

# Patient-Driven Payment Model

Frequently Asked Questions



## PDPM Frequently Asked Questions

### Reimbursement

#### **Q: Why are they changing how my Skilled Nursing Facility (SNF) is being paid?**

SNF payments are always under scrutiny and there has been concern for many years that the system could be gamed since Therapy Minutes were driving the higher reimbursement groups and many assessments scoring into those upper RUGs were at or within 5 minutes of the RUG minutes threshold. At the same time, the IMPACT Act of 2014 requires that the post-acute care sector take on a unified payment system driven by cross-setting measures. The move to PDPM addresses both concerns – removes incentivization on therapy minutes and uses the cross-setting measures to calculate the scores laying the ground work for a unified payment system. The following quotes are from the Proposed Rule as stated by CMS:

- As of FY 2017, of the 66 possible RUG classifications, over 90% of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs, with **over 60% of covered SNF PPS days billed using one of the three Ultra-High Rehabilitation RUGs.**
- The implication of this pattern is that more than half of the days billed under the SNF PPS effectively utilize only a resident’s therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payment for all aspects of a resident’s care.
- While it might be possible to attribute the increasing share of residents in the Ultra-High therapy category to increasing acuity within the SNF population, **we believe the increase in “thresholding”** (that is, of providing just enough therapy for residents to surpass the relevant therapy thresholds) **is a strong indication of service provision predicated on financial considerations rather than resident need.**
- The combination of the observed trends in the current SNF PPS discussed above (which strongly suggest that providers may be basing service provision on financial reasons rather than resident need), the issues raised in the OIG reports discussed above, and the issues raised by MedPAC, has caused us to consider significant revisions to the existing SNF PPS, in keeping with our overall responsibility to ensure that payments under the SNF PPS accurately reflect both resident needs and resource utilization.
- We believe that the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care.

#### **Q: Why is CMS changing from RUG-IV to PDPM?**

Under RUG-IV, most patients are classified into a therapy payment group, which uses 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.

#### **Q: How is my reimbursement going to be calculated for PDPM?**

PDPM no longer calculates a single score for reimbursement for all services as with RUGs IV but separates payment by component and totals them. There are 6 components under PDPM that form the total payment; Nursing (for all Nursing and Social services), Occupational Therapy, Physical Therapy,

Speech-Language Pathology and Non-Therapy Ancillaries will be added together along with a non-case mix component to form facility payments.

**Q: 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.

**Q: Will PDPM UB04 billing training be provided? If no RUG, what coding will be used on UB04?**

That is an excellent question. The UB forms will need to adapt to the scoring but there has not been any specific direction as to how that will occur currently. *We encourage you to reach out to your fiscal intermediary to begin these conversations as well.*

**Q: 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. RUG-IV billing will end on September 30, 2019 and PDPM billing will begin on October 1, 2019.

**Q: 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.

**Q: I heard that we will still use RUGs in nursing so how will this be different?**

The nursing component will use a RUG grouper, but the grouper is changing. Previously, Nursing Groupers had 43 or 44 RUG scores. Within PDPM, there are only 25 RUG scores. The grouper has reduced the ADL end-splits to condense the payment groupings. With PDPM, the higher payments are associated with clinically complex residents. States may still opt to use the 43 and 44 groupers for Medicaid reimbursement until October 1, 2020 at which time CMS will no longer support the RUG-III and RUG-IV methodology.

**Q: 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.

**Q: How does the shift to the 25 grouper affect my revenue?**

According to CMS, the shift in the payment model will be revenue neutral for most SNFs. However, there have been studies indicating that larger organizations (over 100 certified beds) will see a slight decrease in revenue, while not-for-profit and government facilities may see slight increases in revenue. CMS has provided crosswalk and impact tools that look at how the changes will affect specific organizations. These are available [here](#).

**Q: Is the payment reduction of 2% after day 20 per discipline (PT, OT, Nursing)?**

The payment reductions only affect PT/OT. PT and OT will be the two disciplines affected by the 2% reductions every 7 days after day 20. There is no decreasing payment for nursing.

