

PATIENT DRIVEN PAYMENT MODEL

PATIENT-DRIVEN PAYMENT MODEL: FREQUENTLY ASKED QUESTIONS (FAQs)

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1. Payment Overview and Billing

1.1 What is PDPM?

The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Effective beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

1.2 Why is CMS changing from RUG-IV to PDPM?

Under RUG-IV, most patients are classified into a therapy payment group, which uses primarily the volume of therapy services provided to the patient as the basis for payment classification. This creates an incentive for SNF providers to furnish therapy to SNF patients regardless of the patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing administrative burden on SNF providers.

1.3 How are SNF patients classified into payment groups under PDPM?

The PDPM classification methodology utilizes a combination of six payment components to derive payment. Five of the components are case-mix adjusted to cover utilization of SNF resources that vary according to patient characteristics. There is also an additional non-case-mix adjusted component to address utilization of SNF resources that do not vary by patient. Different patient characteristics are used to determine a patient's classification into a case-mix group (CMG) within each of the case-mix adjusted payment components.

The payment for each component is calculated by multiplying the case-mix index (CMI) that corresponds to the patient's CMG by the wage adjusted component base payment rate, then by the specific day in the variable per diem adjustment schedule when applicable. The payments for each component are then added together along with the non-case-mix component payment rate to create a patient's total SNF PPS per diem rate under the PDPM.

1.4 How does the PDPM classification methodology differ from the RUG-IV?

Under RUG-IV, payment is derived from a combination of two case-mix adjusted payment components and two non-case mix adjusted components. The RUG-IV payment methodology assigns patients to payment classification groups, called RUGs, within the payment components, based on various patient characteristics and the type and intensity of therapy services provided to the patient. Under the PDPM, six payment components are utilized to derive payment. The PDPM uses clinically relevant factors, rather than volume-based service for determining

Medicare payment. Under the PDPM, patient characteristics are used to assign patients into CMGs across the payment components to derive payment. Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.

1.5 How do providers bill for services under PDPM?

Providers would bill for services under PDPM using the Health Insurance Prospective Payment System (HIPPS) code that is generated from a 5-day PPS assessment and Interim Payment Assessment (IPA) with an ARD on or after October 1, 2019.

1.6 What does the HIPPS code represent under PDPM?

The HIPPS code under PDPM is still a five character code, as under RUG-IV. However, under RUG-IV, the first three characters represent the patient's RUG classification and the last two characters are an assessment indicator (AI) code, to represent the assessment used to generate the patient classification.

Under PDPM, the first character of the HIPPS code represents the patient's PT component and OT component classification. The second character represents the patient's SLP component classification. The third character represents the patient's nursing component classification. The fourth character represents the patient's NTA component classification. The fifth character represents the AI code.

1.7 Will providers still report the patient HIPPS code in the same way on the UB-04?

Yes, SNF billing practices related to the use of the HIPPS code and revenue codes remain the same under PDPM.

1.8 Is it required that the principal diagnosis on the SNF claim match the primary diagnosis coded in item I0020B?

While we expect that these diagnoses should match, there is no claims edit that will enforce such a requirement.

1.9 Is it required that the SNF primary diagnosis match the primary diagnosis reported for the qualifying hospital stay?

No, the primary diagnosis for the SNF stay may differ from the primary diagnosis reported for the hospital stay that serves as the qualifying hospital stay necessary for SNF coverage.

1.10 What is the default code under PDPM and what does it represent?

The default code under PDPM, which may be used in cases where an assessment is late, is ZZZZZ. The default code under PDPM represents the sum of the lowest per diem rate under each PDPM component, plus the non-case-mix component. In cases where the default code is used, the variable per diem schedule must still be followed.

2. ICD-10 Coding

2.1 How will ICD-10 codes be used under PDPM?

There are two ways in which ICD-10 codes will be used under PDPM. First, providers will be required to report on the MDS the patient's primary diagnosis for the SNF stay. Each primary diagnosis is mapped to one of ten PDPM clinical categories, representing groups of similar diagnosis codes, which is then used as part of the patient's classification under the PT, OT, and SLP components.

Second, ICD-10 codes are used to capture additional diagnoses and comorbidities that the patient has, which can factor into the SLP comorbidities that are part of classifying patients under the SLP component and the NTA comorbidity score that is used to classify patients under the NTA component.

2.2 Where is the ICD-10 to clinical category mapping located?

The ICD-10 to clinical category mapping that will be used under PDPM is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>.

3. NTA Comorbidity Score

3.1 What is the NTA comorbidity score?

The NTA comorbidity score is a weighted count of certain comorbidities that a SNF patient has, which is then used to classify the patient into an NTA component payment group. Comorbidities associated with higher increases in NTA costs are grouped into higher point tiers, while those that are associated with lower increases in NTA costs are grouped into lower point tiers.

3.2 How is a patient's comorbidity score calculated?

The provider will report on the MDS each of the comorbidities that a person has. The patient's NTA comorbidity score is the sum of the points associated with each relevant comorbidity.

3.3 What comorbidities are used under the NTA component?

Under PDPM, we identified 50 conditions that were related to increases in NTA costs in the SNF. These conditions, along with the number of points associated with the condition and how it is reported can be found in the table below.

Conditions and Extensive Services Used for NTA Classification

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

Condition/Extensive Service	Source	Points
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
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

4. Function Score

4.1 How is a patient's function score calculated?

The function score for patient classification under PDPM is now calculated using data from Section GG of the MDS 3.0 (Functional Abilities and Goals) rather than Section G items.

This advances CMS's goal of using standardized assessment items across payment settings. PDPM makes no changes to how Section GG is coded.

The functional score for the PT and OT components is calculated based on ten Section GG items that were all found to be highly predictive of PT and OT costs per day:

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

Similar to the RUG-IV ADL score, each of these ADL areas is assigned a score of up to 4 points. However, in contrast to the RUG-IV ADL score, points were assigned to each response level to track functional independence rather than functional dependence. In other words, higher points

are assigned to higher levels of independence. This approach is consistent with functional measures in other care settings, such as the IRF PPS. Further, under the RUG-IV model, if the SNF codes that the “activity did not occur” or “occurred only once,” these items are assigned the same point value as “independent.” However, we observed that patients who were unable to complete an activity had similar PT and OT costs as dependent patients. Therefore, when the activity cannot be completed, the equivalent section GG responses (“Resident refused,” “Not applicable,” “Not attempted due to medical condition or safety concerns”) are grouped with “dependent” for the purpose of point assignment.

For the two walking items, we use an additional response level to reflect patients who skip the walking assessment due to their inability to walk. This allows us to assess the functional abilities of patients who cannot walk and assign them a function score. Without this modification, we could not calculate a function score for patients who cannot walk because they would not be assessed on the two walking items included in the function score. Patients who are coded as unable to walk receive the same score as dependent patients to match with clinical expectations.

