GREATER NY HEALTHCARE FACILITIES ASSOCIATION

UNDERSTANDING PDPM

PDPM POLICIES; COMPONENTS; & MDS 3.0 CODING IN PDPM

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PROBLEMS WITH CURRENT MODEL:

- ❑ Payment is determined by volume of services provided rather than clinical characteristics of patient
- ❑ Index maximization causes patients with different comorbidities and costs, to still fall into the same RUG
- ❑ Non-Therapy Ancillaries (NTA) supplies and devices can be very costly, but are currently lumped in the Nursing payment
- ❑ TOO MANY ASSESSMENTS!

CMS' Goals:

- ❑ Create a model where payment is linked to clinical characteristics rather than volume of services or index maximization
- ❑ Create a separate NTA payment
- ❑ Reduce provider Burden

CURRENT RUG SYSTEM

CONSISTS OF 3 COMPONENTS

Therapy	Nursing	Non-Case-Mix
• Physical therapy (PT) • Occupational therapy (OT) • Speech-Language Pathology (SLP)	• Nursing services • Social services • Non-Therapy Ancillary (NTA) services	• Room and board • Administrative costs • Capital-related costs

Drugs, Lab services, medical supplies, etc.

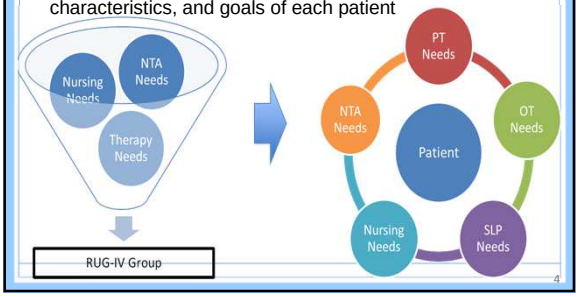
Non Case Mix: Fixed rate. Not based on patient characteristics. Rate is same for all patients

Therapy & Nursing RUGS: Determined by patient characteristics. Rate/RUG different for different patients.

Index maximization:
All services are collapsed into ONLY ONE RUG

RUG-IV vs. PDPM

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



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PDPM Patient Classification

- Under PDPM, each patient is classified into a group for each of the 5 case-mix adjusted components: PT, OT, SLP, NTA, and Nursing
- Each component **utilizes different criteria as the basis for patient classification:**
  - PT: ***Clinical Category, Functional Score***
  - OT: ***Clinical Category, Functional Score***
  - SLP: ***Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder***
  - NTA: ***NTA Comorbidity Score***
  - Nursing: ***Same characteristics as under RUG-IV***

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PDPM COMPONENTS

- **PDPM** consists of **5 Case-Mix Adjusted Components** (all based on patient characteristics) and **1 Non Case Mix Rate**:
  1. **Physical Therapy (PT) = RUG Score**
  2. **Occupational Therapy (OT) = RUG Score**
  3. **Speech Language Pathology (SLP) = RUG Score**
  4. **Non-Therapy Ancillary (NTA) = RUG Score**
  5. **Nursing = RUG Score**
  6. **Non-Case-Mix Rate = FLAT RATE (No RUG Score)**
- PDPM also includes a "Variable Per Diem Adjustment" (VPDA) that adjusts the per diem rate over the course of the stay