## Assessments

**Q: We do not do Medicare skilled MDS assessments, and currently do not do section GG. We have Medicaid and Private Pay residents. Will these changes affect us? (same answer as below)**

**Q: Will section GG become mandatory for those of us who are currently not doing Medicare skilled care?**

The change to PDPM and section GG only affects PPS assessments and Medicare clients currently, not Medicare Advantage, Private Pay, or Medicaid payors. There has been talk at CMS that section G will eventually be replaced by section GG but there has not been further direction to that end. Note: CMS has indicated that effective October 1, 2020, they will no longer support the RUG Methodology. States and other stakeholders will need to make preparations for a shift from the RUG methodology prior to that date.

**Q: Will MDS section I0020 have any effect on PDPM?**

Effective October 1, 2019, CMS is adding MDS item I0020B which will be used for the Primary Diagnosis. Clinical Categories will be determined based on this new item.

**Q: What is section GG?**

Section GG was added in October 2016. Section GG was introduced in order to collect data for establishing the cross-setting measures required by the IMPACT Act of 2014. Section GG uses the CARE (Continuity Assessment Record and Evaluation) Item set.

**Q: How do the upcoming changes in section GG this October affect the functional score computation?**

The function score computation does not go into effect until October 2019. The Section GG changes are in preparation for the 2019 changes to support PDPM. There are no computational changes currently.

**Q: If we're not using Section G for ADLs, do we still need to regularly collect that data?**

ADL data is collected for more than just the MDS. The ADLs help with care planning, understanding improvement and decline, as well as determining resources needed to provide care. Even though Section G won't be used for calculating the ADL score in reimbursement, the data collected is still useful in meeting resident needs.

**Q: Regarding ADL scoring, how would it work to adjust POC charting by CNA's to the verbiage of the new GG when state reimbursement in some states is still based on Section G of the MDS? Case Mix states still utilize G for ADL scores for Medicaid reimbursement.**

This is a debate many companies are having and should be part of any organizations PDPM plan for moving forward – determining how section GG information is collected. There is still a need for section G – state reimbursement still relies on RUGIII and RUGIV and therefore section G coding. Restorative aids may be more helpful in collecting section GG information or it may reside with nursing until the reimbursement calculation is consistent across assessments and types of residents. POC screens can be optimized so that language and not scoring are displayed in the interface and therefore, coding irregularities can be minimized. However, since section GG is a 3-day lookback and only required for the 5-day, IPA and discharge assessment – until it is more globally used – homes will need to identify best internal practices for the collection of this data.

**Q: For the Discharge assessment, will section O ask us to capture minutes for entire stay or just 7 day look back?**

In order to capture therapy delivery information over the course of a patient's entire Part A stay, as it relates to the concurrent and group therapy limit under PDPM, CMS added Items 0425A1 – 00425C5 which will be added to Section O of the MDS. Using a lookback period 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. If the total amount of Group/Concurrent minutes, combined, comprises more than 25 percent of the total amount of therapy for that discipline, a warning message will be issued on the final validation report.

**Q: 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?**

In the case of an interrupted stay as defined under the Interrupted Stay Policy (e.g. where a patient is discharged and then readmitted to the same SNF before midnight of the third day of the interruption window), only those therapies that occurred since the readmission would be included in section O of the MDS for each discharge assessment.

**Q: For the IPA, would the functional scores still be based on the 5d?**

It is our understanding that a **new** function score would be needed to code an IPA.

**Q: How does one find the data that is in I8000A?**

For current assessments, homes should be able to leverage software reports to pull forward the content in I8000A\*. In PointClickCare, you can use the Resident Response List and select I8000A in the lookup – that will pull all the assessments with I8000A coded responses in a list to show compliance with completion and you can compare to the CMS diagnosis mapping tool to ensure the codes used are permitted in PDPM. Mapping tools are available [here](#).

\*At the time of this response, CMS had stated that I8000A was the source of primary diagnosis used for clinical category identification. They have since clarified that a new field, I0020B will be used.

**Assessment Resident Response List Setup**

Report Options Run Report

Unit: All

Floor: All

Status: Both

Date range: All

Summary Only

Sort Residents by: Resident Number

Assessment Type: MDS 3.0  
I9000A) Additional active ICD diagnosis 1

Check to include responses on report:

Blank (no diagnosis code)  
 ICD-9 code

**If we have a death in facility, do they still require an EOPPS same day?**

No changes have been made to the current schedule for PPS, however, October 1, 2019 is over a year away, so we expect confirmation or further direction from CMS before the implementation of PDPM.

