Patient-Driven Payment Model
Frequently Asked Questions

September 2019
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**Frequently Asked Questions**

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Frequently Asked Questions

1. Reimbursement Questions

Why are they changing how my skilled nursing facility 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 groundwork 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 percent of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs, with **over 60 percent 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

- 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 PDPM will 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.

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.

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 service and totals them. There are 6 components under PDPM that form the total payment;
Nursing) for all Nursing and Social services), Occupational Therapy, Speech-Language Pathology and Non-Therapy Ancillaries will be added together along with a non-care mix component to form facility payments.

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.

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. All residents present on September 30th, 2019 and October 1st, 2019 will need both a RUG assessment with ARD pre-October 1 and a PDPM IPA assessment with ARD between October 1 and 7.

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.

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.

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.
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 skilled nursing facilities. 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 cross walk and impact tools that look at how the changes will affect specific organizations. These are available here.

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

- The payment reductions only affect OT/PT and the NTA categories. PT and OT will be the 2 disciplines affected by the 2% reductions every 7 days after day 20. The NTA rate drops from 300% to 100% on day 4. There is not decreasing payment for nursing.

2. Assessment Questions

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

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 Medicare A resident assessments and any payer who chooses to move to PDPM methodology. It is up to facilities to know which insurance/Medicare Advantage payers will use which system for payment on October 1st. You will need to verify that you have the right payer setup to drive the right assessments for MDS before the transition. Private Pay and Medicaid are not affected by PDPM. 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.

Will MDS section I0020 have any effect on PDPM?

- I0020B will be the field where the primary diagnosis for the SNF stay is entered for calculation of the clinical category used in the case mix determination.

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.

How does the upcoming changes in section GG this October be affecting 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.
If we’re not using Section G for ADLs, do we need to regularly collect that data anymore?

- 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.

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. Section G and GG use similar but nuanced descriptions for scoring and the scores are inverted in that section GG score decrease with assistance and section G increase with assistance. POC screens can be optimized so that language and not the scoring of ADLs and Function 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.

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?

- The discharge assessment has minutes recorded in section O, Special Treatments, Procedures and Programs. They are collected from the start date of the Most Recent Medicare A stay (A2400B). See Screen shot. Details can be found from CMS.
3. **Section O – Therapy Minutes Questions**

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

- A new function score would be needed to code an IPA. Per the RAI manual, the assessment period is the last 3 days (i.e., the ARD and two days prior)

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

- Always refer to the RAI manual for the new PPS schedule and rules but the NPE is to notify CMS that the person is no longer on Med A but they still reside in the facility. An OBRA discharge assessment and PPS discharge assessment are required when the person comes off Med A before the physical DISCHARGE from the facility. You would code the PPS discharge at A0310H on the OBRA discharge assessment, but the completion of the NPE item set is not required.

On the MDS currently if the staff answer question A2400A (Has the resident had a Medicare-covered stay since the most recent entry) with “0, No” then the “while not a resident” section for question K0510 is an item that is connected to payment under PDPM so for insurances that will be following the PDPM payments-how should question A2400A be answered? If they answer “no” because it technically is NOT a Medicare stay, then will they be able to code the “while not a resident” section for question K0510A?

- The Nursing CMG PDPM item use is not K0510A1 (while not a resident) it is only K0510A2 that counts for PDPM (while a resident). If you refer to the CMS PDPM grouper it specifies that it is only counted while a resident.

4. **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?**

- Not quite!! Therapy minutes will still be recorded on discharge assessments.

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

- Therapy 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. Payment models so not drive the need for therapies, medical necessity does, and we will be taking care of similar residents before and after PDPM. Therefore, therapy treatments will be needed. Therapy minutes will 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 SLP 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.

- 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). The consensus is that homes will need coding expertise for PDPM but not necessarily coding experts.

If a primary Dx used doesn’t map to a valid clinical category (Return to provider) will the claim be held up?