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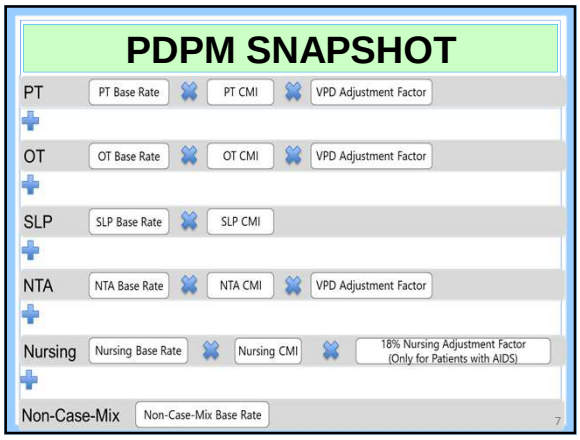
PDPM SNAPSHOT
PT
PT Base Rate
PT CMI
VPD Adjustment Factor
OT
OT Base Rate
OT CMI
VPD Adjustment Factor
SLP
SLP Base Rate
SLP CMI
NTA
NTA Base Rate
NTA CMI
VPD Adjustment Factor
Nursing
Nursing Base Rate
Nursing CMI
18% Nursing Adjustment Factor (Only for Patients with AIDS)
Non-Case-Mix
Non-Case-Mix Base Rate
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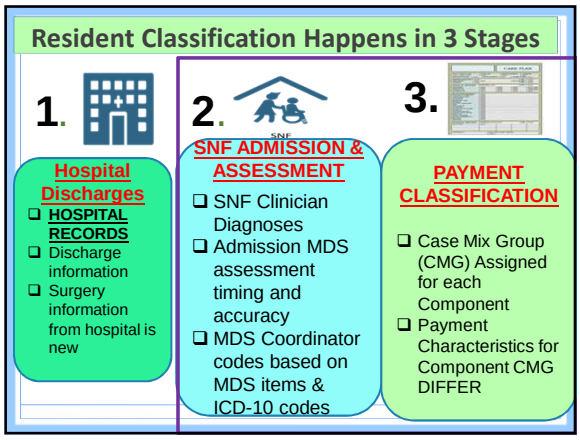
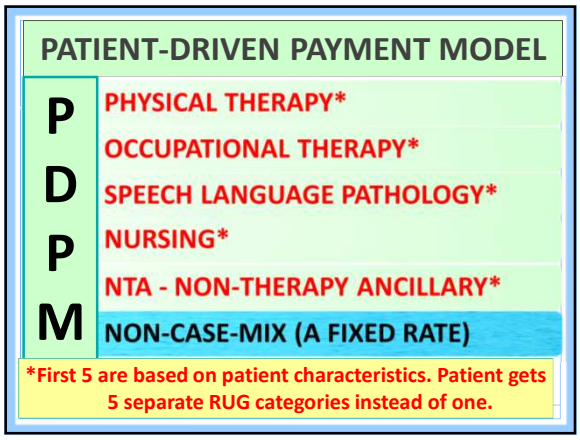

Resident Classification Happens in 3 Stages
1.
Hospital Discharges
HOSPITAL RECORDS
Discharge information
Surgery information from hospital is new
2.
SNF ADMISSION & ASSESSMENT
SNF Clinician Diagnoses
Admission MDS assessment timing and accuracy
MDS Coordinator codes based on MDS items & ICD-10 codes
3.
PAYMENT CLASSIFICATION
Case Mix Group (CMG) Assigned for each Component
Payment Characteristics for Component CMG DIFFER


PATIENT-DRIVEN PAYMENT MODEL
P
D
P
M
PHYSICAL THERAPY*
OCCUPATIONAL THERAPY*
SPEECH LANGUAGE PATHOLOGY*
NURSING*
NTA - NON-THERAPY ANCILLARY*
NON-CASE-MIX (A FIXED RATE)
*First 5 are based on patient characteristics. Patient gets 5 separate RUG categories instead of one.

PHYSICAL THERAPY & OCCUPATIONAL THERAPY COMPONENTS

PT AND OT COMPONENT CRITERIA

Components 1 & 2: PT & OT

- **16 RUG Categories Based on:**
  - **A. Clinical Category – Based on the following:**
    - ① **Clinical Reason for the SNF Stay (Section I0020B)**
    - ② **Recent Surgery Requiring Active SNF Care, if applicable (Section J2100; J2300-J5000)**
  - **B. Functional Score (SECTION GG)**
- Note: PT and OT components will always result in the same case-mix group but will have different case-mix indices and payment rates

PT AND OT: CLINICAL CATEGORY

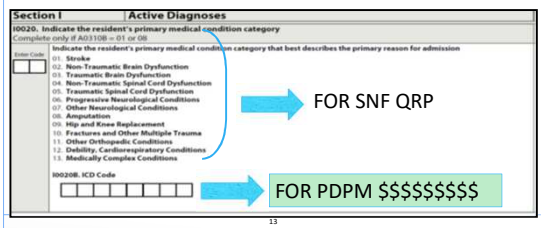
A. CLINICAL CATEGORY

① Classify into a Clinical Category based on the **"Primary Diagnosis for the SNF stay"**