The scoring algorithm for items related to the PT and OT Functional Score:

PT and OT Function Score Construction (Non-Walking Items)

Response	Description	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, N/A, Not attempted due to environmental limitations, Not Attempted	0

PT and OT Function Score Construction for Walking Items

Response	Description	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	Dependent, Refused, N/A, Not Attempted, Not attempted due to environmental limitations, Resident Cannot Walk*	0

*Coded based on response to GG0170I1 (Walk 10 feet?)

Missing section GG responses will receive zero points for the function score calculation. A dash or any other non-recognized character will be considered a missing value.

Unlike section G, section GG measures functional areas with more than one item. This results in substantial overlap between the two bed mobility items, the three transfer items, and the two walking items. Because of this overlap, a simple sum of all scores for each item may inappropriately overweight functional areas measured by multiple items. Therefore, to adjust for this overlap, we calculate an average score for these related items. That is, we average the scores for the two bed mobility items, the three transfer items, and the two walking items. The average bed mobility, transfer, and walking scores are then summed with the scores for eating, oral hygiene, and toileting hygiene, resulting in equal weighting of the six activities. This scoring algorithm produces a function score that ranges from 0 to 24. In section 3.4.1. of the SNF PDPM technical report (available at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/SNFPPS/therapyresearch.html>), we provide additional information on the analyses that led to the construction of the PDPM function score.

The scores in Section GG are rounded only at the end of the calculation. For example, if the transfer items have 1, 0, and 0 points, the unrounded average is 0.33. This would be added to the other scores, unrounded, and then the total score at the end of the sum calculation would be rounded to the nearest integer. This methodology is discussed in the PDPM Classification Walkthrough, available on the PDPM website.

The following chart shows the Section GG Items included in the PT and OT Functional Score.

Section GG Items Included in PT and OT Functional Score

Item	Description	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
GG0170C1	Mobility: Lying to sitting on side of bed	(average of 2 items)
GG0170D1	Mobility: Sit to stand	0-4
GG0170E1	Mobility: Chair/bed-to-chair transfer	(average of 3 items)
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4
GG0170K1	Mobility: Walk 150 feet	(average of 2 items)

For the Nursing Functional Score, which is used to classify patients under the nursing component, we use the same scoring algorithm as described above for the Section GG-based PT and OT Functional score non-walking items.

The following chart shows the Section GG Items included in calculating the Nursing Functional Score.

Section GG Items Included in Nursing Functional Score

Item	Description	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	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	

4.2 What are some notable differences between G and GG scoring methodologies?

First, the scoring methodology for the items used in calculating the GG-based functional score is reversed from the methodology used for the section G-based functional score. More specifically, under Section G, increasing score means increasing dependence. Under Section GG, increasing score means increasing independence.

Second, as compared to the ADL score used under RUG-IV, which exhibits a linear relationship between increasing dependence and increasing payment, the functional scores used under PDPM do not always exhibit this type of relationship between payment and patient functional status. In other words, under RUG-IV, increasing dependence, within a given RUG category, translates to higher payment. However, under PDPM, there is not a direct relationship between increasing dependence and increasing payment.

4.3 Why has CMS chosen to use Section GG data as the basis for the functional score, rather than continuing to use Section G?

Section GG offers standardized and more comprehensive measures of functional status and therapy needs. The use of section GG items better aligns the payment model with other quality initiatives. SNFs have been collecting section GG data since October 2016 as part of the requirements for the IMPACT Act.

CMS conducted several investigations to validate the section GG data. First, we verified that the relationship between section G responses and PT and OT utilization was very similar to the relationship between corresponding section GG responses and PT and OT utilization. Second, we determined that section GG items performed similarly to section G items in predicting PT and

OT utilization. Finally, we compared coding of section GG items during the first 6 months of FY 2017 to coding of these items during the second 6 months of FY 2017 and found only small changes in the frequency of responses. Based on the results of these checks, we believe the FY 2017 section GG data are valid and reliable, and therefore, appropriate to use as a basis of patient classification and payment under PDPM.

4.4 How does the PDPM function score treat missing values for section GG assessment items?

The function score assigns missing section GG responses to receive zero points for the function score calculation, just as other incomplete responses are also assigned zero points. This is also consistent with the current RUG-IV ADL scoring methodology, which assigns the same point value for missing responses and other incomplete responses. Note that a dash or any other non-recognized character is considered a missing value.

4.5 How does the PDPM function score treat the new response of 10: “Not attempted due to environmental limitations”?

The new response of 10: “Not attempted due to environmental limitations” shall receive zero points for function score assignment to make sure every response has a corresponding point value. This is consistent with other similar responses that receive zero points for function score assignment, including “resident refused,” “not applicable,” and “not attempted due to medical condition or safety concerns”.

4.6 Why does CMS assign 0 points to “dependent” responses instead of 1 point?

CMS considered assigning 1 point to “dependent” responses instead. However, this would group “dependent” responses with “substantial/maximal assistance” responses. However, we found that dependent patients have different levels of PT and OT resource utilization than patients receiving substantial/maximal assistance. As described in section 3.4.1 the SNF PDPM technical report, we observed that patients who were unable to complete an activity had similar PT and OT costs as dependent patients. Therefore, we grouped the equivalent section GG responses (“resident refused,” “not applicable,” and “not attempted due to medical condition or safety concerns”) with “dependent” responses for the purpose of point assignment in constructing the function score for PT and OT classification and payment.

In terms of alignment with the SNF Quality Reporting Program (QRP) quality measures, the PDPM function score uses similar scoring logic as the QRP functional outcome measure. As with the PDPM function score, the QRP Change in Self-Care score assigns higher points to higher levels of functional independence and assigns the same point value to “dependent” and incomplete responses. The QRP functional outcome measure, however, differs in scale. Whereas the PDPM function score ranges from 0-4, the QRP Change in Self-Care score ranges from 1-6.

The QRP functional outcome measure assigns 1 point to “dependent” and all “activity was not attempted” codes (“resident refused,” “not applicable,” and “not attempted due to medical condition or safety concerns”), and 2 points to “substantial/maximal assistance”. This score assignment is very similar to that of the PDPM function score.

4.7 Why does the function score not include new section GG items for FY 2019, such as those concerning toileting, dressing, and bathing?

In constructing the function score for PT and OT payment, we investigated the use of all existing section GG items. Toileting is one of the items included in the proposed function scores for the PT, OT, and nursing components of PDPM. We are aware that additional section GG items are scheduled to be implemented in FY 2019, including items that measure a patient’s dressing and bathing abilities. However, because these new items have not yet been implemented, there is no data available on resource utilization associated with these items. Therefore, it is not appropriate to include these items in the calculation of the PDPM function scores at this time. We will consider adding section GG items that are demonstrated to have a meaningful relationship with utilization of SNF resources as new items are added and an appropriate amount of data (for example, one year) is available to assess this relationship. We will also consider other changes to the function score as necessary to reflect additional updates to the section GG items, for example, the addition, deletion, or modification of particular items or responses.

