

# Understanding the PDPM

## Patient Driven Payment Model

CMS published the Fiscal Year 2019 SNF Prospective Payment System (SNF PPS) final rule, which announced their plans for implementation of PDPM scheduled for a start date of October 1, 2019.

In efforts to prepare providers for the upcoming change, CMS has developed a PDPM web page dedicated to the model with multiple resources including crosswalks, training, and an FAQ document which is available at: [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM\\_FAQ\\_Final.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final.pdf).

The December 11, 2018 **SNF Open Door Forum (SNF ODF)** call highlighted several updates for providers.

- ✓ One of the more significant amendments to the model discussed during the ODF call was the use of a **new MDS item, I0020B**, to report the resident's SNF Primary Diagnosis; in essence, "What is the main reason the person is being admitted to the SNF?". This decision, while logical, differs from the final rule which stated this information would be reported at the first line of I8000.
- ✓ Additional MDS items and PDPM topics, including the process of transitioning from RUG-IV to PDPM, were reviewed on the call and are described here in greater detail.

As a Proactive partner, you'll have unlimited access to our transition tools, resources and templates plus one on one work days scheduled with your designated project consultant.

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## Key Concepts of PDPM *Continued...*

### The Variable Per Diem Adjustment accounts for changes in costs at various points in a resident's stay.

The variable per diem schedule, related to OT, PT, and NTA (non-therapy ancillary) is outlined here:

[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/Downloads/PDPM\\_Fact\\_Sheet\\_VPD\\_Final.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/Downloads/PDPM_Fact_Sheet_VPD_Final.pdf).

- PT and OT components are variably adjusted beginning on day 20 (vs. day 14 under RCS-1) based on CMS' finding that PT, OT, and non-therapy ancillary costs declined over the course of the stay.
- Speech-language pathology and nursing services are not subject to the variable adjustment throughout the stay.
- PT and OT are reimbursed at the full rate for days 1-20. On day 21, a decreasing adjustment factor of 2% is applied every 7 days throughout the remainder of the stay.
- If the resident stayed all 100 days, for example, the PT and OT components would be reimbursed at 76% of their initial rate for days 98-100.

### Concurrent & Group Therapy Limits

There is a 25% combined limit per discipline (PT, OT, SLP), per patient, per Part A SNF Stay to ensure the highest caliber of therapy services are received and that individual therapy between the therapist and patient remains the majority of the services rendered.

- CMS will be monitoring percentages input into assessment software to calculate the percentage of group and/or concurrent therapy provided during the Part A SNF stay.
- The provider will receive a warning edit on the validation report to indicate if they have exceeded the 25% limit.
- CMS will be keeping track of facilities that exceed the limit which may result in a penalty for exceeding the limit in the future.

### PDPM Functional & Cognitive Scoring

The function score for PDPM is calculated using data from section GG of the MDS. PDPM makes no changes to how section GG is coded.

*10 items which were found to be predictive of PT and OT costs per day are the basis of Section GG components:*

- **Two bed mobility items**
- **Three transfer items**
- **One eating item**
- **One toileting item**
- **One oral hygiene item**
- **Two walking items**

- Missing GG responses will receive 0 points for the function score calculation.
- All "activity not attempted" codes, including the new response of 10 "not attempted due to environmental limitations" will also receive 0 points for function score calculation.
- 0 points will be assigned to "dependent" responses instead of 1 point due to dependent patients having different levels of PT and OT resource utilization than patients receiving substantial/maximal assistance.
- PDPM cognitive scoring is assessed with The Brief Interview for Mental Status or Cognitive Performance Scale. The PDPM Cognitive Measures is then based on the Cognitive Functional Scale which combines scores from the BIMS and CPS into one scale.
- Under PDPM, cognitive impairment will correlate to the SLP component regardless if the impairment is mild, moderate, or severe.



## Key Concepts of PDPM *Continued...*

### Administrative Level of Care Presumption under PDPM

A beneficiary who is correctly assigned one of the more intensive case-mix classifiers on the initial five-day MDS is automatically classified as meeting the SNF level of care definition up to and including the assessment reference date for that assessment which must occur no later than the 8th day of the SNF stay.

- The purpose of the presumption is “to afford a streamlined and simplified administrative procedure for readily identifying those beneficiaries with the greatest likelihood of meeting the level of care criteria.”  
-83 FR 39253

*For services furnished on or after October 1, 2019, the following classifiers under the Patient Driven Payment Model (PDPM) qualify a beneficiary for the presumption:*

- *Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;*
- *PT and 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;*
- *The NTA component’s uppermost (12+) comorbidity group.*

- The completion of an IPA for a current resident would not entitle a resident to a new presumption of coverage under the PDPM because the presumption has always been tied to the 5-day assessment that is performed at the start of the resident’s SNF stay.

### Interrupted Stay Policy

Clarifies when Medicare will treat multiple SNF stays occurring in a single Part A benefit as a single “interrupted” stay vs. separate stays.

- When the stay is interrupted, the assessment schedule and variable per diem payment schedule continue from the point just prior to discharge. When the stay is not interrupted, both the assessment schedule and the variable per diem rate reset to Day 1.