- *It is possible that the primary diagnosis for the SNF stay may be different from the primary diagnosis from the preceding hospital stay).*
- *Choose the **"REASON why the patient was admitted to the SNF for Post-Acute Care"***

I0020B. NEW ITEM under PDPM: Resident's Primary Medical Condition Category

Item I0020B: Enter the code that represents the primary medical condition that resulted in the resident's SNF admission. Include the primary medical condition coded in this item in Section I: Active Diagnoses in last 7 days.



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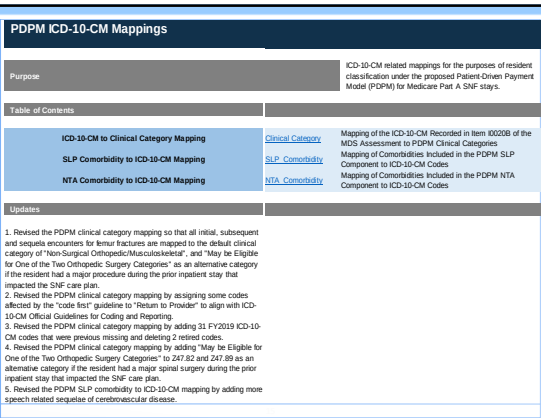
NEW ITEM IN PDPM: I0020B. Indicate the Primary Diagnosis for the SNF Stay

"Primary Diagnosis for the SNF Stay"

- ICD-10-CM codes, coded on the MDS 3.0 in **Item I0020B,** are mapped to a PDPM clinical category.
- ICD-10 mapping available at: https://www.cms.gov/Medicare/Medicare- Fee-for-Service-Payment/SNFPPS/PDPM.html



PDPM ICD-10-CM Mappings

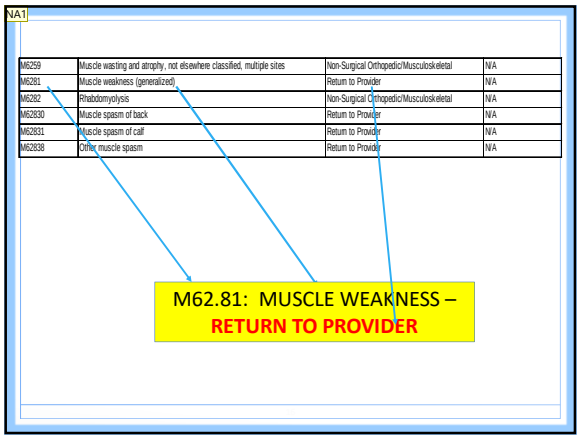
Purpose	ICD-10-CM related mappings for the purposes of resident classification under the proposed Patient-Driven Payment Model (PDPM) for Medicare Part A SNF stays.

Table of Contents

ICD-10-CM to Clinical Category Mapping	Clinical Category	Mapping of the ICD-10-CM Recorded in Item I0020B of the MDS Assessment to PDPM Clinical Categories
SLP Comorbidity to ICD-10-CM Mapping	SLP Comorbidity	Mapping of Comorbidities Included in the PDPM SLP Component to ICD-10-CM Codes
NTA Comorbidity to ICD-10-CM Mapping	NTA Comorbidity	Mapping of Comorbidities Included in the PDPM NTA Component to ICD-10-CM Codes

Updates

1. Revised the PDPM clinical category mapping so that all initial, subsequent and sequela encounters for femur fractures are mapped to the default clinical category of "Non-Surgical Orthopedic/Musculoskeletal", and "May be Eligible for One of the Two Orthopedic Surgery Categories" as an alternative category if the resident had a major procedure during the prior inpatient stay that impacted the SNF care plan.
2. Revised the PDPM clinical category mapping by assigning some codes affected by the "code first" guideline to "Return to Provider" to align with ICD-10-CM Official Guidelines for Coding and Reporting.
3. Revised the PDPM clinical category mapping by adding 31 FY2019 ICD-10-CM codes that were previous missing and deleting 2 retired codes.
4. Revised the PDPM clinical category mapping by adding "May be Eligible for One of the Two Orthopedic Surgery Categories" to Z47.82 and Z47.89 as an alternative category if the resident had a major spinal surgery during the prior inpatient stay that impacted the SNF care plan.
5. Revised the PDPM SLP comorbidity to ICD-10-CM mapping by adding more speech related sequelae of cerebrovascular disease.



