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Medicare Part A
A Review of the Prospective Payment System and the Patient Driven Payment Model

Kathleen Weissberg, OTD, OTR/L
September 17, 2018

Objectives
1. List the qualifiers for Medicare Part A skilled care
2. Identify criteria for Medicare Part A PPS RUG categories
3. Define rule sets for Other Medicare Required Assessments (OMRA)
4. Explain MDS coding for modes of therapy delivery under Medicare Part A
5. Describe the Patient Driven Payment Model as finalized by the Centers for Medicare and Medicaid Services
Overview

- Health insurance program for:
  - 65 or older
  - under age 65 with certain disabilities
  - all ages with End-Stage Renal Disease
- Several “Parts”
  - Part A
  - Part B
  - Part C
  - Part D

Key Terms/Glossary

- Minimum Data Set (MDS) 3.0
- Resident Assessment Instrument (RAI)
- Case Mix Index (CMI)
- Resource Utilization Group (RUG)
- Resource Utilization Grouper
- Assessment Reference Date (ARD)
- Look Back Period
- Care Area Triggers (CATs)
- Care Area Assessments (CAAs)
Methodology of PPS

- Reimburse SNF a pre-determined dollar amount
- Base pre-determined dollar amount on projected/planned care required for resident, defined by resident’s level of need and projected/planned resources to be utilized

Medicare Part A Qualifiers for Skilled Care

- Part A eligibility
- Available Medicare days
- 3 day qualifying hospital stay (past 3 midnights)
- Need for skilled care
- Physician certification
- Reside in certified bed
- Services initiated within 30 days of hospital discharge
Medicare Part A

- Available Medicare days
  - 100 SNF days per benefit period
  - New benefit periods occur after 60 day “wellness” period
  - Resumption of Medicare Part A may occur within 30 days of “cut” when days are remaining in benefit period
  - First 20 days are fully covered by Medicare
  - Days 21-100 Medicare pays per diem (RUG) minus daily co-insurance amount

Medicare Part A

- Skilled care related to therapy
  - Services required daily on an inpatient basis by qualified personnel (nursing 7 days and/or therapy 5 days)
  - Ordered by a physician
  - Medically necessary
  - Reasonable frequency and duration
  - Physician certification for SNF care
  - Reside in a Medicare certified bed
Factors Impacting Facility Reimbursement

- Total RTM/days per therapy discipline during “look-back” window
- Number of disciplines providing service
- Late loss ADL scores (MDS Section G)
  - Bed Mobility
  - Transfers
  - Toilet use
  - Eating
- Extensive services provided
- CMI rank

PPS Assessments

- Communication and documentation are key to accurately capture resources used to provide care for the resident, thus, ensuring appropriate reimbursement (i.e., RUG)
MDS Assessment Schedule

<table>
<thead>
<tr>
<th>Type</th>
<th>ARD Dates</th>
<th>Grace Days</th>
<th>Days Paid</th>
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<tr>
<td>5 Day</td>
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<tr>
<td>60 Day</td>
<td>57–59</td>
<td>60–63</td>
<td>61–90</td>
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<tr>
<td>90 Day</td>
<td>87–89</td>
<td>90–93</td>
<td>91–100</td>
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</table>

* Care Area Assessments may be completed with either the 5-day or 14-day assessment. If completed with the 14-day assessment there is no grace day period for the 14-day MDS.

RUG IV Categories

- Rehabilitation Plus Extensive Services
- Rehabilitation
- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavior Symptoms and Cognitive Performance
- Reduced Physical Functioning
RUG IV Categories

- 8 major categories with 66 groups
- Presumption of coverage extends to top 6 categories
- Special Care High, Special Care Low and Clinically Complex have a differentiating split between residents with and without depressive symptoms

Rehab Ultra High (RUA-C)

- Minimum 720 minutes in last 7 days and
- 2 disciplines must treat:
  - Primary at least 5x/week
  - 2nd at least 3x/week
- 3 sub-categories
  - RUC - ADL score 11-16
  - RUB - ADL score 6-10
  - RUA - ADL score 0-5
Extensive Plus Rehab Ultra High (RUX or L)

- Nursing - Extensive Service qualifications
  and
- Rehab - “Ultra” minimum requirements
  - RUX – ADL score 11-16
  - RUL - ADL score 2-10

Rehab Very High (RVA-C)

- Minimum 500 minutes in last 7 days
  and
- 1 discipline must treat 5 days/week
- 3 sub-categories
  - RVC - ADL score 11-16
  - RVB - ADL score 6-10
  - RVA - ADL score 0-5
Extensive Plus Rehab Very High (RVX or L)

- Nursing - Extensive Service qualifications and
- Rehab - “Very High” minimum requirements
- 2 sub-categories
  - RVX - ADL score 11-16
  - RVL - ADL score 2-10

Rehab High (RHA-C)

- Minimum 325 minutes in last 7 days and
- 1 discipline must treat 5 days/week
- 3 sub-categories
  - RHC - ADL score 11-16
  - RHB - ADL score 6-10
  - RHA - ADL score 0-5
Extensive Plus Rehab High (RHX or L)
- Nursing - Extensive Service qualifications
  and
- Rehab - “High” minimum requirements
- 2 sub-categories
  - RHX - ADL score 11-16
  - RHL - ADL score 2-10

Rehab Medium (RMA-C)
- Minimum 150 minutes in last 7 days
  and
- Any combo of therapies to meet 5 distinct calendar days
- 3 sub-categories
  - RMC - ADL score 11-16
  - RMB - ADL score 6-10
  - RMA - ADL score 0-5
Extensive Plus Rehab Medium (RMX or L)

- Nursing - Extensive Service qualifications
- and
- Rehab – “Medium” minimum requirements
- 2 sub-categories
  - RMX - ADL score 11-16
  - RML - ADL score 2-10

Rehab Low (RLA-B)

- Minimum 45 minutes in last 7 days
- and
- Any combo of therapies to meet 3 distinct calendar days
- and
- Restorative nursing 6 days/week, 2 services
- 2 sub-categories
  - RLB - ADL score 11-16
  - RLA - ADL score 0-10
Extensive Plus Rehab Low (RLX)

- Nursing - Extensive Service qualifications
  and
- Rehab - “Low” minimum requirements
- 1 sub-category
  - RLX - ADL score 2-16

Reporting Distinct Calendar Days

- Beginning 10/1/2013 must report number of distinct calendar days of therapy provided by all rehab disciplines over the 7-day look-back period
  - Qualifying condition for Medium Rehab (RM) Category requires 5 distinct calendar days
  - Qualifying condition for Low Rehab (RL) requires 3 distinct calendar days
  - Prior to 10/1/2013, number of therapy days are summed without regard to separate, distinct calendar days
### RUG-IV Categories