4.8 Why is PT and OT payment higher for case-mix groups with higher functional independence in some cases?

This reflects the finding that PT and OT utilization is highest for patients with moderate functional independence and lower for patients with both the highest levels of functional dependence and independence. In the first case, this likely reflects patients whose functional abilities are too impaired to receive intensive therapy, while the second case likely corresponds to patients who require less therapy because they already have a high level of functional independence. Therefore, we believe PDPM appropriately assigns payment according to the observed relationship between functional independence and PT/OT utilization.

4.9 Is mathematical rounding utilized for the averaging of the bed and mobility transfer items?

The scores in Section GG are rounded only at the end of the calculation. For example, if the transfer items have 1, 0, and 0 points, the unrounded average is 0.33. This would be added to the other scores, unrounded, and then the total score at the end of the sum calculation would be rounded to the nearest integer. This methodology is discussed in the PDPM Classification Walkthrough, available on the PDPM website.

4.10 Does the PDPM case mix make any changes in how GG items are coded?

No, PDPM does not make any changes in how GG items are coded, only how those coded responses factor into payment calculation. Coding for GG items is unaffected by PDPM implementation.

5. Cognitive Score

5.1 How is a patient's cognitive score calculated?

Under PDPM, just as under RUG-IV, a patient's cognitive status is assessed using either the Brief Interview for Mental Status (BIMS). In cases where the BIMS is not or cannot be completed, a Staff Assessment for Mental Status is completed. The Cognitive Performance Scale (CPS) is then used to score the patient based on the responses to the Staff Assessment.

Under RUG IV, the BIMS and the CPS produced separate scores, with no single measure of cognitive status that allowed comparison across all patients. The new PDPM Cognitive Measure is based on the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all patients.

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

5.2 Is the Cognitive Measure a factor in classification for the PT/OT components under PDPM?

No. In developing the case-mix for PDPM, CMS used a statistical regression technique called Classification and Regression Trees (CART) to explore the most appropriate splits in PT and OT case-mix groups using three variables, including the presence of a cognitive impairment. We dropped cognitive status as a determinant of classification because of the reduced role it played in categorizing patients within the CART-generated groups. This improved simplicity with only a negligible impact on predictive accuracy.

5.3 How is the PDPM Cognitive Measure different from the Cognitive Function Score (CFS) proposed in the ANPRM?

After publication of the ANPRM, we received stakeholder comments questioning this scoring methodology, specifically the classification of a CPS score of 0 as “mildly impaired.” Based on a subsequent analysis showing that patients with a CPS score of 0 were similar to patients classified as “cognitively intact” under the CFS methodology, as well as clinical feedback, we determined that it was appropriate to reclassify patients with a CPS score of 0 as cognitively intact, consistent with ANPRM feedback. This analysis is described in more detail in section 3.4.1. of the SNF PDPM technical report, available at <https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/SNFPPS/therapyresearch.html>.

5.4 How is the patient classified under PDPM if neither the BIMS nor the CPS staff assessment is completed to determine cognitive level?

If neither the BIMS nor the staff assessment is completed, then a patient will be classified under PDPM as if the patient were “cognitively intact.” In other words, even if the patient has a cognitive impairment, without the BIMS or staff assessment completed, the cognitive impairment will not be considered as part of the patient’s PDPM classification. An IPA may be done to reclassify the patient in such scenarios to capture the cognitive impairment.

6. Administrative Level of Care Presumption

6.1 What is the “administrative presumption” under the skilled nursing facility (SNF) prospective payment system (PPS), and what is its purpose?

The SNF PPS includes an administrative presumption whereby a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the five-day Medicare-required assessment is automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment, which must occur no later than the eighth day of the SNF stay (see the regulations in the introductory paragraph at 42 CFR 409.30). As explained in the FY 2019 SNF PPS final rule, 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, August 8, 2018, emphasis in the original).

6.2 What are the designated classifiers that can serve to qualify a beneficiary for the presumption?

CMS has designated certain case-mix classifiers as qualifying a beneficiary for the presumption, as follows:

For services furnished prior to October 1, 2019, all groups encompassed by the following categories under the Resource Utilization Groups, version IV (RUG-IV) model:

- Rehabilitation plus Extensive Services;
- Ultra High Rehabilitation;
- Very High Rehabilitation;
- High Rehabilitation;
- Medium Rehabilitation;
- Low Rehabilitation;
- Extensive Services;
- Special Care High;
- Special Care Low; and
- Clinically Complex.

For services furnished on or after October 1, 2019, the following classifiers under the Patient Driven Payment Model (PDPM):

- 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; and
- The NTA component's uppermost (12+) comorbidity group.

If a patient meets any of the four PDPM-related criteria above, the patient qualifies for the presumption.

6.3 What if a beneficiary does not qualify for the presumption?

A beneficiary who is not assigned one of the designated case-mix classifiers is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. As explained in the FY 2016 SNF PPS final rule (80 FR 46406, August 4, 2015), structuring the presumption in this manner serves “. . . specifically to ensure that the presumption does not disadvantage such residents, by providing them with an individualized level of care determination that fully considers all pertinent factors.”

6.4 As part of the changeover from RUG-IV to PDPM, all current SNF patients 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. Does this mean that such current patients could then become entitled to a brand new presumption of coverage under the changeover assessment?

No. The completion of a changeover IPA for a current resident would not entitle such a resident 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 the resident’s SNF stay. As explained in the FY 2019 SNF PPS final rule (83 FR 39251, August 8, 2018), “. . . the use of the administrative presumption reflects the strong likelihood that those beneficiaries who are assigned one of the designated classifiers *during the immediate post-hospital period* require a covered level of care, which would be less likely for other beneficiaries” (emphasis added).

As further noted in the FY 2000 SNF PPS final rule (64 FR 41667, July 30, 1999), the original rationale for the presumption was that SNF stays typically are the most unstable and intensive “. . . at the *very outset* of the stay, during the period *immediately following* the patient’s admission from the prior hospitalization” (emphasis added). This is also reflected in the corresponding instructions at §30.1 of the Medicare Benefit Policy Manual, chapter 8 (available online at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>), which specify that the 5-day assessment can generate a presumption of coverage *only* when conducted pursuant to a SNF admission that *directly* follows the prior hospital stay (i.e., the hospital discharge and subsequent SNF admission both occur on the same day).

Accordingly, as the changeover assessment under PDPM is an IPA and not a 5-day assessment, it cannot trigger a new presumption of coverage. Moreover, consistent with our longstanding policy, for those admissions that occur on or after the PDPM effective date of October 1, 2019, a 5-day assessment can trigger a presumption of coverage only when the SNF admission directly follows discharge from the prior hospital stay.