PT / OT CLINICAL CATEGORIES

② In order to capture surgical information which may be relevant to classifying the patient into a PDPM clinical category, CMS is adding new items in Section J of the MDS.

- **Items J2100 – J5000.** These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission, i.e., the qualifying hospital stay. These items will be used, in conjunction with the diagnosis code captured in I0020B, to classify patients into the PT and OT case-mix classification groups for PDPM. Similar to the active diagnoses captured in Section I, these Section J items will be in the form of check-boxes.

Section J2100: NEW ITEM UNDER PDPM

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Enter Code	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
☐	0. **No** 1. **Yes** 8. **Unknown**

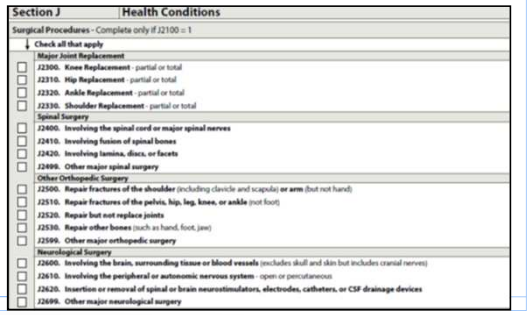
Complete only if 5-Day or IPA.
If YES, proceed to J2300 – J5000

GATEWAY QUESTION

Slide 16

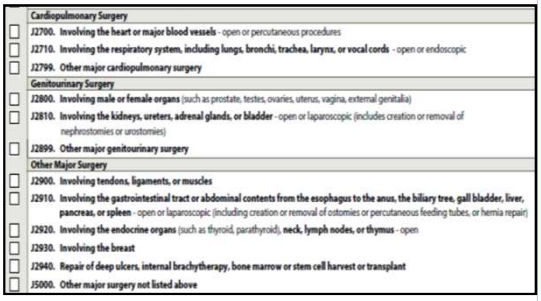
NA1 Nelia Adaci, 6/9/2019

Section J2300 – J500:
(Used to determine PT & OT Clinical Category for specified ICD-10 Codes)



Section J	Health Conditions
Surgical Procedures - Complete only if J2100 = 1	
Check all that apply	
Major Joint Replacement	
☐ J2300.	**Knee Replacement** - partial or total
☐ J2310.	**Hip Replacement** - partial or total
☐ J2320.	**Ankle Replacement** - partial or total
☐ J2330.	**Shoulder Replacement** - partial or total
Spinal Surgery	
☐ J2400.	**Involving the spinal cord or major spinal nerves**
☐ J2410.	**Involving fusion of spinal bones**
☐ J2420.	**Involving lamina, discs, or facets**
☐ J2499.	**Other major spinal surgery**
Other Orthopedic Surgery	
☐ J2500.	**Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐ J2510.	**Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐ J2520.	**Repair but not replace joints**
☐ J2530.	**Repair other bones** (such as hand, foot, jaw)
☐ J2599.	**Other major orthopedic surgery**
Neurological Surgery	
☐ J2600.	**Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐ J2610.	**Involving the peripheral or autonomic nervous system** - open or percutaneous
☐ J2620.	**Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐ J2699.	**Other major neurological surgery**

Section J2300 – J500:
NEW ITEMS UNDER PDPM



Cardiopulmonary Surgery	
☐ J2700.	**Involving the heart or major blood vessels** - open or percutaneous procedures
☐ J2710.	**Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐ J2799.	**Other major cardiopulmonary surgery**
Genitourinary Surgery	
☐ J2800.	**Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐ J2810.	**Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐ J2899.	**Other major genitourinary surgery**
Other Major Surgery	
☐ J2900.	**Involving tendons, ligaments, or muscles**
☐ J2910.	**Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐ J2920.	**Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐ J2930.	**Involving the breast**
☐ J2940.	**Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐ J5000.	**Other major surgery not listed above**

