PDPM GUIDE

The Ultimate Guide
to **PDPM Reimbursement**

Leveraging Your Pharmacy Partner

by **PharMerica**

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PDPM Background

PDPM CONSISTS OF FIVE CASE-MIX ADJUSTED COMPONENTS:

- *Physical Therapy*
- *Occupational Therapy*
- *Speech Language Pathology*
- *Nursing*
- *Non-Therapy Ancillary*

THE PATIENT DRIVEN PAYMENT MODEL (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System.

Effective October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV), which classifies most residents into a rehabilitative therapy payment group that uses primarily the volume of therapy services provided to the patient as the basis for payment classification.

There is no transition period between RUG-IV and the PDPM. RUG-IV billing ends September 30, 2019, and PDPM billing begins October 1, 2019.

PDPM will eliminate the incentive for SNF providers to furnish therapy to SNF patients regardless of the patient's unique characteristics, goals, or needs. Instead, it will improve the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing the administrative burden on SNF providers.

FIGURE 1

Per diem payment "budget neutral" to CMS	Therapy minutes no longer primary driver of reimbursement	Individual patient characteristics drive reimbursement	Group and concurrent therapy modalities capped at 25% per stay	Timing and accuracy of MDS coding is crucial to avoid financial risk

"By addressing each individual patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model." - CMS

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Impact on Rates

FIGURE 2

PT	PT Base Rate	x	PT CMI	x	VPD Adjustment Factor	Starting Day 21 and every 7 days after, decreases by 2%
+						
OT	OT Base Rate	x	OT CMI	x	VPD Adjustment Factor	
+						
SLP	SLP Base Rate	x	SLP CMI			
+						
NTA	NTA Base Rate	x	NTA CMI	x	VPD Adjustment Factor	Drops by 2/3 on Day 4
+						
Nursing	Nursing Base Rate	x	Nursing CMI	x	18% Nursing Adjustment Factor *(Only for patients with AIDS)*	
+						
Non-Case Mix	Non-Case Mix Base Rate					

VPD = Variable Per Diem
CMI = Case-Mix Index

PAYMENTS	CMS
RUG-IV Therapy	$10,215,917,477.00
PDPM Therapy	$9,713,570,838.80
	($502,346,638.20)
RUG-IV Nursing	$12,004,944,797.00
PDPM Nursing	$7,139,525,547.60
	($4,865,419,249.40)
PDPM NTA	$5,385,380,717.90
RUG-IV Non-Case-Mix	$4,440,666,180.40
PDPM Non-Case-Mix	$4,423,051,351.30
	($17,614,829.10)
RUG-IV Total Payments	$26,661,528,455.00
PDPM Total Payments	$26,661,528,456.00
	$1.00

While RUG-IV reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM focuses on the unique, individualized needs, characteristics, and goals of each patient.

The PDPM is intended to be budget neutral, however, many facilities that thrived under the RUG-IV system may be impacted by reimbursement declines under the PDPM because of the tapering of the therapy rates and shift toward care that treats the whole patient. To illustrate the effect of the new model, CMS developed a payment comparison that highlights the difference between RUG-IV and the PDPM.

Facilities can review an impact analysis to understand the estimated effect of the PDPM based on provider and resident data for fiscal year 2017 that represents estimated payments under the PDPM under the

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heading "SNF PDPM Provider-Specific Impact File" at the following website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Since one of the biggest rate drivers under the PDPM is the catch-all non-therapy ancillary (NTA) services component, facilities need to understand the services – including those that they already provide but have not documented in the past – that should be captured on the five-day Minimum Data Set (MDS). Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000. A mapping between ICD-10-CM codes and NTA comorbidities used for NTA classification is available on CMS's PDPM webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

For non-therapy ancillary services, points are allocated to a resident's conditions, which are then factored in to a resident's total score. Recording these services accurately and in a timely manner is essential to maximizing payments under the PDPM since just a few missed points could lose a facility hundreds of dollars a day. And remember that the first three days of the non-therapy ancillary services are three times the rate.