7. HIV/AIDS Policy Change

7.1 How does the PDPM’s payment for SNF patients with HIV/AIDS differ from payment for such patients under the previous case-mix classification model?

As explained in Question 7.3 below, the PDPM includes specific provisions to ensure that it accounts accurately for the increased costs associated with caring for SNF patients with HIV/AIDS. Moreover, in contrast to the imprecision of the previous model's undifferentiated, across-the-board add-on for such patients as discussed in Question 7.2 below, the PDPM's provisions are specifically targeted at those particular rate components that actually account for the disparity in cost between HIV/AIDS patients and others.

7.2 How did the SNF PPS make payment for AIDS patients under the previous Resource Utilization Groups, version 4 (RUG-IV) model?

In accordance with §511(a) of the Medicare Modernization Act of 2003 (MMA, Public Law 108173), the RUG-IV model included a temporary 128% add-on for those SNF patients with AIDS, as identified through the presence of ICD-10-CM code B20 on the claim. The MMA provision was prompted by an analysis showing that compared with other SNF patients who classified into the same RUG, the cost of caring for those patients with AIDS was much higher. The MMA further specified that the add-on was to sunset upon the Secretary's certification that there is “. . . an appropriate adjustment in the case mix . . . to compensate for the increased costs associated with [such] residents.”

The actual 128% level of the MMA's AIDS add-on was merely a general approximation of the added cost of caring for AIDS patients that reflected the state of research and clinical practice at the time. Further, as a simple across-the-board multiplier, the add-on by its very nature was not accurately targeted at those particular rate components that actually account for the disparity in cost between AIDS patients and others. As discussed further in Question 7.3 below, as the PDPM was developed, its rate components were designed specifically with the need for addressing those issues in mind.

Accordingly, the FY 2019 SNF PPS final rule that finalized the PDPM included the prescribed certification “. . . that there is an appropriate adjustment in the PDPM to compensate for the increased costs associated with residents with AIDS” and, thus, provided that the MMA's temporary AIDS add-on would be replaced “. . . with the PDPM's permanent adjustment in the case mix that appropriately accounts for the increased costs of patients with AIDS, effective with the conversion to the PDPM on October 1, 2019” (83 FR 39255, August 8, 2018).

7.3 How does the PDPM account for the increased costs of SNF patients with AIDS?

As explained in section 3.8.2. of the SNF PDPM technical report (available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html>), ensuring the PDPM's ability to account accurately and appropriately for the increased costs associated with caring for AIDS patients has been a key consideration in designing the various elements of the new model. Research indicated that for those SNF patients with AIDS, wage-weighted nursing staff time was 18 percent greater, and

NTA costs per day were 151 percent higher, than for other patients. As a result, patients with AIDS receive a special 18% add-on to the nursing component of the payment, and they are also assigned the highest point value (8 points) of any condition or service for purposes of classification under the PDPM's NTA 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 claim. Further, the PDPM's AIDS-related adjustments for both the nursing and NTA components will be handled through the Pricer tool rather than the Grouper tool.

Regarding the PDPM's AIDS adjustment to the NTA component, it should be noted that within every NTA case-mix group except ND (with a score range of 3-5), the addition of 8 points to the NTA score results in consistently reassigning the patient to one and only one NTA group. However, simply adding 8 points to the ND group's lowest score (3) would mathematically place the patient in the score range of the NB group (9-11), whereas making the very same 8-point adjustment to either of the ND group's two higher scores (4 or 5) would mathematically place the patient in the score range of the NA group (12+). Therefore, in order to maintain consistency in reassigning all applicable cases within a given group to one and only one NTA group under the AIDS adjustment, we have decided that all cases in the ND group that qualify for this adjustment—including those with that group's lowest score of 3—will uniformly be reassigned to the NA group.

8. Payment Rates/Case Mix Index (CMI)

8.1 What are the case-mix adjusted components of the PDPM?

The PDPM utilizes five case-mix adjusted components including a physical therapy (PT) component, an occupational therapy (OT) component, a speech-language pathology (SLP) component, a non-therapy ancillary (NTA) services component, and a nursing component. Different patient characteristics are used to determine a patient's classification within each component.

8.2 Are the rates for rural and urban providers different under PDPM?

Yes, similar to RUG-IV, PDPM has different base rates for urban and rural providers, which means that the case-mix adjusted rates for urban and rural providers will also be different.

8.3 Are the PDPM rates still labor-adjusted in the same way as under RUGIV?

Yes, PDPM uses the same labor adjustment methodology, specifically the application of the SNF PPS wage index to the labor-related share of the total case-mix adjusted per diem rate.

8.4 Are the PDPM rates still adjusted by a VBP adjustment factor and in cases where a provider fails to submit data required by the SNF QRP?

Yes, PDPM rates will still be adjusted to reflect the Value-Based Purchasing (VBP) adjustment factor for that particular provider, as well as reflect a reduction in the market basket adjustment for a given year in cases where a provider fails to report data required due to the SNF Quality Reporting Program (QRP).

8.5 Will PDPM rates be updated by the SNF Market Basket Adjustment each year? What about the forecast error adjustment?

Yes, PDPM base rates will continue to reflect annual adjustments due to the SNF market basket, including adjustment for productivity. Additionally, CMS will continue to evaluate the need for a forecast error adjustment each year, using the existing methodology.

9. Variable Per Diem

9.1 What is the variable per diem adjustment?

The SNF PPS is required to pay on a “per diem” basis, which means that there is a payment rate associated with each day of the patient’s SNF stay. Since its inception, the SNF PPS has used a constant per diem rate, meaning that the payment rate for each day of the stay is the same, as long as the patient stays in the same payment group. However, under PDPM, an adjustment is applied to certain PDPM components that varies the per diem payment over the course of the stay. This adjustment factor is called the variable per diem (VPD) adjustment.

9.2 How is the VPD adjustment calculated under the PDPM?

Under the PDPM, the PT, OT and NTA payment components are subject to a VPD adjustment. There are two distinct VPD adjustment schedules and factors; one for both the PT and OT components and one for the NTA component. For each component, once a patient has been classified into a classification group, the case-mix index (CMI) for that group is multiplied against the component base rate, and then that product is multiplied against the applicable per diem adjustment factor is then applied to determine the case-mix adjusted payment associated with each of these payment components for each utilization day under PDPM.

For the PT and OT components, the VPD schedule is outlined below.

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

For the NTA component, the VPD schedule is outlined below.