- CMS updated the grouper so that if the primary dx doesn’t map to a clinical category it will default to a Z for that one case mix group and that would be reflected in the HIPPS code, but the claim would not be held up.

For the 50 NTA items will you get credit for all if they are documented in Section I?

- The RAI manual provides this detail starting on page 6-30 about where the NTA items get captured. For example, a stage IV pressure ulcer does not get captured in section I, but in Section M, M0300D1- where pressure ulcers are documented- refer to the RAI for each NTA item and where on the MDS it should be documented to be captured.
5. PointClickCare Specific Questions

Where do I find all of the PDPM release information?

PDPM release information can be found in a few places:

- Help files under PDPM Enhancements (top of the navigation list on the left.)
- Release newsletter Home Page PointClickCare Announcements
- Pulse, PointClickCare Online Community, Release Hub (if you don’t yet have access see the “MDS 3.0 regulatory Update and PDPM Resources” Home Page Announcement with the link to an instruction Guide request instructions here)

Where did you find the comparison report in PointClickCare?

- The RUG to PDPM Comparison Report can be found in the NEW Reports menu. You will need to make sure you have all of the right setup completed, so please refer to your PointClickCare Helpfiles, PDPM Enhancements for the instructions on how to update your setting to make this report work.

How do I find the Case Mix Analyzer for PDPM?

- To calculate the PDPM rates, you must enable Diagnosis Clinical Category in Clinical > Setup > Diagnosis Configuration and complete the Urban/Non-Urban Area in Admin > Setup > A/R Configuration. Access must also be granted in Security, Clinical Role RUGIV PDPM Comparison Report under Assessment Reports.

I’m reviewing the 4.0.0 Release newsletter before starting PDPM setup and was wondering if you could give more details on what the pros and cons for using multiple Contractual accounts for each category versus just using one room and board contractual? I’m trying to get an answer out of our accounting team as to how they want to setup the system moving forward but am not sure what the benefit of using the separate accounts is meant to be to explain to them.

- This is a facility preference on wanting to keep track of each component separately or not. There was interest in being able to breakdown each component for revenue purposes.
  
- Having the revenue broken down by component will allow you to match costs associated with each component to the related revenue.

Will PointClickCare load the PDPM rates effective 10/1/19? And how will sequestration, wage index and VBP adjusted rates apply?

- All the PDPM rate components for FY 2019 are currently loaded in the system and are being used to calculate the PDPM rate on the RUG to PDPM comparison report available under the new reports tab in PointClickCare. As of 4.0.1, the rate components for FY2020 will also be loaded. This will include the wage indexes and the Relative importance factors to enable us to calculate the reimbursement rates for payers reimbursing on PDPM. As long as the Med A Urban/Non-Urban Area is configured correctly in A/R configuration, the resident rates will be wage-adjusted accordingly. If your facility is affected by VBP adjustments, you can indicate in the Payer Rate schedule that you are expecting X% of the Medicare rate. As sequestration only impacts the amount being paid by Medicare and not the coinsurance, the existing reimbursement reduction of 2% will continue to be used (Apply reduction to net reimbursement? In Payer rules).
**CRM – Preadmission Screening Form**

- This was included in the 4.0.0 release.

**Can you help me to understand what is needed in the CMI setup for each center? I thought this was calculated in the background. If not, where can I get the CMI?**

- 4.0.1 will be available either 9/18, 9/23, or 9/25 – depending on which distribution group your in. The CMI setup is for calculating the UNK rate, pending an actual assessment.

To determine what values to enter, we’d recommend revising the Case-Mix Classification groups from the Federal [Register here](#).

- See Table 21 for PT and OT schedule.
- See Table 23 for SLP schedule.
- See Table 26 for Nursing schedule.
- See Table 28 for NTA schedule.

It would be up to your organization to determine the best value to use for calculating the Unknown rate. That can be either the highest value, the lowest value or middle/average, etc.