SECTION J2300 – J5000

- ❑ * J2300, J2310, J2320, J2330, J2400, J2410, and J2420 can qualify for the ***Major Joint Replacement or Spinal Surgery primary diagnosis clinical category.***
- ❑ ** J2500, J2510, J2520, and J2530 can qualify for the ***Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) primary diagnosis clinical category.***
- ❑ *** J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, and J2940 can qualify for the ***Non-Orthopedic Surgery primary diagnosis clinical category.***

EXAMPLE

- *Example: Patient has a Wedge Compression Fracture of the 3rd Lumbar Vertebra, subsequent encounter for fracture with routine healing*
  - ***I0020B will be coded as S32.030D***

1) *If patient was treated in Prior Hospital Stay with Spinal Fusion Surgery and Coded in Section J, then patient will qualify under the **Major Joint Replacement /Spinal Surgery" Category***

2) *If treated without surgery or if treated with Spinal Fusion Surgery but was NOT coded in MDS, then patient will qualify only under **"Other Orthopedic" Category***

PDPM Clinical Categories

10 PDPM CLINICAL CATEGORIES	
Major Joint Replacement or Spinal Surgery	Acute Infections
Acute Neurologic	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Non-Surgical Orthopedic/Musculoskeletal	Cancer
Non-Orthopedic Surgery	Medical Management

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PT & OT Clinical Categories

- Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification.

PDPM Clinical Categories	4 PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

PT / OT CLINICAL CATEGORIES

All patient diagnoses have been cross-walked to one of FOUR PT/OT clinical categories:

CLINICAL CATEGORY
1. MAJOR JOINT REPLACEMENT OR SPINAL SURGERY
2. OTHER ORTHOPEDIC
3. MEDICAL MANAGEMENT
4. NON ORTHOPEDIC SURGERY & ACUTE NEUROLOGIC

REMINDERS

- ***Not "all diagnoses are considered valid primary diagnoses for the SNF stay."***
- *Some diagnoses will NOT be mapped to one of the 4 Clinical categories and will be **rejected.***
- *Invalid primary diagnoses are listed as **"return to provider"** in the ICD-10 Clinical Category Crosswalk.*
- *EXAMPLES OF INVALID PRIMARY DIAGNOSES:*
  - *C00.2 (Malignant Neoplasm of External Lip, unspecified)*
  - *I68.8 (Other Cerebrovascular Disorders in Diseases, classified elsewhere)*
  - *S82.266D (Non-Displaced Segmental Fracture of Shaft of Unspecified Tibia, Subsequent Encounter for Closed Fracture with Routine Healing)*

PT AND OT: FUNCTIONAL SCORES

② **FUNCTIONAL SCORE:**

- After getting classified in a Clinical Category, the patient is also classified into a PT and OT component group using **the patient's functional score**
- Based on Section GG Item Scores: Includes Late Loss ADL's and some Early Loss ADL's

Section GG (FUNCTIONAL SCORE - PT & OT COMPONENTS)

SELF-CARE ITEMS:

1) Self Care: EATING
2) Self Care ORAL HYGIENE
3) Self Care: TOILETING HYGIENE

MOBILITY ITEMS:

4) BED MOBILITY - Sit to lying
   BED MOBILITY - Lying to sitting on side of bed
5) TRANSFER - Sit to stand
   TRANSFER - Chair/bed transfer
   TRANSFER - Toilet Transfer
6) AMBULATION - Walk 50 feet w/ 2 turns
   AMBULATION - Walk 150 feet

GG0130: EATING

- **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
  - *If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or TPN, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. **Assistance with tube feedings or TPN is not considered when coding Eating.***
  - *If the resident eats finger foods using his or her hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.*

GG0130: ORAL HYGIENE

- **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
  - ***If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.***

GG0130: TOILETING HYGIENE

- **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment..
  - ***Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement.***
  - ***If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower-body clothing and perineal hygiene.***

GG0130: TOILETING HYGIENE

- ***Toileting hygiene takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident's need for assistance in managing clothing and perineal cleansing.***
- ***If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving his or her bowels.***

GG0170: BED MOBILITY

- **Sit to Lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- **Lying to Sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

GG0170: TRANSFERS

- **Sit to Stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
- **Chair/Bed-to-Chair Transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
- **Toilet Transfer:** The ability to get on and off a toilet or commode.