<table>
<thead>
<tr>
<th>RUG Category</th>
<th>Minutes Required</th>
<th>Number of Disciplines</th>
<th>Days per Week</th>
<th>OR Average Daily Minutes (Short Stay)</th>
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<tr>
<td>Ultra High</td>
<td>720</td>
<td>2</td>
<td>1 discipline at least 5 days and 1 at least 3 days</td>
<td>144+</td>
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<td>Very High</td>
<td>500</td>
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<td>1 discipline at least 5 days</td>
<td>100–143</td>
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<td>High</td>
<td>325</td>
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<td>1 discipline at least 5 days</td>
<td>65–99</td>
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<td>Medium</td>
<td>150</td>
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<td>Combination of disciplines at least 5 days</td>
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<td>Low</td>
<td>45</td>
<td>1</td>
<td>At least 3 days of any combination of disciplines AND 2 or more restorative nursing services for 15 minutes at least 6 days</td>
<td>15–29</td>
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</table>
Restorative Nursing Programs

- Range of motion (passive)
- Range of motion (active)
- Splint or brace assistance
- Bed mobility
- Transfer
- Walking
- Dressing or grooming
- Eating or swallowing
- Amputation/prosthetic care
- Communication
- Urinary and/or bowel training program

Combination NRRP’s

- These NRRPs count as 1 service even if both provided:
  - Any scheduled toileting program and bladder retraining program
  - Passive and active ROM
  - Bed mobility and walking
Extensive Services

- Minimum ADL score = 2
- Ventilator/respirator while a resident
- Tracheostomy while a resident
- Isolation for active infectious disease while a resident

Special Care High

- Minimum ADL score = 2
- Comatose
- Septicemia
- Diabetes (with daily injections and 2 days w/ order changes related to diabetic condition only)
- Quadriplegia with ADL score ≥ 5
- COPD and SOB when lying flat
Special Care High

- Fever with pneumonia, vomiting, weight loss or feeding tube
- Parenteral/IV feedings
- Respiratory therapy = 7 days
- Split for depression symptoms

Special Care Low

- Minimum ADL score = 2
- CP, MS, Parkinson’s with ADL score > 5
- Respiratory failure and oxygen therapy while a resident
- Feeding tube
- Foot infections, diabetic foot ulcer, open lesion of foot with treatment
- Radiation or dialysis while a resident
Special Care Low

- Ulcers with 2+ treatments
  - 2 or more Stage II pressure ulcers
  - 1 or more Stage III or IV pressure ulcers
  - 2 or more venous/arterial ulcers
  - 1 Stage II pressure ulcer and 1 venous/arterial ulcer
- Split for depression symptoms

Clinically Complex

- Extensive Services, Special Care High/Low with ADL score <2
- Pneumonia
- Hemiplegia with ADL score ≥ 5
- Surgical wounds/open lesions with treatment
- Burns
- Chemotherapy, oxygen therapy, IV meds or transfusions while a resident
Behavior Symptoms and Cognitive Performance

- ADL score ≤ 5
- Cognitive impairment BIMS score ≤ 9 OR
- Hallucinations or delusions OR
- Physical or verbal behaviors directed toward others, rejection of care or wandering

Reduced Physical Functioning

- Everyone else
- Restorative nursing services
  - Urinary and/or bowel training program
  - Passive and/or active ROM
  - Amputation/prosthesis care training
  - Splint or brace assistance
  - Dressing or grooming training
  - Eating or swallowing training
  - Transfer training
  - Bed mobility and/or walking training
  - Communication training
Reporting Distinct Calendar Days

- Must report number of distinct calendar days of therapy provided by all rehab disciplines over the 7-day look-back period
  - Qualifying condition for Medium Rehab (RM) Category requires 5 distinct calendar days
  - Qualifying condition for Low Rehab (RL) requires 3 distinct calendar days

Counting Minutes

- Direct treatment time
- Re-evaluation
- Transportation to/from rehab gym
- Design/fabrication of splints
- Treatment planning including HEP
- Caregiver training
- Design/training of RNP/FMP
- Set up time
- Point of Care documentation
- Home assessment
- Wheelchair fitting
- Modalities as appropriate
- Family conference/meetings
- Student treatment (Part A)
Clinical Documentation

- Not billable unless Point of Care
- To be maintained in the medical record
- Should accurately reflect the resident’s current treatment plan and responses to skilled interventions

To Do or Not To Do . . . That is the Question

**DO**
- Record actual minutes
- Be aware of the observation period
- Make certain all documentation is complete
- Follow the POC
- Address medical declines
- Adhere to Medicare skilled criteria
- Ensure all areas are addressed prior to discharge

**DON'T**
- Round up/down minutes
- Treat in a vacuum
- Provide treatment if the resident does not benefit
- Write over errors on documentation/logs
- Submit incomplete documentation
- Add eval minutes to MDS
RUG Group End Splits

- Areas that influence how a resident will classify into a RUG group
  - ADLs RUG-IV - Scores range from 0-16
    - ADL scores impact **every** RUG classification
      - RHA (ADL 0-5) = $353.31; RHB (ADL 6-10) = $401.32; RHC (ADL 11-16) = $445.90
  - Presence of Depression - Yes or No
    - Impacts Special Care High, Special Care Low and Clinically Complex RUG Groupers
  - Restorative Nursing - Number of programs ≥ 2 or < 2
    - Impacts Behavioral Symptoms & Cognitive Performance as well as Reduced Physical Function
Rapid RUG – IV Guide

RUG – IV Case Mix Rate

<table>
<thead>
<tr>
<th>RUG-IV Category</th>
<th>Nursing Index</th>
<th>Therapy Index</th>
<th>Nursing Component</th>
<th>Therapy Component</th>
<th>Non-case mix therapy comp</th>
<th>Non-case mix component</th>
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Assessment Policies

What is the difference between an OMRA and a Scheduled Assessment?
Assessment Policies

- Other Medicare Required Assessments
  - Start of Therapy (SOT)
  - End of Therapy (EOT)
  - End of Therapy with Resumption (EOT-R)
  - Change of Therapy (COT)
- Medicare Short Stay Assessment

Start of Therapy OMRA

- Optional
- Completed to classify a resident into a RUG-IV Rehabilitation group
- Completed only if the resident is not already classified into a Rehabilitation RUG-IV
Start of Therapy OMRA

- Allows use of an OMRA
  - To signal start of therapy between scheduled PPS assessments
  - Or within the window for Medicare required assessments
- ARD day 5-7 from first therapy day
- Therapy RUG effective the day therapy starts

Start of Therapy OMRA
Combining Assessments

- PPS Scheduled Assessment
  - ARD must be within window for the Medicare-required assessment and
  - ARD must be 5-7 days after the start of therapy
- If both ARD requirements are not met, the assessments may not be combined
End of Therapy (EOT) OMRA