**Where do you get the PDPM Default CMI. We have our Wage Index from the federal register and can see the different Therapy CMI ## but just not sure where to get the number.**

- This is part of the set up for PDPM- refer to newsletter for 3.7.19.2- the facility can determine the default CMI to calculate this- they will be asked to enter a default CMI for each PDPM Case mix Category.

- The values you populate in the default CMI fields will be used to calculate revenue before an assessment has been locked and the care level is still set to UNK.

- Currently, most facilities use their historical averages to set the rate for UNK care level, and we expect that customers will do something similar with PDPM. If you don’t know what to expect your average CMI value to be, you can use 1.00 for each of them as this is the expected National Average. These values will only be used when there is no locked assessment available to calculate the rate, and those transactions typically get reversed when the assessment gets locked, so you can update them whenever you want to.

**My facility would like the option to numerically rank ICD10 codes, currently the options to rank codes are “principal” or “other” this will not be sufficient for billing in the new PDPM environment. How do we fix that?**

- Those are configurable fields in your Medical Diagnosis setup. Once you have determined your preferred setup, you will need to re-rank and classify all residents’ diagnoses.

**Will we still be able to do MDS RUGs for PPS and have payer’s setup that can still be billed with RUGs even after 10/1/19? Since some of the Medicare Advantage plans are NOT going to PDPM. So, will we be able to do both in PointClickCare after 10/1/19?**

- We will continue to support RUGS until CMS determines a retirement date. Please refer to the 4.0.0 release notes for more information.
Is there a training database to start inputting PDPM information? Something similar to the training database to train new nurses on how to use PointClickCare?

- Your current training database can be used to train PDPM.

We use Data Relay. Can you tell me in which database table the HIPPS score?

- The PDPM HIPPS will show in the following tables:
  
  **Census tables:**
  - Census_item and census_assessment_info are the two tables.
  - Census_item will have the first 4 letters of HIPPS.
  - Census_assessment_info has the full 5 letters.

  **Assessment tables:**
  - Assessment_Responses tables must query for Question_key='Z0100A'

- Note: these fields will not start populating with PDPM information until October 1. For assessments, the ARD must be on or after 10/1. For payers, the payer must be setup on PDPM as of October 1 to see the rates. You can then use the HIPPS to determine the individual case mix groups if you wish.

We have residents with IV abx with this dx. from NTA list. Can we use A code in SNF? We were told no previously. T827XXA Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter

- We are not able to advise you whether you can use an initial encounter code or not as it is really specific to the resident’s situation. The following guidelines from CMS may help determine if you are able to use them or not. Please refer to Chapter 19.

For those Medicare Advantage plans that will not process claims using PDPM HIPPS but still requires RUGS - what will their new rates be for 10/01/2019? Medicare rates change every year October 1st - for those insurances that will be RUG based on 10/1/19 will PointClickCare be adding new rates for them or will be billing using the existing 10/1/2018 rates?

- You would continue maintaining those rates by obtaining them from your insurance providers as you do now.

If the diagnosis code feeds to the MDS and answers the question within the MDS, as outlined in the CMS Fact Sheet ‘Condition and Extensive Services Used for NTA Classification,’ that Dx will NOT show points on the Dx tab in the NTA Points column. Is this correct? Also, will the diagnosis codes, summarized in the NTA Comorbidity tab of the PDPM ICD-10 Mappings excel spreadsheet, display NTA points in the NTA Point column of the Dx tab?

- In order to know which are feeding the score, how would the customer identify this? Would it be via the NTA link in the analyzer and filter through to determine where any points not listed on the Dx tab are stemming from?

  - The example:
    Area – Dx Tab – PDPM Comorbidities (NTA Points) column
Example:
The column is available, but it is not showing points in the column where expected. On this resident chart example there are 5 dx where points are expected, but nothing in the column. (Screenshot attached for reference.)