Variable Per Diem Adjustment Factors and Schedule – NTA

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

9.3 How is the VPD affected by default billing?

For late assessments under PDPM, similar to under RUG-IV, the provider will bill the default HIPPS code for the number of days out of compliance and then the 5-day assessment HIPPS code for the remainder of the stay, unless an IPA is completed. One caveat is that the default billing will be assessed prior to the 5-day assessment HIPPS code, in terms of counting days for the variable per diem. For example, if a 5-day assessment is two days late, then Days 1 and 2 of the stay, with regard to the variable per diem adjustment, will be calculated using the default HIPPS code and then the 5-day assessment HIPPS code will control payment beginning on Day 3 of the variable per diem schedule.

10. Assessment Schedule

10.1 How many SNF PPS assessments will there be under PDPM?

There will be 3 SNF PPS assessments under PDPM: 5-day Assessment, Interim Payment Assessment (IPA), and the PPS Discharge Assessment.

10.2 Are the SNF PPS assessments required?

The 5-day assessment and the PPS Discharge Assessment are required. The IPA is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment.

10.3 What are the ARD, completion and transmission requirements for the IPA?

- The ARD (Item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day assessment.
- The IPA must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- The IPA authorizes payment for remainder of the PPS stay, beginning on the ARD.
- The IPA must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

10.4 What are the ARD, completion and transmission requirements for the PPS Discharge Assessment?

- The ARD for the PPS Discharge Assessment is equal to the end date of the most recent Medicare Stay (A2400C) or End date, unless it is an interrupted stay.
- The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- The PPS Discharge Assessment must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- The PPS Discharge Assessment must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).

10.5 Will Grace Days still be used as part of the MDS Assessment process?

As explained in the SNF PPS FY 2019 Final Rule, the concept of grace days will not be eliminated and the days previously known as grace days will now be folded into the standard days considered as options for the ARD.

10.6 What ISC (Item Set Code) will be used for the 5-day Assessments?

The Item set for the 5-day assessment is the NP Item set.

10.7 What ISC will be used for the IPA?

The item set for the IPA is the IPA item set, a specifically tailored item set that only includes demographic items and those necessary for PDPM classification.

10.8 What ISC will be used for the PPS Discharge Assessment?

The Item set for the PPS Discharge assessment is the NPE item set.

10.9 What are the applicable standard Medicare payment days for the 5-day assessment?

The 5-day Assessment will pay for all covered Part A days until the Part A discharge (except in cases when an IPA is completed).

10.10 What are the applicable standard Medicare payment days for the IPA?

The IPA will pay for all days from the ARD of the IPA through the part A discharge (unless another IPA assessment is completed).

10.11 What effect does the IPA have on the Variable Per Diem payment rate?

The IPA does not affect the variable per diem. When an IPA is completed and payment changes, it continues the variable per diem schedule that was established by the 5-day assessment.

10.12 Can the 5-day PPS Assessment be combined with OBRA assessments?

Yes, the 5-day assessment can be combined with an OBRA assessment.

10.13 Can the IPA be combined with any OBRA assessments?

No, the IPA cannot be combined with any other assessments.

10.14 Can any PPS assessments be combined?

No PPS assessments can be combined. The 5-day assessment must be completed prior to any other PPS assessment, followed by the IPA and the PPS Discharge Assessment should be the last PPS assessment completed.

10.15 How will late assessments be treated under PDPM?

For late assessments under PDPM, similar to under RUG-IV, the provider will bill the default HIPPS code for the number of days out of compliance and then the 5-day assessment HIPPS code for the remainder of the stay, unless an IPA is completed. One caveat is that the default

billing will be assessed prior to the 5-day assessment HIPPS code, in terms of counting days for the variable per diem. For example, if a 5-day assessment is two days late, then Days 1 and 2 of the stay, with regard to the variable per diem adjustment, will be calculated using the default HIPPS code and then the 5-day assessment HIPPS code will control payment beginning on Day 3 of the variable per diem schedule. Because the IPA is completely optional, there will be no late assessment penalties for that assessment.

11. Minimum Data Set (MDS) Items/Policies

11.1 What new items/sections are being added to the MDS under PDPM?

Item I0200B: SNF Primary Diagnosis, Items J2100-J5000: Patient Surgical History, and Items O0425A1-O0425C5: Discharge Therapy Items will be added to the MDS.

K0100: Swallowing Disorder, I4300 Active Diagnosis: Aphasia, and O0100D2 Special Treatments and Procedures: Suctioning: While a resident will be added to the Swing Bed PPS Assessment.

A new column, Column 5 will be added to Section GG to capture interim performance in the IPA.

11.2 How will “Item I0020B: SNF Primary Diagnosis” be used for payment?

Item I0020B will be added for 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 I0020 is coded as any response 1 – 13.

11.3 How should we code I0020A on the MDS under PDPM?

Item I0020A is being retired on the MDS 3.0. Only I0020 and I0020B will be used.

11.4 Will section I0020B override section I0020, 1-13 for the primary reason for SNF admission since the categories in I0020 do not match up to the 10 clinical categories for PDPM?

Only the code in Item I0020B is used for PDPM classification purposes.

11.5 How will “Items J2100-J5000: Patient Surgical History” be used for payment?

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. These items will be used, along with the patient’s primary diagnosis coded in item I0020B, to classify patients into a PDPM clinical category, which is then used as part of the PT, OT, and SLP case-mix classification groups for PDPM. Similar to the active diagnoses captured in Section I, these Section J items will be in the form of check-boxes.

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 or 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
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 - the kidneys, ureter, adrenals, and bladder—open, laparoscopic
J2899	Other major genitourinary surgery
J2900	Major surgery - tendons, ligament, or muscles

Item	Surgical Procedure Category
J2910	Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen—open or laparoscopic
J2920	Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus—open
J2930	Major surgery - the breast
J2940	Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant
J5000	Major surgery - Other not listed above

The PDPM Classification Walkthrough, available on the PDPM website (at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>), outlines the impact of Section J coding on the patient's clinical category. The specific procedure code is not necessary for patient classification.

11.6 What will Items O0425A1-O0425C5 Discharge Therapy Items be used for?

Items O0425A1 – O0425C5 will be added to Section O of the MDS to record the amount of therapy a Part A patient receives during their entire SNF Stay.

11.7 How will providers report therapy in Items O0425A1-O0425C5?

Using a lookback of the entire PPS stay, providers will report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient.

In the case of an interrupted stay, providers would report the amount of therapy furnished the patient since the beginning of the Part A stay, including all parts of an interrupted stay. For example, if a patient's Part A stay began on November 1, 2019 and ended on December 31, 2019, with two interrupted stay occurrences during this period, then all therapies since November 1, 2019 would be coded on the discharge assessment completed with an ARD of December 31, 2019.

11.8 Why are items being added to the Swing Bed PPS Assessment?

The items being added to the Swing Bed PPS Assessments are currently existing MDS items. They are: K0100: Swallowing Disorder, I4300: Active Diagnosis: Aphasia, and O0100D2: Special Treatments, Procedures and Programs: Suctioning, While a Resident. Until now, these items have not been part of the Swing Bed PPS Assessment because they have not been used for

payment. However, each of these items will now be used to classify swing bed patients under PDPM.