- Resident classified in a Rehabilitation RUG
- Is discharged from therapy services OR therapy services not provided for 3 consecutive calendar days for any reason
- ARD for EOT OMRA must be set for day 1, 2 or 3 from the date of the last therapy session
- Resident continues to require skilled services

End of Therapy OMRA

- ARD 1-3 days after therapy ends
  - For ARD purposes, day 1 is first day after last therapy treatment was provided
- Payment for therapy ends on last treatment day
- Non-therapy RUG starts next day
End of Therapy OMRA Combining Assessments

- PPS Scheduled Assessment
  - ARD must be within window for the Medicare-required assessment and
  - ARD must be 1-3 days after the last day therapy
- If both ARD requirements are not met, the assessments may not be combined

EOT with Resumption (EOT-R) OMRA

- EOT OMRA requirements met
- MDS item set revised to contain O0450A and O0450B
- Therapy resumes within 5 consecutive calendar days of last therapy service date at the same RUG-IV classification
- No therapy evaluation required
- No Start of Therapy OMRA required
Take Note

- Rehab RUG billed prior to EOT would be billed starting first day of resumption of therapy
- The next COT observation window starts on the date of item 00450B
- Therapy start date in 00450 on the next PPS assessment is the date of therapy resumption

Change of Therapy (COT) OMRA

- Resident classified in a Rehabilitation RUG
- Therapy intensity changes outside the observation window
- Therapy services (days, minutes or disciplines) do not reflect the assigned RUG-IV classification
COT OMRA

- ARD set for day 7 of a COT observation period
- Rolling 7-day observation window beginning the day following the ARD for the most recent scheduled or unscheduled PPS assessment
  - Except where last assessment was EOT-R
- COT observation window ends every 7 calendar days thereafter

COT OMRA

- COT OMRA applies:
  - Whether the change in intensity of therapy (i.e., RTM, frequency, # of disciplines) is scheduled or unscheduled/unplanned
  - Whether the different RUG category is higher or lower than the original RUG category
  - Resident is receiving therapy but is classified into a nursing RUG because of index maximization
  - ADL scores are not considered when deciding if COT OMRA is completed
COT OMRA

- ARD set day 7 of COT observation period
- If Day 7 falls within a scheduled ARD window:
  - Complete the PPS assessment ONLY BEFORE the COT observation period ends
  - Combine assessments if the scheduled assessment has not been completed
- A scheduled assessment cannot occur after an unscheduled assessment in the ARD window

Combining Assessments

- If Day 7 of a COT OMRA window falls within the assessment reference date window of a scheduled MDS assessment then the COT OMRA and the scheduled MDS may be combined
- If the ARD of a scheduled MDS is set for a date that is ON or BEFORE Day 7 of the COT observation period, then no COT OMRA is required
- If Day 7 of the COT OMRA is the discharge date, no COT OMRA is required
Combining Assessments:
Scheduled & Unscheduled PPS Assessments

- What happens if I do not combine them as I should?
  - If a scheduled assessment ARD is set for a day that is after the ARD set for an unscheduled assessment, and the ARD for the unscheduled assessment is set for a day within the scheduled assessment ARD window, then the scheduled assessment is not used for payment purposes.

ARD Compliance

Effective April 1, 2012:

- Facilities are permitted to set the ARD of an unscheduled PPS assessment NO MORE THAN 2 DAYS after the ARD window has passed
  - If not set and patient is still in facility covered by Med A, late days billed as default
  - If discharged or otherwise not covered by Med A, assessment CANNOT be completed and days are provider-liable
Medicare Short Stay Assessment

- To be considered a Medicare Short Stay assessment
  - Resident discharged from Part A on or before day 8 of the Part A stay
  - Completed only 1 to 4 days of therapy
  - Therapy must start during the last 4 days of the Part A stay
  - Eight conditions must be met

1. The assessment must be a Start of Therapy OMRA
   - Completed alone or combined with any OBRA assessment, 5-day or readmission/return assessment
   - Start of Therapy OMRA may not be combined with a PPS 14-, 30-, 60- or 90-day assessment
   - Combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility
2. PPS 5-day or readmission/return assessment has been completed
3. ARD must be on or before the 8th day of the Part A Medicare covered stay
Medicare Short Stay Assessment

4. ARD of the Start of Therapy OMRA must be the last covered Medicare Part A day
5. The ARD of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date
6. Therapy services started during last 4 days of the Medicare Part A covered stay (including weekends)

Medicare Short Stay Assessment

7. At least one therapy discipline continued through the last day of the Medicare Part A covered stay
   ▪ One therapy must have dashes in end of therapy date (Section O) indicating ongoing therapy; or
   ▪ End of therapy date equal to end of covered Medicare stay date
8. The RUG group assigned must be Rehabilitation Plus Extensive Services or a Rehabilitation group
Medicare Short Stay Assessment

- RUG category calculated using
  - Actual minutes
  - Date therapy starts
  - Date of admit
  - ADL score
  - ARD

- Avg. daily minutes = 15-29: Low (RLx)
- Avg. daily minutes = 30-64: Medium (RMx)
- Avg. daily minutes = 65-99: High (RHx)
- Avg. daily minutes = 100-143: Very High (RVx)
- Avg. daily minutes = 144+: Ultra High (RUx)
Medicare Short Stay Assessment

- Earliest start of therapy date is 1st day of the short stay:
  - Use Short Stay assessment RUG from the beginning of the short stay through the end of the stay

- Earliest start of therapy date is after 1st day of the short stay:
  - If a 5-day or readmission/return assessment was completed, use that RUG for the first day of the short stay through the day before therapy started; then use Short Stay RUG from the day therapy started through the end of the short stay; or
  - If Start of Therapy OMRA is combined with a 5-day or readmission/return assessment, use non-therapy RUG for the first day of the short stay through the day before therapy started; then use therapy RUG from the day therapy started through the end of the short stay
Medicare Short Stay Assessment

- Therapy RUG for days on which therapy was received
- Non-therapy RUG for days on which no therapy was delivered

Facts Regarding MDS Completion

- Day of admission = day 1
- Therapy may only count treatment since admission to SNF
  - Nursing may code pre-admission conditions for care planning purposes
- Evaluation minutes **DO NOT** count toward MDS minutes
- Grace days are expected
- The 5 and 14-Day assessment periods can overlap
Resident Admitted to Acute Facility and Returns

- Admitted and returns later
  - Medicare assessment schedule restarted
- Out of facility over a midnight, but < 24 hours and not admitted
  - Medicare assessment schedule not restarted
  - Known as the “midnight rule”
  - Day preceding midnight not a covered/payable Part A day