GG0170: WALKING

- **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
- **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG CODING

- Section GG assesses the need for assistance with self-care and mobility activities
- **Must be a collaboration & integration between Therapy and Nursing!**
- **Requires supporting documentation**
- Utilized not just for SNF-QRP's but also for PDPM!!!

Section GG Coding

Overview of Coding Instructions:

- **Admission Performance** – code based on first 3 days of Medicare Part A stay (based on A2400B)
- Coding is based on "**Usual Performance**" – will require **clinical judgment**
- If activity occurs multiple times (e.g., eating, toileting, dressing, bed mobility activities, bed/chair transfers, do not code most dependent, do not code most independent.
- Some items may only be assessed once, code that status. (e.g., car transfers, curbs, stairs).

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GG0130 and GG170: Review of Coding Instructions

Steps for Assessment:

- Assess the resident's self-care performance based on ***direct observation,*** **INCORPORATING** ***resident's self-report*** and ***reports from qualified clinicians, care staff, or family documented in the resident's medical record*** during the three-day assessment period.
- CMS anticipates that ***an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.***
- **QUALIFIED CLINICIAN:** Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

GG0130 and GG170: Review of Coding Instructions

- *Information added to Steps for Assessment strengthening concept of* ***collaboration to collect the resident's self-performance in the items to be*** *assessed during the 3-Day Assessment Period.*
- *Documentation in the medical record is used to support assessment coding of section GG*

GG0130 and GG170: Review of Coding Instructions

- The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. **If treatment has started, for example, on the day of admission, a *baseline functional status assessment* can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.**
- Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

GG0130: Review of Coding Instructions

Assessment Period

- Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - For the 5-Day PPS assessment, ***code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission.***
  - This functional assessment must be completed within the *1st 3 calendar days of Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, & the following two days, ending at 11:59 PM on day 3.*
  - The admission function scores are to reflect the resident's admission baseline status & are to be based on an assessment.

GG0130 and GG170: Review of Coding Instructions

- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific.
- ***Documentation in the medical record is used to support assessment coding of Section GG.***
- ***Data entered should be consistent with the clinical assessment documentation in the resident's medical record.***
- ***This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.***

GG0130 & GG170: Review of Coding Instructions

Code the resident's usual performance for each activity using the six - point scale:

- ❑Code **"06"** for Independent
- ❑Code **"05"** for Setup or clean - up assistance
- ❑Code **"04"** for Verbal Cues, Supervision or Touching/Steadying Assistance, CGA
- ❑Code **"03"** for Partial/moderate assistance
- ❑Code **"02"** for Substantial/maximal assistance
- ❑Code **"01"** for Dependent or the assistance of two or more helpers to complete the activity.

GG0130 & GG0170: Review of Coding Instructions

- ❑Code **"07"**, If Resident refused
- ❑Code **"09"** If Not applicable: If the activity was not attempted & the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- ❑**Code "10",** Not attempted due to environmental limitations. Examples include lack of equipment and weather constraints.
- ❑Code **"88"**, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

PT / OT CLINICAL CATEGORIES

FUNCTIONAL SCORE

Scoring Response for Section GG Items		Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, refused, not attempted	0

Section GG items		Score
GG0130A1	Self-care: Eating	0–4
GG0130B1	Self-care: Oral hygiene	0–4
GG0130C1	Self-care: Toileting hygiene	0–4
GG0170B1	Mobility: Sit to lying	0–4 (avg. of 2 bed mobility items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0–4 (avg. of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to- chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0–4 (avg. of 2 walking items)
GG0170K1	Mobility: Walk 150 feet	

