement – partial or total
J2320	Ankle Replacement – partial or total
J2330	Shoulder Replacement – partial or total
J2400	Spinal surgery – spinal cord or major spinal nerves
J2410	Spinal surgery – fusion of spinal bones
J2420	Spinal surgery – lamina, discs, or facets
J2499	Spinal surgery – other
J2500	Ortho surgery – repair fractures of shoulder or arm
J2510	Ortho surgery – repair fractures of pelvis, hip, leg, knee, or ankle
J2520	Ortho surgery – repair but not replace joints
J2530	Ortho surgery – repair other bones
J2599	Ortho surgery – other
J2600	Neuro surgery – brain, surrounding tissue/blood vessels
J2610	Neuro surgery – peripheral and autonomic nervous system – open and percutaneous
J2620	Neuro surgery – insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices

Item	Surgical Procedure Category
J2699	Neuro surgery – other
J2700	Cardiopulmonary surgery – heart or major blood vessels – open and percutaneous procedures
J2710	Cardiopulmonary surgery – respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords – open and endoscopic
J2799	Cardiopulmonary surgery – other
J2800	Genitourinary surgery – male or female organs
J2810	Genitourinary surgery – kidneys, ureter, adrenals, and bladder – open, laparoscopic
J2899	Genitourinary surgery – other
J2900	Major surgery – tendons, ligament, or muscles
J2910	Major surgery – GI tract and abdominal contents from esophagus to anus, billary tree, gall bladder, liver, pancreas, spleen – open laproscopic
J2920	Major surgery – endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open
J2930	Major surgery – breast
J2910	Major surgery – deep ulcers, internal brachytherapy, bone marrow, stem cell harvest/transplant
J5000	Major surgery – other not listed above

MDS Changes: New and Revised Items (2)

- Discharge Therapy Collection Items:
  - Items 0425A1 – O0425C5 (New Items)
  - Using a look-back of the entire PPS stay, providers report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient
  - If the total amount of group/concurrent minutes, combined, comprises more than 25% of the total amount of therapy for that discipline, a warning message is issued on the final validation report
- Section GG Functional Items – Interim Performance:
  - On the IPA, section GG items will be derived from a new column “5” which will capture the interim performance of the patient
  - The look-back for this new column will be the three-day window leading up to and including the ARD of the IPA (ARD and the 2 calendar days prior to the ARD)

MDS Changes: New and Revised Items (3)

- Existing MDS Items Being Added to Swing Bed Assessment:
  - K0100: Swallowing Disorder
  - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease
  - I4300: Active Diagnosis: Aphasia
  - O0100D2: Special Treatments, Procedures & Programs: Suctioning, While a Resident
- Existing Items Being Added to 5-day PPS Assessment and IPA:
  - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease

Concurrent & Group Therapy Limits

- 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

Concurrent & Group Therapy Limits: Compliance

- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425):
  - Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay
  - If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the provider will receive a warning message on their final validation report
- How to calculate compliance with the concurrent/group therapy limit:
  - Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)
  - Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2 + O0425X3)
  - Step 3: C/G Ratio (Step 2 Result/ Step 1 Result)
  - Step 4: If Step 3 Result is greater than 0.25, then non-compliant

Concurrent & Group Therapy Limits: Example

- SNF Patient 1
  - Total PT Individual Minutes (O0425C1): 2,000
  - Total PT Concurrent Minutes (O0425C2): 600
  - Total PT Group Minutes (O0425C3): 1,000
- Does this comply with the concurrent/group therapy limit?
  - 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

Interrupted Stay Policy

- Given the introduction, under PDPM, of the variable per diem adjustment, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the variable per diem schedule
- Frequent patient readmissions and transfers represents a significant risk to patient care, as well as a potential administrative burden on providers from having to complete new patient assessments for each readmission
- To mitigate this potential incentive, PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window:
  - This type of policy also exists in other post-acute care settings (e.g., Inpatient Rehabilitation Facility PPS)

Interrupted Stay Policy

- If a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay:
  - Assessment schedule continues from the point just prior to discharge
  - Variable per diem schedule continues from the point just prior to discharge
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay:
  - Assessment schedule and variable per diem schedule reset to day 1
- This policy applies not only in instances when a patient physically leaves the facility, but also in cases when the patient remains in the facility but is discharged from a Medicare Part A-covered stay.
  - Example: If a patient in a SNF stay remains in the facility under a Medicaid-covered stay but returns to skilled care within the interruption window.

Administrative Presumption

- The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring an SNF level of care through the assessment reference date for that assessment
- Those beneficiaries not assigned one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition but instead receive an individual determination using the existing administrative criteria
- The following PDPM classifiers are designated under the presumption
  - Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
  - PT & OT Groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
  - SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
  - The NTA component's uppermost (12+) comorbidity group

Payment for Patients with AIDS

- Under RUG-IV, patients with AIDS receive 128% increase in the per diem rate associated with their RUG-IV classification
- This add-on was merely a general approximation of the added cost of caring for patients with AIDS, which was not accurately targeted at the specific rate components that actually account for the disparity in cost between those patients and others:
  - Two primary cost components that drive increased cost for this subpopulation are Nursing and NTA costs
  - Under RUG –IV given most patients are classified into a therapy group and criteria used to classify patients into therapy groups, increased therapy utilization also increased impact of the AIDS add-on, contrary to research indicating that AIDS is associated with a statistically significant decrease in per diem therapy costs

Payment for Patients with AIDS

- As the PDPM was developed, its rate components were specifically designed to account accurately and appropriately for the increased cost of AIDS-related care, as determined through our research
- Accordingly, the PDPM addresses costs for this subpopulation in two ways:
  - Assigns those patients with AIDS the highest point value (8 points) of any condition or service for purposes of classification under its NTA component
  - 18% add-on to the PDPM Nursing component
- As under the previous RUG-IV model, the presence of an AIDS diagnosis continues to be identified through the SNF's entry of ICD-10-CM Code B20 on the SNF claim

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

PDPM HIPPS Coding

PT/OT, SLP, NTA Payment Groups to HIPPS Translation:

PT/OT Payment Group	SLP Payment Group	NTA Payment Group	HIPPS Character
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

PT/OT Payment Group	SLP Payment Group	NTA Payment Group	HIPPS Character
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L
TM			M
TN			N
TO			O
TP			P

PDPM HIPPS Coding

Nursing Payment Group to HIPPS Translation:

Nursing Payment Group	HIPPS Character
ES3	A
ES2	B
ES1	C
HDE2	D
HDE1	E
HBC2	F
HBC1	G
LDE2	H
LDE1	I
LBC2	J
LBC1	K
CDE2	L
CDE1	M

Nursing Payment Group	HIPPS Character
CBC2	N
CA2	O
CBC1	P
CA1	Q
BAB2	R
BAB1	S
PDE2	T
PDE1	U
PBC2	V
PA2	W
PBC1	X
PA1	Y

PDPM HIPPS Coding

Assessment Indicator Crosswalk

HIPPS Character	Assessment Type
0	IPA
1	PPS 5-day
6	OBRA Assessment (not coded as a PPS Assessment)

PDPM HIPPS 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

RUV-IV & PDPM Transition

- As discussed in the FY 2019 SNF PPS Final Rule, there is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers and CMS:
  - RUG-IV billing ends September 30, 2019
  - PDPM billing begins 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 VPD 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 relevant penalty for late assessments would apply