CONDITIONS AND EXTENSIVE SERVICES USED FOR NTA CLASSIFICATION

CONDITIONS / EXTENSIVE SERVICE	SOURCE	POINTS
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV Feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status – Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis – Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1

Continued...

CONDITIONS / EXTENSIVE SERVICE	SOURCE	POINTS
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatment/Programs: Isolations Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer: Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code –Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatment/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy – Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity – Except RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

To account more accurately for the variability in patient costs over the course of a stay, under the PDPM, an adjustment factor is applied (for certain components) and changes the per diem rate over the course of the stay. For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay.

Leah Klusch, *RN, BSN, FACHCA, Founder and Director of The Alliance Training Center*

MDS and the PDPM:

5 Questions with Leah Klusch, RN, BSN, FACHCA

Both RUG-IV and the PDPM utilize the MDS 3.0 as the basis for patient assessment and classification.

Q1. Does the new coding system include a focus on pharmacy?

A. Yes. One of the big issues is that the system was therapy driven previously and will change to be clinical indicator driven. And diagnostic codes related to many common diseases and conditions that we're treating mostly with medications can drive higher payments. The consultant pharmacists are aware of which diagnostic categories CMS has isolated that could trigger nursing payment levels. Using all of these nursing qualifiers as a start, the consultant pharmacists look at the entire picture of a resident and what in particular they're being treated for. A lot of times, a medication is ordered but there isn't a diagnosis code with it because someone may have missed that there's a comorbidity.

Q2. What additional clinical knowledge does the MDS coordinator need under the PDPM?

A. In most cases, the MDS coordinator is not filling out the whole form but is simply managing the data collection process from all team members in the first seven days. And one of the biggest issues with the PDPM is that there are deficiencies in the knowledge base at many facilities, especially smaller and rural ones, that will affect the operational success of a building. If a facility is not in tune to the changes, and the codes aren't in one rich MDS document, there will be consequences because in 70 percent of the cases, the rate will stay calculated the way it originally is until discharge unless the resident experiences a remarkable change in condition. We are moving to a totally new system that doesn't have any parallels to the old one in any way so everyone has to work together to get up to speed since the completion of the MDS is an interdisciplinary process.

Q3. With the MDS more influential than ever for reimbursements, why is accuracy so critical?

A. Right now, the accuracy of the MDS database is only moderate and, in some areas of the country, poor. And that is not adequate because accuracy is assumed in the regulatory process, meaning that all of the information in the MDS has to be accurate to the directions in the manual that is in force at the time. The team's understanding the specifics of what's on the MDS, what the definitions are and what can be coded is imperative. Accuracy is also critical to get the maximum advantage; you can increase rates $125 a day just by coding a few things on the list of non-therapy ancillary items that are not subject to a gradual payment reduction after 20 days, so you have to make sure the coding reflects the accurate condition of the patient.

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Q4. Why is a deeper dialogue between the SNF provider and pharmacy required under this new model?

A. During the first week of a resident's stay, communication and follow up from the consultant pharmacist is critical so facilities have to work on how to enrich information flow in that time period. One area in particular where consultant pharmacists can add tremendous value is in building sensitivity around clinical conditions that require pharmacy intervention with the Director of Nursing, Case Manager and Unit Manager when people are first admitted. At admission, when the pharmacist receives the first set of orders, what do they see and how do they communicate that in the first week? For example, maybe a consultant pharmacists sees a medication and needs to have a meeting to ask if there's a diagnosis or a reason why the resident is taking the medicine since we need to have a diagnosis for every medication we're giving.

Q5. Once a resident is classified into a clinical category, how can a consultant pharmacist help protect against negative revenue implications?

A. The most important thing is understanding that high-cost medications that can be coded in non-therapy ancillary have three times the rate for the first three days of the stay – and that's not the first 72 hours. That means facilities often just have hours to gather the information since those are the only three days that will affect the rate. This payment system itself can be a risk to the facility; it needs to be able to get that medication with the three-day payment limit on it then re-evaluate whether to continue it at a lower payment rate or if there is an alternative that can be used. There will be many issues with payment if everything isn't coded right in those first three days so it is critical facilities involve the consultant pharmacist and correctly handle information when a person is first admitted by having a step-by-step process and communication system in place.