LOA or “Skip” Days

- Medicare assessment schedule is adjusted to exclude the LOA
  - Resident leaves a SNF at 6:00 PM on Wednesday (Day 27) and returns Thursday (Day 28) at 9:00 AM
  - Wednesday is non-billable
  - Thursday becomes Day 27
  - Choose Thursday as the ARD
    - Wednesday is no longer a billable Part A day
LOA or “Skip” Days

- For unscheduled assessments, ARD is not affected by the LOA
- EOT OMRA is performed if resident receives no therapy for 3 consecutive days, which may include LOA days
  - Resident misses therapy Monday & Tuesday, goes to ER Wednesday, returns Thursday
  - EOT OMRA is required
  - EOT OMRA controls payment for Medicare-billable days

LOA or “Skip” Days

- Day 7 of COT observation period is 7 days after last ARD, regardless of LOA
  - ARD for 30 Day assessment 11/7
  - Resident in ER 11/9, returning 11/10
  - COT observation period ends 11/14
    - COT OMRA sets payment for Medicare billable days beginning Day 1 of COT observation period
- Therapy minutes delivered on a “skip” day are counted
Coding Therapy

- Code only medically necessary therapies occurring after admission/readmission
  - Ordered by a physician (physician’s assistant, nurse practitioner, and/or clinical nurse specialist) based on an assessment and treatment plan
  - Documented in the resident’s medical record
  - Care planned and periodically evaluated
Modes of Therapy

Individual Therapy

- The treatment of one resident at a time
- The resident receives the therapist’s full attention
- Treatment individually at intermittent times during the day is individual treatment and is added for the daily count

Coding Instructions

- Individual minutes
  - Enter the total number of minutes of therapy provided on an individual basis in the last 7 days
  - Individual services are provided by one therapist or assistant to one resident at a time
Modes of Therapy
Concurrent Therapy

- Medicare Part A
  - The treatment of 2 residents at the same time both of whom must be in line-of-sight of the treating therapist
- Medicare Part B
  - The treatment of two or more residents at the same time is documented as group treatment

Coding Instructions

- Concurrent minutes
  - Enter the total number of minutes of therapy provided on a concurrent basis in the last 7 days
  - Concurrent therapy is the treatment of 2 residents at the same time, when they are performing different activities, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A
  - For Part B, residents may not be treated concurrently; a therapist may treat one resident at a time
Concurrent Therapy

- Minute Allocation
  - Report total unallocated concurrent therapy minutes on the MDS 3.0
  - Concurrent therapy minutes will be allocated (divided by two)

Modes of Therapy

Group Therapy

- Definition
  - Structured, planned treatment
  - Four individuals (regardless of payer source)
  - Same or similar activities
  - Single therapist (assistant)
Coding Instructions

- Group minutes
  - Enter total group minutes provided in last 7 days
- Group therapy for Part A
  - Treatment of 4 residents
  - Performing same or similar activities
  - Supervised by a therapist or an assistant
  - Group minutes cannot exceed 25% of the discipline-specific total; applied to allocated minutes
- For Medicare Part B
  - Treatment of two patients at the same time is documented as group treatment

Group Therapy

- Minute Allocation
  - Report total unallocated group therapy minutes on the MDS 3.0
  - Group therapy minutes will be allocated (divided by four)
Modes of Therapy

Group Therapy

What happens if one of the participants gets sick or refuses to come to therapy?

As long as the facility had originally planned the session for four participants, then the group session can still be counted for the other group members.

Note: The minutes in this case are still divided by four for each remaining participant.

Coding Instructions

- Days
  - Enter the number of days therapy services were provided in the last 7 days
  - A day of therapy is defined as treatment for 15 minutes or more during the day

- Therapy Start/End Date
  - Enter dashes if therapy is ongoing
  - Enter last day of treatment for EOT OMRA
Coding Tips

- Do NOT include therapies provided at the hospital or another LTC facility
- In the case of readmission, only therapies since readmission may be counted
- Time spent on documentation or on initial evaluation are not counted

Coding Tips

- Reevaluations conducted as part of treatment should be counted
- Treatment time starts with the first treatment activity and ends when the intervention is ended, as long as the services were not interrupted
- Adjusting equipment/preparing for therapy is set-up time and included
- Record only the actual minutes of therapy
- Do not round minutes
Non-Skilled Services

- Services provided upon request that are not medically necessary
- Repetitive exercises or maintenance treatments provided by a therapist
- Services provided once a maintenance program is established and resident is discharged
- Services provided by aides

Co-Treatment

- When two clinicians from different disciplines treat a resident at the same time
- Both disciplines may code the treatment session in full
- Case by case basis; documentation must justify use
Co-Treatment

- Not every patient will receive this mode
- Documentation must support reason for co-treatment
- Goals and session focus for each therapist are different
- CPT codes billed for the session would be different

Revised Student Provisions

- Line-of-sight supervision not required
  - However use best clinical judgement
- Follow state practice act if more strict
- No change to manner of recording minutes
- Student’s time not separately reimbursable
Billing for Students
Individual Therapy

- When a therapy student is involved with the treatment of a resident the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant
- The supervising therapist/assistant shall not be engaged in any other activity or treatment

Billing for Students
Concurrent Therapy

- Medicare Part A
- When a therapy student is involved with treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:
  - Student is treating one resident and the supervising therapist/assistant is treating another resident; or
  - Student is treating 2 residents; or
  - Student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time.
Billing for Students
Group Therapy

- Medicare Part A
- When a student is involved with group therapy, and one of the following occurs, the minutes may be coded as group therapy:
  - Student is providing the group treatment and the supervising therapist/assistant is not supervising other individuals; or
  - Supervising therapist/assistant is providing group treatment and the student is not providing any treatment.

Supervision of Aides

- Therapy Aides cannot provide skilled services
- Only the time a therapy aide spends on set-up for skilled services preceding individual therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy)
- The therapy aide must be under direct supervision of the therapist or assistant
Group Therapy Threshold

- Total minutes spent in group CANNOT exceed 25% of the discipline-specific total
  - Cap applied to allocated group minutes
  - Exceeding this threshold will create a minute adjustment on the MDS

Adjusted Group Minutes

- If group percentage is greater than 25%, then adjusted minutes are calculated by:
  - Adding all individual minutes
  - ½ of the concurrent minutes
  - Multiply the sum by 4.0
  - Then divide by 3.0
CMS Final Rule: PDPM

“One cannot be prepared for something while secretly believing it will not happen.”