PT & OT Functional Score: GG Items

Section GG items included in the PT & OT Functional Score

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	

RUG-IV & PDPM Function Score Differences

Notable differences between G & GG scoring methodologies:

- **Reverse Scoring Methodology:**
  - Under Section G, increasing score means increasing dependence
  - Under Section GG, increasing score means increasing independence
- **Non-linear Relationship to Payment:**
  - Under RUG-IV, increasing dependence, within a given RUG category, translates to higher payment
  - Under PDPM, there is not a direct relationship between increasing dependence and increasing payment

PT & OT Component: Payment for 3 Clinical Categories is lower for the most & least dependent patients (who are less likely to require high therapy amounts of therapy), compared to those in between (who are more likely to require high amounts of therapy)

PT & OT Components: Payment Groups

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

FY 2020 PROPOSED RULE: BRONX, KINGS, NY, QUEENS, RICHMOND, WESTCHESTER

WAGE INDEX = 1.2639 PT/OT

Clinical Categ	GG Score	RUG	PT RATE	OT RATE	TOTAL RATE
Maj Jt Repl or Spinal Surg	0-5	TA	$111.06	$100.67	$211.73
	6-9	TB	$123.40	$110.13	$233.53
	10-23	TC	$136.46	$114.19	$250.65
	24	TD	$139.37	$103.38	$242.74
Other Orthoped	0-5	TE	$103.07	$95.27	$198.34
	6-9	TF	$116.87	$108.11	$224.97
	10-23	TG	$121.22	$110.81	$232.03
	24	TH	$84.20	$77.70	$161.90
Medical Management	0-5	TI	$82.02	$79.73	$161.75
	6-9	TJ	$103.07	$97.97	$201.05
	10-23	TK	$110.33	$104.05	$214.39
	24	TL	$79.12	$75.00	$154.12
NonOrthop Surg & Acute Neurologic	0-5	TM	$92.19	$87.84	$180.02
	6-9	TN	$107.43	$101.35	$208.78
	10-23	TO	$112.51	$104.73	$217.24
	24	TP	$78.39	$73.65	$152.04

SPEECH LANGUAGE PATHOLOGY THERAPY COMPONENT

SLP Component

- For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:

STEP 1:

a) Acute Neurologic Clinical Classification

b) Certain SLP-related Comorbidities

c) Presence of Cognitive Impairment

STEP 2:

a) Use of a Mechanically-Altered Diet

b) Presence of Swallowing Disorder

1. (a) SLP Component: I0020B

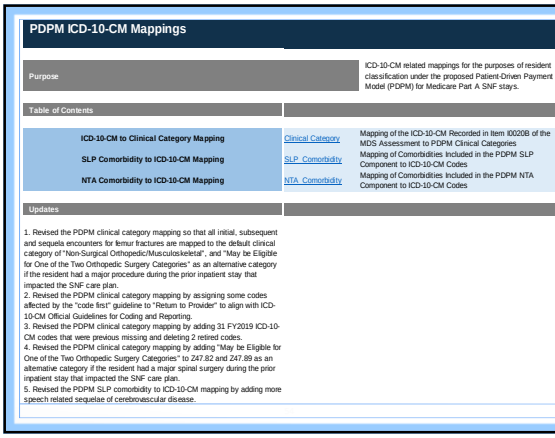
Clinical Category will be determined from I0020B (Acute Neurologic)

Examples:

- D33.4: Benign neoplasm of spinal cord
- G61.0: Guillain-Barre syndrome
- G80.4: Ataxic Cerebral Palsy
- I69.151Hemiplegia following non-traumatic intracerebral hemorrhage affecting right dominant side
- I69.120 Aphasia following non-traumatic intracerebral hemorrhage

I0020B. Indicate the Primary Diagnosis for the SNF Stay: Triggers SLP Component if ACUTE NEUROLOGIC ICD-10-CM CODE is coded

- The item will ask ***"What is the main reason this person is being admitted to the SNF?"***
- Item I0020B will be coded when Item I0020 is coded as any response 1 – 13.