The Role of Pharmacy

MEDICARE MDS ASSESSMENT SCHEDULE TYPE	ASSESSMENT REFERENCE DATE	APPLICABLE STANDARD MEDICARE PAYMENT DAYS
Five-day Scheduled PPS Assessment	Days 1 – 8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

ARD = Assessment Reference Date
PPS = Prospective Payment System
RAI = Resident Assessment Instrument
CAA = Care Area Assessment

F636 The facility must conduct – initially and periodically – a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

F639 A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

F641 The assessment must accurately reflect the resident's status.

Under federal regulations, facilities must perform a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. In addition to cognitive, physical, and psychological understanding, medications must also be included in this review.

Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines, and the CAAs) to assess each resident. The MDS, under F641, needs to accurately reflect the resident's status at the time of assessment. To complete this step, a facility is expected to use resident observation and communication as well as a variety of other sources, including communication with licensed and non-licensed staff members and the resident's physician, representative, or family members.

Under PDPM, there are fewer scheduled MDS assessments but they are now more robust. The five-day scheduled PPS assessment must be performed on days 1 – 8; a facility risks reduced payments if coding is not performed timely and accurately with the involvement of a multi-disciplinary care team.

FIGURE 3

HOSPITAL DISCHARGES

- Request thorough discharge information
- Become familiar with surgery information

SNF ADMITS

- Timely and proper documentation of diagnoses by SNF clinician(s)
- MDS staff codes based on MDS items and ICD-10 codes

PAYMENT CLASSIFICATION

- Coded items drive case-mix Index scores for each component
- Drivers for each component differ based on individual patient characteristics

Ensuring the MDS coding accuracy can be a challenging process and requires time and effort by knowledgeable team members to completely capture all of the conditions that should be included in a resident's case-mix designation initially. Not only does this process require a bit of investigation when evaluating residents, it is also helpful to keep a list of common NTA codes on hand. In this initial stage, the expertise of the consultant pharmacists and their role in documentation is significant and includes an enhanced admission MRR process to help identify potential missed diagnoses.

THREE MEDICARE MDS ASSESSMENT TYPES UNDER THE PDPM

- *Five-day Scheduled PPS Assessment*
- *Interim Payment Assessment (Optional)*
- *PPS Discharge Assessment*

A consultant pharmacist also has the requisite knowledge and experience to assist with the clinically complex residents which facilities will be rewarded for taking in and serving under the PDPM. With an increased focus on appropriate services for these residents, and medications being essential treatments for many of their conditions, pharmacists are invaluable to managing drug therapy, outcomes, and costs to allow facilities to profit in this new reimbursement environment.

"Many MDS nurses or members of the interdisciplinary team coding the MDS do not have current manuals, adequate updated training, and efficient hardware and software, which has a significant impact on data accuracy and operational success."

– Leah Klusch, Founder and Director of TATCI

PharMerica Resources

PHARMERICA HAS BEEN PREPARING for the impending reimbursement model change since it was announced and offers a range of products and services to support clients through the transition to PDPM and beyond to help optimize revenue.

CLINICAL EXPERTISE

With 32 percent of facilities lacking confidence in the preparedness of their clinical teams for the PDPM, according to one survey, PharMerica can serve as a central member of a facility's care team to assess and manage medically complex patients.

CONSULTANT PHARMACISTS

PharMerica's consultant pharmacists act as an integral part of a facility's own interdisciplinary team by contributing their expertise in geriatric clinical pharmacy. PharMerica has over 200 clinical pharmacists throughout the country who make monthly visits to facilities. These consultant pharmacists perform patient-specific medication regimen reviews utilizing the RxPertise software platform to generate recommendations to enhance the overall therapeutic outcome for each resident, mitigate the risk of re-hospitalization, and ensure compliance with regulations. Our consultant pharmacists also serve as your pharmacy best-practice expert, educating your staff with current medication and disease-state management information and consultation to prepare your staff for survey.