- Nelson Mandela
Overview

- CMS released a Final Rule [CMS-1696-F] on July 31, 2018
- Finalizes the Patient-Driven Payment Model (PDPM) to replace the current RUG-based system
- Implementation date October 1, 2019
- PDPM is revised from RCS-1 and the Proposed Rule based on stakeholder feedback

Overview

- Bifurcate the “nursing case-mix” component
  - Nursing component
  - Non-Therapy Ancillary
- Separate the “therapy case-mix” component
  - Physical Therapy component
  - Occupational Therapy component
  - Speech-Language Pathology component
- Separate rates for urban and for rural facilities
- No proposed change to the non-case-mix component
Making Sense of It

- Not a change of benefits – PDPM is a new revenue delivery system
- Shift from volume to a patient characteristic model
- Budget neutral
  - Goal is to compensate SNFs accurately based on the complexity of beneficiary and resources necessary to care for them
- Reducing administrative burden
- No change to Medicare eligibility for skilled care

As Per CMS …

“PDPM is not intended to affect any of the Medicare and Medicaid Conditions of Participation for SNFs. Facilities should continue to follow these regulations as they always have. Additionally, even though under PDPM, the majority of PPS assessments will now be removed, all OBRA assessments will still be required. PDPM will not affect the OBRA requirements.”
<table>
<thead>
<tr>
<th>RUG-IV</th>
<th>PDPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three rate components</td>
<td>Three rate components, plus three variable</td>
</tr>
<tr>
<td></td>
<td>rate components</td>
</tr>
<tr>
<td>Four late-loss ADLs from Section G</td>
<td>Mid-loss and late-loss ADLs from Section</td>
</tr>
<tr>
<td>impact RUG</td>
<td>GG impact case-mix</td>
</tr>
<tr>
<td>Patient active diagnoses impacts one of</td>
<td>Primary clinical reason for the stay</td>
</tr>
<tr>
<td>three components</td>
<td>impacts two of five components</td>
</tr>
<tr>
<td>One level of NTA payment</td>
<td>Six levels of NTA payment</td>
</tr>
<tr>
<td>Intensity of therapy impacts RUG level</td>
<td>Therapy intensity is not a factor</td>
</tr>
<tr>
<td>Six required plus four unscheduled</td>
<td>Two required, plus one ‘optional’ unscheduled</td>
</tr>
<tr>
<td>assessments</td>
<td>assessment</td>
</tr>
<tr>
<td>66 payment categories</td>
<td>~28,800 categories</td>
</tr>
</tbody>
</table>

Calculating the Rates

- PT, OT, and SLP costs correspond to:
  - 43.4 percent, 40.4 percent, and 16.2 percent of the therapy component of the federal per diem rate for urban SNFs
  - 42.9 percent, 39.4 percent, and 17.7 percent of the therapy component of the federal per diem rate for rural SNFs
Calculating the Rates

- NTA costs comprise 43.4 percent of the current nursing component of the urban federal base rate, and the remaining 56.6 percent accounts for nursing and social services salary costs.

- These percentages for the nursing component of the federal base rate for rural facilities are 42.7 percent and 57.3 percent, respectively.
Calculating the Rates

### FY 2020 PDPM Unadjusted Federal Rate Per Diem--Urban

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
<th>Non-Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$103.46</td>
<td>$78.05</td>
<td>$59.33</td>
<td>$55.23</td>
<td>$22.15</td>
<td>$92.63</td>
</tr>
</tbody>
</table>

### FY 2020 PDPM Unadjusted Federal Rate Per Diem--Rural

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
<th>Non-Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$98.83</td>
<td>$74.56</td>
<td>$67.63</td>
<td>$62.11</td>
<td>$27.90</td>
<td>$94.34</td>
</tr>
</tbody>
</table>

PT/OT Component

- 16 case-mix groups
- Variable per diem adjustment factors involved in CMI calculation
- Factors predictive of PT/OT costs include:
  - Clinical reasons for the SNF stay
  - Resident’s functional status
  - Cognitive score is not a factor of classification
Clinical Reason for the SNF Stay

- Determined based upon ICD-10 on first line in item I8000
- Providers will not record surgical procedures but instead select a surgical procedure category in J2000

As Per CMS …

“For proper classification and payment under PDPM, facilities will only be required to record the primary reason for SNF care at the time of SNF admission and record the associated ICD-10-CM code and procedural information.

PDPM requires facilities to code the diagnosis that corresponds most closely to the primary reason for SNF care rather than the primary reason for the prior hospitalization.

Facilities currently must assess beneficiaries’ health status and reason for SNF care at admission in order to treat them appropriately and formulate a patient-centered care plan.”
### Clinical Reason for SNF Stay

<table>
<thead>
<tr>
<th>PDPM Clinical Category</th>
<th>Collapsed PT and OT Clinical Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>Major Joint Replacement or Spinal Surgery</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery</td>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
</tr>
<tr>
<td>Acute Neurologic</td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Orthopedic/Musculoskeletal</td>
<td>Other Orthopedic</td>
</tr>
<tr>
<td>Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)</td>
<td></td>
</tr>
<tr>
<td>Medical Management</td>
<td>Medical Management</td>
</tr>
<tr>
<td>Acute Infections</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular and Coagulations</td>
<td></td>
</tr>
</tbody>
</table>
**PT/OT Component Function**

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set-up assistance, Independent</td>
<td>4</td>
</tr>
<tr>
<td>Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>Partial/moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>Substantial/maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>Dependent, Refused, N/A, Not Attempted</td>
<td>0</td>
</tr>
</tbody>
</table>
PT/OT Component Function

PT and OT Function Score Construction for Walking Items

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06: Set-up assistance, Independent</td>
<td>4</td>
</tr>
<tr>
<td>04: Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03: Partial/moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02: Substantial/maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>01, 07, 09, 88, 10: Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*</td>
<td>0</td>
</tr>
</tbody>
</table>

PT/OT Component Function

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self-Care: Eating</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0130B1 Self-Care: Oral Hygiene</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0130C1 Self-Care: Toileting Hygiene</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0170B1 Mobility: Sit to Lying</td>
<td>0-4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170C1 Mobility: Lying to sitting on side of bed</td>
<td>0-4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170D1 Mobility: Sit to Stand</td>
<td>0-4 (average of 3 items)</td>
</tr>
<tr>
<td>GG0170E1 Mobility: Chair/bed-to-chair transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170F1 Mobility: Toilet transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170I1 Mobility: Walk 10 feet</td>
<td>N/A</td>
</tr>
<tr>
<td>GG0170J1 Mobility: Walk 50 feet with 2 turns</td>
<td>0-4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170K1 Mobility: Walk 150 feet</td>
<td></td>
</tr>
</tbody>
</table>
### PT and OT Case-Mix Classification Groups