*An “interrupted” stay is one in which a patient is discharged from SNF care and subsequently readmitted under the following TWO conditions:*

- *The patient returns to the same SNF (not a different SNF); AND:*
- *The patient returns within 3 days or less (the “interruption window”)*

- An interrupted stay policy is required to ensure quality care by discouraging providers from discharging a patient and readmitting for purposes of resetting the variable per diem adjustment schedule so that rates are maximized.
- During transition, this policy would only apply in cases where a resident discharges from Part A on or after Oct. 1, 2019. Per CMS representative, “If the patient’s Part A discharge began before Oct. 1, 2019, and the patient is readmitted on or after Oct. 1, 2019, then this would be considered a new stay, and all PDPM policies would be effective.
- For example, the PDPM assessment schedule would apply for these patients, beginning the new stay with a 5-day assessment and on day 1 of the variable per-diem schedule.”

## MDS Changes

### New items/sections being added to the MDS under PDPM include:

- **Item I0020B:** SNF Primary Diagnosis
- **Items J2100-J5000:** Patient Surgical History
- **Items 00425A1-00425C5:** Discharge Therapy Items
- **Item K0100:** Swallowing Disorder (added to Swing Bed assessment)
- **Item I4300:** Active Diagnosis, Aphasia (added to Swing Bed assessment)
- **Item 00100D2 Special Treatments & Procedures:** Suctioning (added to Swing Bed assessment)
- **Column 5** will be added to section GG to capture interim performance in the IPA
- **Interim Payment Assessment:** Optional assessment for significant change(s) that impact reimbursement

As with RUG-IV, MDS accuracy under PDPM will be paramount in order to receive appropriate reimbursement for the care and services provided to the resident.

While the SNF Primary Diagnosis reported at I0020B determines the resident’s Clinical Category, providers should focus on ensuring accuracy and specificity of all diagnosis codes. Many conditions contribute to the SLP and NTA comorbidities and are only included if the diagnosis is approved for PDPM and reported throughout Section I in the available options or manually entered into I8000 slots. Comorbidity crosswalks can be accessed from the CMS PDPM webpage ([www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html)).

In January 2019, CMS posted a draft version of the October 2019 MDS item sets which can be downloaded at [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-Item-Sets-v1-17-0-DRAFT-for-October-1-2019-Release.zip](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-Item-Sets-v1-17-0-DRAFT-for-October-1-2019-Release.zip).

Watch for a draft 2019 RAI manual to be posted during the first quarter of 2019.



### Other Considerations Under PDPM

#### PDPM Payments for SNF patients with HIV/AIDS

PDPM accounts for increased costs of SNF patients with AIDS by assigning the highest point value of any condition/service for PDPM classification under the NTA component (8 points). There is also an 18% add-on to the nursing component. Presence of an AIDS diagnosis is reported through entry of an ICD.10 code on B20 on the claim.

#### Transition Policy

### RUG-IV will end September 30, 2019. — PDPM will begin on October 1, 2019.

All providers are required to complete an IPA with an ARD no later than October 7, 2019 for all Part A patients.

- Providers will still have up to 14 days after the ARD to complete the assessment. Transitional IPAs with an ARD after October 7, 2019 will be counted as late and an assessment penalty would apply.
- Providers express concern regarding accurate reimbursement for those residents who “bridge” the transition period. CMS stresses that the rules and guidelines for RUG-IV remain in effect through September 30, 2019 and, if appropriate criteria are met, a Short Stay assessment may be completed.
- For resident’s admitted near the end of September who do not qualify for a Short Stay assessment, the 5-day assessment is still required for reimbursement under RUG-IV for the September dates of stay.
- It is unlikely that a resident receiving therapy who admits, for example, on September 29th, will classify into a rehab RUG as would normally happen with completion of the 5-day assessment on day 8 of the Part A stay since, for transition, the 5-day assessment must be completed by September 30th. While this may seem concerning, a nursing RUG will still be assigned and PDPM reimbursement will take effect on October 1st.
- It is also important to consider the NTA variable per diem which is multiplied by 3 for the first three days of the resident’s Part A stay; this may help balance the perceived loss for those residents admitted near the end of September. “Oct. 1, 2019, will be considered day 1 of the variable per-diem schedule under PDPM even if a patient began their stay prior to Oct. 1, 2019,” said officials.

#### See example below of MDS assessment schedule through transition:

- Resident admits – 9/29/19
- Entry Tracking record ARD – 9/29/19
- PPS 5-day assessment ARD – 9/30/19 (Resulting RUG = reimbursement rate for 9/29 and 9/30)
- Transitional IPA – ARD no later than 10/7/19 (Resulting Case Mix Groups = reimbursement rate for the remainder of the Part A stay, unless another IPA is completed)

#### Medicaid Issues

The Optional State Assessment (OSA) will be introduced by CMS to fill in gap assessments for Medicaid patients. The OSA is a state optional assessment. Since the OSA requirements will be set by each state, the RAI manual will not provide direction on the coding schedule. The OSA cannot be combined with any Federally required assessments. The OSA is a temporary assessment and will be supported by CMS for FY 2020 (October 1, 2019-September 30, 2020).

CMS will support the RUG III and RUG IV Health Insurance Prospective Payment System (HIPPS) codes until September 30, 2020 on the 5 day PPS, OBRA comprehensive and OBRA quarterly assessment types.

#### NTA Comorbidity Score

The provider will report on the MDS each of the comorbidities. The NTA comorbidity score is the sum of the points associated with each relevant comorbidity. The NTA Comorbidity Score is described in more detail here: [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/Downloads/PDPM\\_Fact\\_Sheet\\_NTAComorbidityScoring\\_Final.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_Final.pdf).