PDPM Application: Under the PDPM, MDS coding will require more accuracy and clinical judgment at admission since once the patient has been assessed, payment is set in motion and will be difficult to change. Since accurately recording residents' diagnoses and specific medical issues is vital for proper compensation, our consultant pharmacists can play a key role in identifying the correct patient-centered care that will reward providers as well as in optimizing medication therapy for medically complex patients. Our PDPM-specific services include:

- Evaluation of new admissions to understand the list of current medications and conditions.
- Training on disease-state management, including toolkits for specific conditions that feature in-services, assessment worksheets and current care protocols.
- MDS coding education, including in-services.

COST OPTIMIZATION

While much of the focus of the PDPM is on the revenue side, there is much to gain on the expense side by focusing on improved pharmacy cost management. In addition to PharMerica consultant pharmacists who can help optimize medication therapy for medically complex patients, we offer various proven cost containment tools.

QUANTITY LIMIT PROGRAM

PharMerica's Quantity Limit Program lowers cost by setting dispensing limits for specific medications typically used in short-stay conditions or where smaller packaging is available. Creating automatic quantity limits lowers cost by reducing waste and limiting exposure to high-cost medications. Specifically, the program was developed to address:

- **Short-Stay Therapies** – quantity limits for select medications to treat conditions that tend to have shorter length of stays.
- **Hospital Carry-Over Therapies** – quantity limits on select medications to treat conditions in hospitals that could inadvertently get carried over from the hospital stay.
- **Package Size Opportunities** – quantity limits for select medications in pre-packaged containers where a smaller size package is available.
- **Alternative Payor** – quantity limits for medications can be billed to an alternative payor such as Medicare Part B for certain ESRD medications.
- **High-Cost Drug Therapies** – quantity limits for selected high-cost medications, where quantities are reduced to a 3-7 day supply to minimize waste.

PDPM Application: With the current length of stay expected to drop from the current average of 23 days because of the two percent payment penalty for PT and OT starting day 21 and every seven days thereafter, the Quantity Limit Program will reduce facilities' exposure to high-cost medications for these shorter stays that will result from rate tapering.

THERAPEUTIC INTERCHANGE AND GLOBAL AUTHORIZATION

PharMerica's pharmacy dispensing system includes a module that immediately identifies cost-saving therapeutic interchange opportunities at the point of order for Medicare Part A and managed care patients. The system automatically generates patient-specific drug substitution recommendations and routes them to the prescriber for their approval to substitute the order with the lower-cost alternative medication. A pre-approval protocol allows PharMerica's pharmacies to substitute for lower-cost preferred medications without further coordination with the physician and is automatically implemented in the 28 states where global authorization is allowed by state law.

PDPM Application: These programs substitute higher-cost medications with less expensive alternatives that are clinically efficacious, with the alternatives reviewed clinically by a third-party drug information center as well as PharMerica's Pharmacy and Therapeutics Committee, for greater financial success.

EDUCATION

While the PDPM improves services to medically complex residents, facilities need to provide just the right level of care to each resident. PharMerica can help by providing training and education on conditions and therapies.

DISEASE-STATE MANAGEMENT (E.G. DIABETES, COPD, WOUND CARE, HIV/AIDS)

To support the development of systems that reduce healthcare costs and improve quality of life for patients with complex, chronic conditions, PharMerica's consultant pharmacist subject matter experts provide education and materials to assist in developing protocols and pathways: from guides on how to clean an inhaler to optimizing COPD, diabetes, or HIV medication therapy.

PDPM Application: Training, worksheets, and care protocols will illustrate how facilities can optimize medication therapy and outcomes in medically complex patients, who will be more attractive under the PDPM.

PMC UNIVERSITY

PharMerica University provides a wide range of accredited, continuing education programs designed for administrators and nurses online or on site. The courses, offered through a partnership with Pedagogy, Inc., a leader in specialized online education, cover a variety of topics from infection control and infusion and wound care to respiratory and pain management.