**Therapy**

**How will this affect therapy provision in my facility?**

Therapy providers should be reaching out to facilities to talk about options. Therapists believe they will still be providing just as much therapy as prior to PDPM, but there may be a shift in modality to more concurrent and group therapies as well as individual minutes.

Therapy providers should be connecting with facilities in order to talk about how the primary diagnosis will drive the OT and PT and how they can confer with the facility to ensure that it reflects the comprehensive care the residents will need throughout their stay in the SNF.

**With therapy being driven by clinical classification, does this mean no more collecting therapy minutes?**

Therapy minutes will still be recorded on discharge assessments.

**Do you anticipate a decrease in need for therapy services?**

Physiotherapist organizations are specifically stating that they feel there will be just as much therapy provided and that there was not as much overuse of therapy as anticipated by CMS. Therefore, therapy minutes will still be submitted on the Discharge Assessment so that we can continue to study therapy provision. We do suggest that homes have conversations with their therapy providers to determine the impact they think this will have and how to mitigate any risks associated with a change in reimbursement.

**ICD 10 Coding**

**Will ICD-10 codes have different values?**

Codes are grouped into clinical categories (10 for nursing, further collapsed to 4 for PT/OT) which do drive reimbursement. HIV/AIDS codes submitted on claims will incur a rate adjustment.

Though the codes themselves may not have scoring attributed, the NTA comorbidities have many codes with points assigned to them that drive the NTA category and NTA reimbursement. The ICD10 mapping

to the PT/OT clinical categories determines rates as well. MDS coordinators will need to have a good grasp on ICD coding and how that relates to co-morbidities and clinical categories in order to optimize reimbursement.

### **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.

### **Many facilities eliminated the coding positions and placed the coding responsibilities on MDS coordinators. Would you advise facilities to reexamine that decision and bring back staff degreed/specifically trained in detailed diagnosis coding?**

ICD-10 coding has a very large impact on the overall reimbursement scoring of the MDS in PDPM. Homes will need to work hard with current staff to make them proficient in coding – especially coding the clinical categories correctly. Currently, we are trained to use primary codes to promote therapy provision which are disallowed as primaries in PDPM (Z51.89 – for example). If you are not hiring coders moving forward, additional training on ICD10 coding, specifically for PDPM, would be of great benefit to your MDS team.

## **Questions for PointClickCare**

### **When will PointClickCare announce any changes to current processes to meet needs of the PDPM?**

Our current focus is on understanding the extent of changes required for PDPM in preparation for October 2019. This October, the MDS update enhances section GG coding which will allow us the ability to develop predictive tools in preparation for PDPM. These changes will be made available as soon as design and development are completed, which is dependent on CMS providing the data specifications. CMS has indicated they will make the data specifications available as soon as possible, but no definitive date has been provided. Once the data specifications are released by CMS, we will update clients with more information.

### **Where do you find the comparison in PointClickCare?**

It has not yet been released and we do not have a release date yet as we are dependent on CMS data specifications to complete the report. The additional MDS item set changes will come in October that provides all the GG coding so that we can calculate the function score and we are committed to providing a comparison tool, but CMS has not yet provided a date for the release of the data specifications. The data specifications tell software engineers exactly how to build PDPM calculations and implement changes to the MDS Item Sets and Data Specifications so that we are all computing scores the same way. In the interim, you can use the cross walk and impact tools available from CMS. These tools are found [here](#).

## **Will PointClickCare have a test system available to practice PDPM?**

The best thing you can do now is to train your staff around the ICD10 coding and that does not require any PointClickCare changes to manage. The mapping tools are available [here](#). Make sure you select the most recent version (all are listed). There are additional resources required from CMS before actual coding of PDPM scoring can occur. When those data specifications are available, PointClickCare will provide further notification to customers.

[Link to CMS – PDPM site with information fact sheets, frequently asked questions, training and resources](#)

## **How can we get the data work sheet provided by CMS?**

That data worksheet can be downloaded [here](#).

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