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Section GG Function Score</th>
<th>PT/OT Case-Mix Group</th>
<th>PT CMI</th>
<th>OT CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>0-5</td>
<td>TA</td>
<td>1.53</td>
<td>1.49</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>6-9</td>
<td>TB</td>
<td>1.69</td>
<td>1.63</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>10-23</td>
<td>TC</td>
<td>1.88</td>
<td>1.68</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>24</td>
<td>TD</td>
<td>1.92</td>
<td>1.53</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>0-5</td>
<td>TE</td>
<td>1.42</td>
<td>1.41</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>6-9</td>
<td>TF</td>
<td>1.61</td>
<td>1.59</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>10-23</td>
<td>TG</td>
<td>1.67</td>
<td>1.64</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>24</td>
<td>TH</td>
<td>1.16</td>
<td>1.15</td>
</tr>
<tr>
<td>Medical Management</td>
<td>0-5</td>
<td>TI</td>
<td>1.13</td>
<td>1.17</td>
</tr>
<tr>
<td>Medical Management</td>
<td>6-9</td>
<td>TJ</td>
<td>1.42</td>
<td>1.44</td>
</tr>
<tr>
<td>Medical Management</td>
<td>10-23</td>
<td>TK</td>
<td>1.52</td>
<td>1.54</td>
</tr>
<tr>
<td>Medical Management</td>
<td>24</td>
<td>TL</td>
<td>1.09</td>
<td>1.11</td>
</tr>
<tr>
<td>Non-Orthopedic/Acute Neurologic</td>
<td>0-5</td>
<td>TM</td>
<td>1.27</td>
<td>1.30</td>
</tr>
<tr>
<td>Non-Orthopedic/Acute Neurologic</td>
<td>6-9</td>
<td>TN</td>
<td>1.48</td>
<td>1.49</td>
</tr>
<tr>
<td>Non-Orthopedic/Acute Neurologic</td>
<td>10-23</td>
<td>TO</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td>Non-Orthopedic/Acute Neurologic</td>
<td>24</td>
<td>TP</td>
<td>1.08</td>
<td>1.09</td>
</tr>
</tbody>
</table>

### SLP Component

- 12 case-mix groups
- No variable per diem adjustment factor
- Factors predictive of SLP costs include:
  - Clinical reasons for the SNF stay
  - Presence of a swallowing disorder or mechanically-altered diet
  - Presence of an SLP-related comorbidity or cognitive impairment
Clinical Reason for the SNF Stay

- Residents are first categorized into one of two groups on first line of Item I8000 on the MDS assessment
  - Acute Neurologic clinical category
  - Non-Neurologic group

Cognition

<table>
<thead>
<tr>
<th>Cognitive Level -- BIMS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0200: Repetition of Three Words</td>
</tr>
<tr>
<td>C0300: Temporal Orientation Three Questions</td>
</tr>
<tr>
<td>C0400: Recall Three Questions</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
Cognitive Level -- CPS Score

<table>
<thead>
<tr>
<th>Impairment Count (number of the following)</th>
<th>Cognitive Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making Not independent (1, 2, 3)</td>
<td>Cognitive Intact</td>
</tr>
<tr>
<td>Understood Not independent (1, 2, 3, 4)</td>
<td>Mildly Impaired</td>
</tr>
<tr>
<td>Short term Not ok (1)</td>
<td>Moderately Impaired</td>
</tr>
</tbody>
</table>

Severe Impairment Count (number of the following)

<table>
<thead>
<tr>
<th>Impairment Count (number of the following)</th>
<th>Cognitive Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making Not independent (1, 2, 3)</td>
<td>Cognitive Intact</td>
</tr>
<tr>
<td>Understood Not independent (1, 2, 3, 4)</td>
<td>Mildly Impaired</td>
</tr>
</tbody>
</table>

MDS Items:
B0100  C1000  B0700  C0700  C1000

Morris, Fries, Mehr, Hawes, Philips, Mor, & Lipsitz (1994)

Cognition

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS Score</th>
<th>CPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Intact</td>
<td>13-15</td>
<td>0</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>8-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0-7</td>
<td>3-4</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>--</td>
<td>5-6</td>
</tr>
</tbody>
</table>
SLP-Related Comorbidities

<table>
<thead>
<tr>
<th>Aphasia</th>
<th>Laryngeal Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVA, TIA, or Stroke</td>
<td>Apraxia</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>TBI</td>
<td>ALS</td>
</tr>
<tr>
<td>Tracheostomy Care (While a Resident)</td>
<td>Oral Cancers</td>
</tr>
<tr>
<td>Ventilator or Respirator (While a Resident)</td>
<td>Speech and Language Deficits</td>
</tr>
</tbody>
</table>

SLP Component

- Combine clinical category, cognitive impairment, and presence of an SLP-related comorbidity into a single predictor
- When either a swallowing disorder or mechanically-altered diet is present, resident SLP costs increased
- Increase even more when both are present
### SLP Case-Mix Classification Groups

<table>
<thead>
<tr>
<th>Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment</th>
<th>Mechanically Altered Diet or Swallowing Disorder</th>
<th>SLP Case-Mix Group</th>
<th>SLP CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Neither</td>
<td>SA</td>
<td>0.68</td>
</tr>
<tr>
<td>None</td>
<td>Either</td>
<td>SB</td>
<td>1.82</td>
</tr>
<tr>
<td>None</td>
<td>Both</td>
<td>SC</td>
<td>2.66</td>
</tr>
<tr>
<td>Any one</td>
<td>Neither</td>
<td>SD</td>
<td>1.46</td>
</tr>
<tr>
<td>Any one</td>
<td>Either</td>
<td>SE</td>
<td>2.33</td>
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<tr>
<td>Any one</td>
<td>Both</td>
<td>SF</td>
<td>2.97</td>
</tr>
<tr>
<td>Any two</td>
<td>Neither</td>
<td>SG</td>
<td>2.04</td>
</tr>
<tr>
<td>Any two</td>
<td>Either</td>
<td>SH</td>
<td>2.85</td>
</tr>
<tr>
<td>Any two</td>
<td>Both</td>
<td>SI</td>
<td>3.51</td>
</tr>
<tr>
<td>All three</td>
<td>Neither</td>
<td>SJ</td>
<td>2.98</td>
</tr>
<tr>
<td>All three</td>
<td>Either</td>
<td>SK</td>
<td>3.69</td>
</tr>
<tr>
<td>All three</td>
<td>Both</td>
<td>SL</td>
<td>4.19</td>
</tr>
</tbody>
</table>

---

**As Per CMS ...**

"With regard to the comment about the SLP component base rate, we utilized the proportion of the current therapy base rate corresponding to each therapy discipline as the basis for allocating the therapy base rate as the basis for allocating the therapy base rate among each of the individual components. As SLP services represented approximately 17 percent, on average, of overall therapy costs, we believed it was appropriate to allocate this percentage as the base rate for the SLP component.