B19.20 Hepatitis – populates I2400
K58.1 Irritable Bowel Syndrome – I6200
Z16.24 Resistance to Multiple Antibiotics – I1700
N39.0 UTI – populate I2300

Not clear why the NTA points are not showing. There are other residents with similar issue. As we review charts, there are some where a few Dx show points, but not all points that are expected show.

Can you explain why the points are or are not showing? And if there is another step, we need to complete in order for them to appear in the column?

• We used CMS’s PDPM ICD-10 Mapping file, located at the bottom of the CMS PDPM website, which specifies which diagnosis codes map to NTA and SLP Co-Morbidities. Diagnosis on these 2 spreadsheets will be flagged accordingly and NTA points displayed on the Diagnosis tab. These are diagnosis that specifically need to populate in I8000 of the MDS. Diagnosis that map to a Section I checkbox (and are not included on the spreadsheet) are not flagged on the Diagnosis tab as CMS does not provide the specific diagnosis codes that map to the Section I checkboxes.

• The NTA section of the PDPM Analyzer will show the user which diagnosis from I8000 and section I checkboxes counted towards the point total.

• In the example described below, the 2 highlighted diagnosis will populate the checkboxes of Section I of the MDS and therefore not show the NTA points on the Med Diag tab.

We used the CMS mapping tools. If customers feel we are missing diagnoses that should be counted as NTA, they should enter a case so that we can address the issue.

B19.20 Hepatitis – populates I2400
K58.1 Irritable Bowel Syndrome – populates to I8000
J44.9 COPD – I6200 - since this populate a checkbox, the NTA points will not be reflected on the Diagnosis tab, they will show on the NTA tab in the PDPM Analyzer
Z16.24 Resistance to Multiple Antibiotics – I1700 - since this populate a checkbox, the NTA points will not be reflected on the Diagnosis tab, they will show on the NTA tab in the PDPM Analyzer
N39.0 UTI – populate I2300

If on chart but not on MDS, you would see it here as in this example below:

I am not sure whether we are Urban/Non-Urban or what additional choices I should make?

- You can find your county and urban/rural information in the wage index files from CMS.
- Is PointClickCare making any care plan updates to our standard library to reflect PDPM?
- In 4.0.0 we released new clinical standard content that will include a care plan library. The care plan library is nursing focused and may not have all dx r/t PDPM, but part of the focus/goal/intervention are resident specific descriptions that can be appended to include specific dx.

With PDPM what happens to our HMO RUG assessments? What about the PPS schedules for those payers?

- The payer set up has an option (see 3.19.2 newsletter) to say that a payer uses RUG and when a resident is admitted with that payer, they will have the PPS schedule and the MDS will generate a RUG.

Will there be alerts in the dx tab of the chart for diagnosis that are NTA’s?

- With the 4.0.0 release a column was added in the dx tab that will shoe NTA points for each dx if applicable. This will help with ranking DX with NTA’s on the MDS to ensure that they get captured.

I heard there is a “GG Assessment tool” that is built into POINTCLICKCARE. I heard that it can be turned on to trigger on admission and then it can be scheduled to be completed as needed for additional assessment that would require this info. Can you confirm this to be correct, and is there an ETA when this will be available?

- This is the functional abilities GG UDA has been available for about 3 years. There is an admission and a DC functional abilities UDA. The facilities can begin using it at any time it is currently available. An IPA functional abilities GG UDA to be completed prior to a UDA was made available with 4.0.0.
The PDPM HIPPS calculated in POINTCLICKCARE is different than in my scrubber software. Why is that?

- PointClickCare uses the actual CMS PDPM grouper to calculate the PDPM HIPPS, based on all assessment data recorded. We cannot speak to other software.

For All PointClickCare Customers, additional FAQs were provided with the 4.0.0 Release webinar. If you have additional questions for PointClickCare, customers can call Customer Support, and anyone can email PDPMQuestions@pointclickcare.com.

Additional information can be found at CMS. Click here.