11.9 What is Column 5 used for in Section GG?

On the IPA, 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 a three-day window preceding and up to the ARD of the IPA (ARD - 2).

11.10 How will assessment modifications be treated under PDPM?

All rules applied to assessment modifications and submissions will remain the same as they currently are.

11.11 How will PDPM affect Medicare Advantage Plans?

For patients utilizing Medicare Advantage plans, the MA plans themselves will decide whether they will incorporate any aspects of PDPM into their payment system.

11.12 How will PDPM affect NOMNC, ABNs and Denial Letters?

PDPM makes no changes in Notice of Medicare Non-Coverage (NOMNC), Advance Beneficiary Notice (ABN) and denial letter policies.

12. Therapies under PDPM (Concurrent and Group Therapy Limit)

12.1 Will Medicare still pay for skilled therapy services under PDPM?

Yes, skilled therapy services will still be reimbursed by Medicare under PDPM. While PDPM does change the manner in which patients are classified into payment groups under the SNF PPS, it does not change any of the coverage criteria or documentation requirements associated with the skilled therapy service coverage under PDPM. More importantly, PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients.

12.2 What if my patient is only receiving PT services. Will I still receive a payment rate for the OT and SLP components?

Yes, patients are classified into a payment group for each of the therapy components, regardless of whether or not the patient is receiving services within that particular therapy discipline.

12.3 What is the limit on the provision of group and concurrent therapy to Part A patients in SNFs?

There is a 25% combined limit per discipline (PT, OT, SLP), per patient, per Part A SNF stay.

12.4 Why is there a 25% limit on group and concurrent therapy?

This limit was implemented to ensure that SNF patients continue to receive the highest caliber of therapy services possible, specifically that individual therapy between the therapist and patient represents a significant majority of the services received.

12.5 What is the look back for therapy provision?

The look back is the entire SNF Part A stay starting at Day 1 and finishing on the last day that any therapy was provided.

12.6 Will providers be responsible for calculating the percentage of group and concurrent therapy provided?

Providers may want to calculate the percentage for their own purposes and to make sure that they do not exceed the limit. However, they will not be expected to report the percentage to CMS. CMS assessment software will calculate the percentage of group and concurrent therapy provided to each patient.

12.7 Will the minutes of therapy be allocated prior to calculation of the percentage?

No, the limit on concurrent and group therapy utilizes unallocated therapy minutes as the basis for the calculation.

12.8 How will CMS monitor compliance with the concurrent/group therapy limit?

Assessment software will calculate the percentage of group and/or concurrent therapy provided during a Part A SNF stay. CMS and its contractors will monitor these percentages once this policy goes into effect.

12.9 What happens if a patient receives more than 25 percent of their therapy in a concurrent/group setting?

The provider will receive a warning edit on the validation report that will inform them that they have exceeded the 25% limit. The edit will state: “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 provision and be aware of facilities that exceed the limit and will re-visit the idea of a penalty for exceeding the limit in the future.

12.10 If there is a three day break in therapy will an EOT be required under PDPM?

Under PDPM, there are not a required number of days of treatment per week in order to receive a certain therapy component classification (thus no EOT will be required); however, there is still a daily skilled care requirement for SNF Part A patients, as discussed in Chapter 8 of the Medicare Benefit Policy Manual, specifically section 30.6.

12.11 Will providers be able to “bill for therapy evaluations” under PDPM?

Currently therapy evaluation minutes are not counted on the MDS. Only minutes spent treating a patient is. The same policy will be in effect under PDPM. Therapy evaluation minutes will not be counted on the MDS.

12.12 How is student therapy time captured under PDPM?

There is no change for how students’ time is “captured” in SNFs. For guidance on how a student’s time can be counted on the MDS, please refer to the MDS RAI Manual, specifically in the section entitled “Modes of Therapy” in Chapter 3, Section O.

12.13 In order to obtain the PT, OT and/or ST components of the PDPM rate, do those disciplines actually have to be treating a patient before the 5-day assessment is completed?

Because therapy payment under PDPM is based on patient characteristics and not therapy minutes, it is possible that a patient will not have been seen by PT, OT, or SLP prior to the time the 5-day assessment is completed. However, SNF patients will still receive a classification for

these therapy components and the associated payments for these components, based on the patient's classification.

13. Interrupted Stay Policy

13.1 What is the Interrupted Stay Policy?

The Interrupted Stay Policy is a component of the SNF payment policy introduced alongside the Patient Driven Payment Model (PDPM). The Interrupted Stay Policy sets out criteria for determining when Medicare will treat multiple SNF stays occurring in a single Part A benefit period as a single “interrupted” stay, rather than separate stays, for the purposes of the *assessment schedule* and the *variable per diem payment schedule*.

13.2 How will the interrupted stay policy affect the assessment schedule and variable per diem?

When the stay is considered “interrupted” under the Interrupted Stay Policy, both the assessment schedule and the variable per diem payment schedule continue from the point just prior to discharge. When the stay is not considered interrupted, both the assessment schedule and the variable per diem rate reset to Day 1, as it would in a new stay.

13.3 When is a stay considered “interrupted” under the Interrupted Stay Policy?

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

- The patient returns to Part A care in the *same* SNF (not a different SNF); AND:
- The patient returns during the “interruption window”

If both conditions are met, the subsequent stay is considered a continuation of the previous “interrupted” stay:

- Variable per diem schedule continues from the day of the previous discharge
 - If patient was discharged on Day 7, payment rates resume at Day 7 upon readmission
- Assessment schedule continues from the day of the previous discharge
 - No new 5-day assessment is required
 - Optional IPA may be completed at clinician's discretion

If the patient is readmitted to the same SNF *outside the interruption window*, OR in *any* instance when the patient is *admitted to a different SNF* (regardless of time between stays), then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay. This would mean that:

- Variable per diem schedule resets to Day 1.
- Assessment schedule resets to Day 1.
 - New 5-day assessment required.

Note that if a resident drops to a non-skilled level of care or otherwise leaves Part A SNF care, the patient is considered to have been discharged for the purposes of the interrupted stay policy, even if the patient remains in the facility.