While the base rate for the SLP component is lower than the other therapy component base rates, the case-mix weights for this component are far greater for the SLP component than for either of the PT or OT components. This reflects that when SLP services are predicted to be necessary, there is adequate reimbursement for these services."
As Per CMS …

“With respect to the concerns raised by commenters with regard to the potential impact of PDPM on patient care, specifically the possibility that some providers may stint on care or provide fewer services to patients, we plan to monitor closely service utilization, payment, and quality trends which may change as a result of implementing PDPM. If changes in practice and/or coding patterns arise, then we may take further action, which may include administrative action against providers as appropriate and/or proposing changes in policy (for example, system recalibration, rebasing case-mix weights, case mix creep adjustment) to address any concerns. We will also continue to work with the HHS Office of Inspector General, should any specific provider behavior be identified which may justify a referral for additional action.

Nursing

- Nursing categories based on function

- Reduce the number of nursing case-mix groups from 43 to 25

- The nursing ADL score incorporates section GG items

- Residents classified into one and only one of these 25 nursing case-mix groups
### Nursing Component Function

#### Nursing Function Score Construction

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06 Set-up assistance, Independent</td>
<td>4</td>
</tr>
<tr>
<td>04 Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03 Partial/moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02 Substantial/maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>01, 07, 09, 88, 10 Dependent, Refused, N/A, Not Attempted</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Section GG Item

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self-Care: Eating</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0130C1 Self-Care: Toileting Hygiene</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0170B1 Mobility: Sit to Lying</td>
<td>0-4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170C1 Mobility: Lying to sitting on side of bed</td>
<td>0-4</td>
</tr>
<tr>
<td>GG0170D1 Mobility: Sit to Stand</td>
<td>0-4 (average of 3 items)</td>
</tr>
<tr>
<td>GG0170E1 Mobility: Chair/bed-to-chair transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170F1 Mobility: Toilet transfer</td>
<td></td>
</tr>
</tbody>
</table>
Non-Therapy Ancillary

- Two categories predictive of cost
- Resident comorbidities
- Use of extensive services
- Each comorbidity and service is assigned points based on its relative impact
- Total comorbidity score used to classify the resident into an NTA case-mix group

### NTA

<table>
<thead>
<tr>
<th>NTA Score Range</th>
<th>NTA Case-Mix Group</th>
<th>NTA CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>NA</td>
<td>3.25</td>
</tr>
<tr>
<td>9-11</td>
<td>NB</td>
<td>2.53</td>
</tr>
<tr>
<td>6-8</td>
<td>NC</td>
<td>1.85</td>
</tr>
<tr>
<td>3-5</td>
<td>ND</td>
<td>1.34</td>
</tr>
<tr>
<td>1-2</td>
<td>NE</td>
<td>0.96</td>
</tr>
<tr>
<td>0</td>
<td>NF</td>
<td>0.72</td>
</tr>
</tbody>
</table>
Variable CMI

- Adjustment factor for PT/OT
  - 1.00 for days 1 to 20
  - Payment for PT/OT would decline 2 percent every 7 days after day 20

- Adjustment factor for NTA 3.0 for days 1-3
  - Change to 1.0 beginning day 4 of the stay

- SLP does not include variable CMI

<table>
<thead>
<tr>
<th>Medicare Payment Days</th>
<th>Adjustment Factor</th>
<th>Medicare Payment Days</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>1.00</td>
<td>63-69</td>
<td>0.86</td>
</tr>
<tr>
<td>21-27</td>
<td>0.98</td>
<td>70-76</td>
<td>0.84</td>
</tr>
<tr>
<td>28-34</td>
<td>0.96</td>
<td>77-83</td>
<td>0.82</td>
</tr>
<tr>
<td>35-41</td>
<td>0.94</td>
<td>84-90</td>
<td>0.80</td>
</tr>
<tr>
<td>42-48</td>
<td>0.92</td>
<td>91-97</td>
<td>0.78</td>
</tr>
<tr>
<td>49-55</td>
<td>0.90</td>
<td>98-100</td>
<td>0.76</td>
</tr>
<tr>
<td>56-62</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Variable CMI NTA

<table>
<thead>
<tr>
<th>Medicare Payment Days</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>3.0</td>
</tr>
<tr>
<td>4-100</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Hip Replacement Example

<table>
<thead>
<tr>
<th>FY 2020 PDPM Unadjusted Federal Rate Per Diem--Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate Component</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Case-Mix Group</td>
</tr>
<tr>
<td>Case-Mix Index</td>
</tr>
<tr>
<td>Per Diem Amount</td>
</tr>
<tr>
<td>Subtotal</td>
</tr>
</tbody>
</table>

Total $715.20 Days 1-3
Days 4-20: $565.35
Days 21-27: $561.54
Hip Replacement Example

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
<th>Non-Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case-Mix Group</td>
<td>CDE2</td>
<td>NE</td>
<td>TB</td>
<td>TB</td>
<td>SA</td>
<td></td>
</tr>
<tr>
<td>Case-Mix Index</td>
<td>1.86</td>
<td>0.96</td>
<td>1.69</td>
<td>1.63</td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td>Per Diem Amount</td>
<td>$98.83</td>
<td>$74.56</td>
<td>$67.63</td>
<td>$62.11</td>
<td>$27.90</td>
<td>$94.34</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$183.82</td>
<td>$214.73</td>
<td>$114.29</td>
<td>$101.24</td>
<td>$18.97</td>
<td>$94.34</td>
</tr>
</tbody>
</table>

Total $727.40 Days 1-3
Days 4-20: $584.25
Days 21-27: $579.94

<table>
<thead>
<tr>
<th>Resident A</th>
<th>Resident B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Received?</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy Minutes</td>
<td>730</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>No</td>
</tr>
<tr>
<td>ADL Score</td>
<td>9</td>
</tr>
<tr>
<td>Clinical Category</td>
<td>Acute Neurologic</td>
</tr>
<tr>
<td>PT and OT Function Score</td>
<td>10</td>
</tr>
<tr>
<td>Nursing Function Score</td>
<td>7</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Moderate</td>
</tr>
<tr>
<td>Swallowing Disorder?</td>
<td>No</td>
</tr>
<tr>
<td>Mechanically Altered Diet?</td>
<td>Yes</td>
</tr>
<tr>
<td>SLP Comorbidity?</td>
<td>No</td>
</tr>
<tr>
<td>No Comorbidity Score</td>
<td>7 (IV Medication and DM)</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>Septicemia</td>
</tr>
<tr>
<td>Depression?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

BOTH are RUB @ $616.50/day
### Patient A

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>SCORE</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT Component</td>
<td>TO</td>
<td>$177.57</td>
</tr>
<tr>
<td>(Non-ortho, Acute Neuro, 10-23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP Component</td>
<td>SH</td>
<td>$63.13</td>
</tr>
<tr>
<td>(Any two, Either)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Component</td>
<td>HBC2</td>
<td>$230.72</td>
</tr>
<tr>
<td>(7 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTA Component</td>
<td>NC</td>
<td>$144.39</td>
</tr>
<tr>
<td>(7 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Case Mix</td>
<td></td>
<td>$92.63</td>
</tr>
</tbody>
</table>