PDPM Application: Additional disease-state management education, as well as training on IV medications (one of the biggest categories of NTAs), are available through this convenient resource.

FAQs

By CMS and *Provider* Magazine

Q1. What is PDPM?

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

Q2. Why is CMS changing from RUG-IV to PDPM?

A. 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.

Q3. How are SNF patients classified into payment groups under PDPM?

A. 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.

Q4. How does the PDPM classification methodology differ from the RUG-IV groups under PDPM?

A. 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.

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Q5. How do providers bill for services under PDPM?

A. Providers would bill for services under PDPM using the Health Insurance Prospective Payment System (HIPPS) code that is generated from assessments with an ARD on or after October 1, 2019.

Q6. What does the HIPPS code represent under PDPM?

A. The HIPPS code under PDPM is still a five character code, as under RUG-IV. However, under RUG-IV, the first three characters represent the patient's RUG classification and the last two characters are an assessment indicator (AI) code, to represent the assessment used to generate the patient classification. Under PDPM, the first character of the HIPPS code represents the patient's PT component and OT component classification. The second character represents the patient's SLP component classification. The third character represents the patient's nursing component classification. The fourth character represents the patient's NTA component classification. The fifth character represents the AI code.

Q7. Will providers still report the patient HIPPS code in the same way on the UB-04?

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

Q8. How will "Item I0020B: SNF Primary Diagnosis" be used for payment?

A. Item I0020B will be added for providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis. The item will ask, "What is the main reason this person is being admitted to the SNF?" Item I0020B will be coded when I0020 is coded as any response 1-13.

Q9. Is it required that the principal diagnosis on the SNF claim match the primary diagnosis coded in item I0020B?

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

Q10. What is the default code under PDPM and what does it represent?

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

Q11. How will ICD-10 codes be used under PDPM?

A. 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.

Q12. Where is the ICD-10 to clinical category mapping located?

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

Q13. How many SNF PPS assessments will there be under PDPM?

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

Q14. Are the SNF PPS assessments required?

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

Q15. What are the case-mix adjusted components of the PDPM?

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

Q16. What is the NTA comorbidity score?

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

Q17. How is a patient's comorbidity score calculated?

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

Q18. What comorbidities are used under the NTA component?

A. Under PDPM, we identified 50 conditions that were related to increases in NTA costs in the SNF. These conditions, along with the number of points associated with the condition and how it is reported can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_Final.pdf.

Q19. How is the VPD adjustment calculated under the PDPM?

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

Q20. Where can I find out more information about PDPM and how to prepare for the transition from RUG-IV to PDPM on October 1, 2019?

A. Providers should check the CMS Patient Driven Payment Model webpage (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) and the AHCA Patient-Driven Payment Model (PDPM) Resource Center (https://www.ahcancal.org/facility_operations/medicare/Pages/PDPM-Resource-Center.aspx). The CMS webpage contains links to several files and documents that were developed to help SNF providers better understand the potential payment impact of changing from the RUG-IV payment model to the PDPM payment model on individual providers if care delivery patterns do not change. It also has other files to help providers better understand the MDS and claims data elements required under PDPM and what the base PDPM payment rate would be prior to the variable per-diem payment adjustments for PT, OT, and NTAS services as the length of stay progresses.

VARIABLE PER DIEM ADJUSTMENT FACTORS & SCHEDULE: PT AND OT

MEDICARE PAYMENT DAYS	ADJUSTMENT FACTOR
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

VARIABLE PER DIEM ADJUSTMENT FACTORS & SCHEDULE: NTA

MEDICARE PAYMENT DAYS	ADJUSTMENT FACTOR
1-3	3.0
4-100	1.0

IF YOU HAVE FURTHER QUESTIONS ABOUT PDPM, PLEASE CONTACT YOUR ACCOUNT MANAGER OR CALL US AT 800-564-1640. YOU CAN ALSO REACH US OUT AT INFO@PHARMERICA.COM.

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