13.4 What is a “benefit period” and how can multiple SNF stays occur in one benefit period?

A “benefit period” starts on the day the beneficiary begins receiving inpatient hospital or SNF benefits under Medicare Part A (see section 1861(a) of the Act; §409.60). Under section 1812(a)(2)(A) of the Act, Medicare Part A covers a maximum of 100 days of SNF services per spell of illness, or “benefit period.” SNF coverage also requires a prior qualifying, inpatient hospital stay of at least 3 consecutive days’ duration (counting the day of inpatient admission but not the day of discharge). (See section 1861(i) of the Act; §409.30(a)(1)). Once the 100 available days of SNF benefits are used, the current benefit period must end before a beneficiary can renew SNF benefits under a new benefit period. For the current benefit period to end so a new benefit period can begin, a period of 60 consecutive days must elapse throughout which the beneficiary is neither an inpatient of a hospital nor receiving skilled care in a SNF. (See section 1861(a) of the Act; §409.60). Once a benefit period ends, the beneficiary must have another qualifying 3-day inpatient hospital stay and meet the other applicable requirements before Medicare Part A coverage of SNF care can resume. (See section 1861(i); §409.30)

While the majority of SNF benefit periods, approximately 77 percent, involve a single SNF stay, it is possible for a beneficiary to be readmitted multiple times to a SNF within a single benefit period, and such cases represent the remaining 23 percent of SNF benefit periods. For instance, a patient can be readmitted to a SNF within 30 days after a SNF discharge without requiring a new qualifying 3-day inpatient hospital stay or beginning a new benefit period. SNF admissions that occur between 31 and 60 days after a SNF discharge require a new qualifying 3-day inpatient hospital stay, but fall within the same benefit period. (See sections 1861(a) and (i) of the Act; §§409.30, 409.60)

13.5 Why has CMS introduced the Interrupted Stay Policy alongside the PDPM case-mix model, when this policy was not part of the SNF benefit using the previous RUG-IV case-mix?

While other Medicare PAC benefit categories have interrupted stay policies, the SNF benefit under the RUG-IV case-mix model had no need for such a policy because, given a patient's case-mix group, payment did not change over the course of a stay. In other words, assuming no change in a patient's condition or treatment, the payment rate was the same on Day 1 of a covered SNF stay as it was at Day 7. Accordingly, a beneficiary's readmission to the SNF—even if only a few days may have elapsed since a previous discharge—could essentially be treated as a new and different stay without affecting the payment rates.

However, the PDPM uses a *variable per diem rate* that adjusts the per diem payment rate across the length of a stay to better reflect how and when costs are incurred and resources used over the course of the stay. Under PDPM, earlier days in a given stay receive higher payments, with payments trending lower as the stay continues. In other words, the adjusted payment rate on Day 1 and Day 7 of a SNF stay may not be the same.

Thus, in the context of the PDPM case-mix model, an Interrupted Stay policy is required to ensure quality care by discouraging providers from discharging a patient and then readmitting the patient shortly thereafter to reset the patient's variable per diem adjustment schedule and maximize the payment rates for that patient.

13.6 Why did CMS decide to always treat admissions to a different SNF as a new stay and exclude such cases from the Interrupted Stay Policy?

CMS conducted regression analyses that, overall, suggest that a readmission to a different SNF, regardless of whether it was a direct SNF-to-SNF transfer, or whether the beneficiary was re-hospitalized or discharged to the community before the second admission, are more comparable to a new stay than an interrupted stay, particularly in terms of the three payment components relevant to the variable per diem adjustments (PT, OT, and NTA). More information on these analyses can be found in section 3.10.3. of the SNF PMR technical report available at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/SNFPPS/therapyresearch.html>.

13.7 What is the “interruption window”?

The interruption window is the maximum period of time that may elapse between discharge from a covered SNF Part-A stay and a subsequent readmission to the same SNF for a covered SNF Part-A stay before the Interrupted Stay Policy no longer applies and the subsequent stay is considered a new stay. CMS has defined the interruption window as beginning on the first non-covered day following a covered SNF Part-A stay and ends at 11:59pm on the third consecutive non-covered day. It should be noted that the first non-covered day may be different depending on

if the patient leaves the facility (facility discharge) or merely is discharged from Part A but continues in the facility under a different payer (Part-A discharge).

13.8 Why did CMS use an interruption window of 3 days or less between SNF stays to determine when the Interrupted Stay Policy applies?

We believe that the metric of 3 days represents a reasonable window after which it is more likely that a patient's condition and resource needs will have changed. Our analyses found that some types of costs, notably NTA costs, tend to be higher for cases where the gap is longer than 3 days, suggesting that such stays are more like new stays than continuing stays and thus supporting the 3-day metric for resetting the variable per diem schedule. More information on these analyses can be found in section 3.10.3. of the SNF PMR technical report available at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/SNFPPS/therapyresearch.html>.

We also believe consistency with other payment systems, like that of IRF and IPF, is helpful in providing clarity and consistency to providers in understanding Medicare payment systems, as well as making progress toward standardization among PAC payment systems.

13.9 Should clinicians conduct initial evaluations for therapy upon readmission of a patient in an interrupted stay under the Interrupted Stay Policy?

A new 5-day PPS assessment is not required after the interruption in the case of an interrupted stay that meets the criteria defined by the Interrupted Stay Policy. Such a stay is considered a continuation of the previous stay. In this case, providers are not required to complete an evaluation for the purposes of PPS payment upon the patient's readmission after an interruption in a stay.

If patient care needs have changed significantly, clinicians may complete an Interim Patient Assessment (IPA) at their discretion.

A new 5-day assessment is required if the interruption lasts longer than 3 days or if the beneficiary is readmitted to a different SNF, e.g. if the two stays do not meet the criteria of an interrupted stay.

13.10 Why does CMS not require a new 5-day assessment after an interruption in the case of an interrupted stay?

A reduction in burden is achieved by not requiring a 5-day assessment for patients returning to the same SNF during the interruption window. While SNFs may be required to complete OBRA

assessments and other statutorily required assessments beyond the scope of SNF PPS payment, it will no longer be the case that

SNFs must conduct a patient assessment upon readmission for all patients for the purposes of PPS payment. In conjunction with the implementation of the PDPM, CMS reduced the assessment schedule significantly to ease provider burden. The Start of Therapy OMRA, the assessment that would have previously been required for PPS payment upon a readmission, is no longer required. The new schedule utilizes the 5-day Assessment and PPS Discharge Assessments as the only required assessments, with IPAs being optional at clinician discretion.

The new assessment schedule reduces provider burden while still providing enough data to accurately monitor provider behavior, changes in patient condition, and outcomes via the 5-day assessment, IPA assessments, and discharge assessments. While a 5-day assessment would not be required upon readmission in the case of an interrupted stay, the provider has the option of completing an IPA as it determines appropriate to assess whether the patient's condition and care needs have changed.

13.11 Will CMS require SNFs to indicate on the claim form when a patient has been readmitted and/or when an evaluation was complete after the patient was readmitted?

CMS does not anticipate that providers will be required to report on the claim form when a patient is readmitted or an evaluation is completed for such a patient, though we will have providers report on the claim when an interrupted stay occurred. It will be indicated on the claim in the same way as a Leave of Absence.