**PDPM Composite Per Diem Rate** $704.43 (+$92.93 vs. RUG)

Day 1-3 Rate = $997.22

### Patient B

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>SCORE</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT Component</td>
<td>TC</td>
<td>$204.33</td>
</tr>
<tr>
<td>(MJR, 10-23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP Component</td>
<td>SA</td>
<td>$15.06</td>
</tr>
<tr>
<td>(None, neither)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Component</td>
<td>LBC1</td>
<td>$147.95</td>
</tr>
<tr>
<td>(1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTA Component</td>
<td>NE</td>
<td>$74.93</td>
</tr>
<tr>
<td>(1 point)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Case Mix</td>
<td></td>
<td>$92.63</td>
</tr>
</tbody>
</table>

**PDPM Composite Per Diem Rate** $534.89 (-$81.61 vs. RUG)

Day 1-3 Rate = $684.75
MDS Changes: Interim Payment Assessment

- 5-day SNF PPS scheduled assessment used to classify a resident for the entirety of the Part A stay

- Providers may reclassify residents as appropriate from the initial five day classification using a new assessment called an Interim Payment Assessment (IPA), which is comprised of the five day SNF PPS MDS Item Set (Item Set NP)

MDS Changes: Interim Payment Assessment

- SNFs to determine when IPAs completed for patients to address potential changes in clinical status and what criteria should be used to decide when an IPA is necessary.
- CMS will NOT be finalizing the proposed criteria for triggering of IPA but will seek additional stakeholder input on this issue.
- The ARD will be date facility chooses relative to the triggering event.
- Payment effective date = IPA ARD but will not reset VBPA
- Will not be susceptible to assessment penalties (as it is optional)
As Per CMS …

“We are not finalizing the proposed criteria for the triggering of the IPA, but rather we will seek additional stakeholder input on this issue. Because the IPA will be optional and providers can determine their own criteria for when an IPA is completed, we are revising the ARD criteria we proposed. The ARD for the IPA will be the date the facility chooses to complete the assessment relative to the triggering event that causes a facility to choose to complete the IPA. Payment based on the IPA will begin the same day as the ARD. The IPA will not be susceptible to assessment penalties, given the optional nature of the assessment. We reiterate that we expect facilities to complete IPAs as they deem necessary to address clinical changes throughout a SNF stay and that the removal of the requirement to complete these assessments does not in any way negate the need to provide excellent skilled nursing and rehabilitative care and continually monitor and document patient status.”

Group and Concurrent Therapy

- CMS states that individual therapy is generally best for a resident
- No treatment minimums, but PDPM expects “Reasonable and Necessary care per Chapter 8 of the Medicare Benefit Policy Manual
- Limit concurrent and group therapy to no more than 25% of a resident’s therapy minutes by discipline
MDS Changes: Discharge Assessment

- Discharge assessment completed at the time of facility discharge

- Section O would capture therapy start and end date, total individual minutes, total concurrent minutes, total group minutes, and total days of therapy by discipline

- Non-fatal warning edit on validation report if 25% threshold is exceeded

---

MDS Changes: Interrupted Stay Policy

- When a resident is discharged from a SNF and returns to the same SNF by 12:00am at the end of the third day of the interruption window, the stay will be treated as a continuation of the previous stay

- If absence exceeds 3 days, a new 5-day completed and variable per diem adjustment would reset
MDS Changes: Interrupted Stay Policy

- Example 1: DC from SNF on Day 3 of the stay. Four days after the date of DC, is readmitted to the same SNF.
  - New 5-day assessment; VPDA schedule is reset
- Example 2: DC from SNF on Day 7; readmitted to the same SNF within the 3-day interruption window
  - This is a continuation of the previous stay. NO new 5-day assessment; VPDA schedule continue where it left off
- Example 3: DC from SNF on Day 7; readmitted to a different SNF within the 3-day interruption window
  - SNF would conduct a new 5-day assessment; VPDA resets to Day 1

1. Always reset VPDA to day one when residents are DC’d and readmitted to a different SNF
2. Only reset VPDA to day one when residents are DC’d >3 calendar days and readmitted to the same SNF
3. Always complete 5-day MDS when residents are DC’d and readmitted to a different SNF
4. Only complete 5-day MDS when residents are DC’d >3 calendar days and readmitted to the same SNF**Unless criteria for Interim Payment Assessment are met
MDS Changes: Interrupted Stay Policy

- Readmission after an interrupted stay would not trigger an IPA. If an IPA is warranted, the provider should complete one.
- In cases where a resident is discharged and then readmitted to a SNF in a manner that triggers an interrupted stay, only those therapies that occurred since the readmission would be included in section O of the MDS for each discharge assessment.
- For an interrupted stay, a new therapy evaluation is not needed.
- The beneficiary may be readmitted 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 interrupted stay policy would operate in the same manner for discharges to the community.

MDS Changes: Grace Days

Incorporate the grace days into the existing assessment window

<table>
<thead>
<tr>
<th>Medicare MDS assessment schedule type</th>
<th>Assessment reference date</th>
<th>Applicable standard Medicare payment days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day Scheduled PPS Assessment</td>
<td>Days 1-8</td>
<td>All covered Part A days until Part A discharge (unless an IPA is completed)</td>
</tr>
<tr>
<td>PPS Discharge Assessment</td>
<td>PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Administrative Presumption

Effective October 1, 2019, the following classifiers designated for purposes of the administrative presumption under the PDPM:

- The case-mix classifiers in the following nursing categories: Extensive Services, Special Care High, Special Care Low, and Clinically Complex;
- The following PT and OT groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- The following SLP groups: SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component’s uppermost comorbidity group

Other Payers As Per CMS …

“We believe that the primary reason that Medicaid programs may adopt PDPM is due to its focus on patient characteristics and goals, rather than on service utilization.

We would encourage states that decide to transition to PDPM to ensure they are monitoring the impacts of such a change on their beneficiaries and the care they receive.

In terms of those states that opt not to transition to PDPM and instead use some form of legacy payment system … we are not aware of any difficulties or complexities for providers or states in managing these systems concurrently. These states still have access to MDS data for rate setting purposes and nothing associated with PDPM implementation, in and of itself, would affect state access to MDS data.

We acknowledge that some Medicare Advantage plans could change their payment models to mirror PDPM, while others may not change their payment models in relation to the changes finalized in this rule.”
Transitioning to PDPM

- Providers would bill under RUG-IV for all days up to and including September 30, 2019 and then bill under PDPM for all days beginning October 1, 2019.

- Beginning on October 1, 2019, all PDPM related assessment scheduling and other PDPM payment-related policies would take effect.

Thank you!

Kathleen Weissberg, OTD, OTR/L