13.12 Should SNFs complete a discharge assessment or NPE even if the patient may possibly return to the SNF within the 3 day “interruption window”?

In the case of an interrupted stay, no PPS assessments are required, including a PPS Discharge assessment. However, OBRA assessment requirements still exist and an OBRA discharge would need to be completed.

13.13 How should the SNF count total volume, mode, and type of therapy in section O of the MDS for purposes of the discharge assessment when a patient's stay included one or more interrupted stays?

SNFs should report the therapies furnished since the beginning of the Part A stay, including all parts of an interrupted stay in section O of the MDS for each discharge assessment.

13.14 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.

13.15 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.

13.16 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 during the interruption 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.

13.17 How will the Interrupted Stay Policy interact with the SNF Quality Reporting Program (QRP), specifically with regard to matching stays?

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.

13.18 What happens if a resident drops to a non-skilled level of care but remains in the facility? Do the same interrupted stay rules apply?

An interrupted stay may occur in cases when the patient is discharged from Part A, but remains in the facility and then returns to a Part A stay. In such instances, however, an NPE would not be completed. OBRA assessment requirements remain unaffected.

13.19 How should providers complete item A0310G1, "Is this SNF Part A interrupted stay"?

In order to complete this item, providers should wait to observe if the patient returns on an interrupted stay before coding the ND.

13.20 If a resident qualifies for a new stay due to an absence exceeding the interruption window, should a PPS discharge assessment be completed for the first stay?

Yes, the PPS Discharge Assessment should be completed for the initial stay.

13.21 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.

13.22 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.

14. Transition Policy and Medicaid Issues

14.1 How is CMS transitioning 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. All days of service on or prior to September 30, 2019 will be billed under RUG-IV, while all days of service beginning October 1, 2019 will be billed under PDPM.

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.

The HIPPS code derived from the transitional IPA should be used to bill for dates of service beginning October 1, 2019.

14.3 Is there not a way to get a PDPM HIPPS code without doing another assessment?

Due to the significant differences in items and item coding between RUG-IV and PDPM, such as the coding of item I0020B with a primary diagnosis code, and because these item and coding changes are not effective until October 1, 2019, there is no way to produce a PDPM HIPPS code on assessments with ARDs prior to October 1, 2019. Therefore a new assessment once PDPM begins is required.

14.4 Can providers complete a short-stay assessment for patients admitted in the last few days of September 2019?

No special rules apply in cases of patients admitted near the end of September 2019. If the patient qualifies for a short-stay assessment, then a short-stay assessment may be completed. If the patient does not qualify for a short-stay assessment, then no short-stay assessment may be completed.

14.5 How does the PDPM transition affect Medicaid?

There are two main ways in which the transition to PDPM may affect state Medicaid programs, calculation of the Upper Payment Limit (UPL) and changes in NF reimbursement for case-mix states. With regard to the UPL calculation, while budget neutral in the aggregate and not impacting the scope of services covered under the SNF PPS, PDPM implementation changes how payment is made for SNF services, which can have an impact on UPL calculations. We encourage states to evaluate the impact of PDPM on their UPL calculations.

With regard to NF reimbursement, we know that some states use a version of RUG-III or RUG-IV to determine payment for NF patients. With PDPM implementation, CMS will continue to report RUG-III and RUG-IV HIPPS codes, based on state requirements, in Item Z0200.

However, case-mix states also may rely on the myriad of PPS assessments to capture changes in patient case-mix, including the scheduled and unscheduled assessments under the different RUG versions. As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all unscheduled PPS assessments will be retired. To fill this gap in assessments, CMS will introduce the Optional State Assessment (OSA), which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules.

14.6 What assessment types are being retired?

PDPM utilizes a streamlined assessment schedule, which requires only the 5-day scheduled PPS assessment as the basis for payment under the SNF PPS, as opposed to the current SNF PPS assessment schedule, which requires various scheduled assessments (i.e., 5-day, 14-day, 30-day, 60-day, 90-day), as well as unscheduled assessments, typically referred to as Other Medicare-Required Assessments (OMRAs) (i.e., Start of Therapy OMRA (SOT), End of Therapy OMRA (EOT), Change of Therapy OMRA (COT)). It should be noted that PDPM implementation has no impact on assessments completed as a result of the Omnibus Budget Reconciliation Act of 1987 (i.e., OBRA assessments).

14.7 Why are assessment types being retired?

Given the focus on stable patient characteristics, rather than frequently changing service utilization, as the basis for payment under the SNF PPS, it will no longer be necessary to have as many assessments as currently exist under the SNF PPS to track changes in service provision over time.

14.8 What is the optional assessment called?

The Optional State Assessment (OSA)

14.9 What are the completion and submission requirements for the optional assessment?

The OSA is a state-optional assessment, meaning that, similar to Section S items, the requirements for completing the OSA would be set by each individual state. For example, a state may require Medicaid providers to complete an OSA in each instance when a PPS scheduled or unscheduled assessment (other than the 5-day PPS assessment) would have been required under RUG-III or RUG-IV.

The MDS 3.0 RAI manual will not contain coding instructions for items that only appear on the OSA. As stated above, completion of the OSA is at the discretion of each State; therefore, the RAI manual will not provide direction on the coding schedule of the OSA. Further, no additional data elements, such as Section S items, may be added to the OSA. Finally, the OSA cannot be combined with any Federally-required assessments.

14.10 How long will the OSA be in place?

There is currently no definitive timeline for retiring the OSA. Once states are able to collect the data necessary to consider a transition to PDPM, CMS will evaluate the continued need for the OSA, in consultation with the states.

14.11 Will States be able to require section S items or other MDS items on the OSA?

No, States will not be able to add any additional items to the OSA.

14.12 Are States able to implement PDPM for their case mix payments?

Yes, states are able to implement PDPM for their case-mix payments, though certain elements of PDPM may not work for such payments (e.g., the variable per diem adjustment).

14.13 Will CMS support RUG-III/IV from 10/1/19-9/30/20? If so, how?

CMS will continue to report the RUG-III and RUG-IV Health Insurance Prospective Payment System (HIPPS) codes, as requested by the state, until September 30, 2020 on the 5-day PPS, OBRA comprehensive and OBRA quarterly assessment types. If a State requires the calculation of RUG-III or RUG-IV more frequently, the State may require its providers to submit the OSA at time points determined by the State. Beginning October 1, 2020, states must use the OSA as the basis for calculating RUG-III and RUG-IV HIPPS codes.

14.14 I have questions about PDPM and Medicare Advantage. To whom should I direct these questions?

Any questions regarding the impact of PDPM on Medicare Advantage plans should be directed to MA plan sponsors.

14.15 I have questions about the OSA. To whom should I direct these questions?

Any questions regarding the OSA should be directed to the relevant state agency governing the state's Medicaid policy issues.