PDPM ICD-10-CM Mappings

Purpose	ICD-10-CM related mappings for the purposes of resident classification under the proposed Patient-Driven Payment Model (PDPM) for Medicare Part A SNF stays.

Table of Contents

ICD-10-CM to Clinical Category Mapping	Clinical Category	Mapping of the ICD-10-CM Recorded in Item I0020B of the MDS Assessment to PDPM Clinical Categories
SLP Comorbidity to ICD-10-CM Mapping	SLP Comorbidity	Mapping of Comorbidities Included in the PDPM SLP Component to ICD-10-CM Codes
NTA Comorbidity to ICD-10-CM Mapping	NTA Comorbidity	Mapping of Comorbidities Included in the PDPM NTA Component to ICD-10-CM Codes

Updates

1. Revised the PDPM clinical category mapping so that all initial, subsequent and sequela encounters for femur fractures are mapped to the default clinical category of "Non-Surgical Orthopedic/Musculoskeletal", and "May be Eligible for One of the Two Orthopedic Surgery Categories" as an alternative category if the resident had a major procedure during the prior inpatient stay that impacted the SNF care plan.
2. Revised the PDPM clinical category mapping by assigning some codes affected by the "code first" guideline to "Return to Provider" to align with ICD-10-CM Official Guidelines for Coding and Reporting.
3. Revised the PDPM clinical category mapping by adding 31 FY2019 ICD-10-CM codes that were previous missing and deleting 2 retired codes.
4. Revised the PDPM clinical category mapping by adding "May be Eligible for One of the Two Orthopedic Surgery Categories" to Z47.82 and Z47.89 as an alternative category if the resident had a major spinal surgery during the prior inpatient stay that impacted the SNF care plan.
5. Revised the PDPM SLP comorbidity to ICD-10-CM mapping by adding more speech related sequelae of cerebrovascular disease.

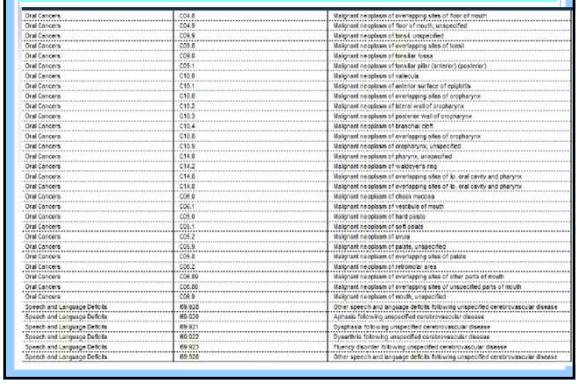
1. (b) SLP Comorbidities

- Predictive of higher SLP costs; Conditions & services combined into a single SLP-related comorbidity flag
- Patient qualifies if any of the conditions/services is present

SLP COMORBIDITIES	
Aphasia	Laryngeal Cancer*
CVA,TIA, or Stroke	Apraxia*
Hemiplegia or Hemiparesis	Dysphagia*
Traumatic Brain Injury	ALS*
Tracheostomy (while Resident)	Oral Cancers*
Ventilator (while Resident)	Speech & Language Deficits*

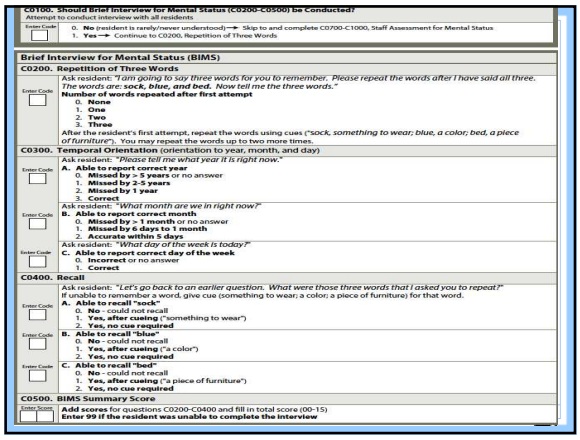
**ICD-10-CM CODE Required to Map*

SLP CO-MORBIDITY ICD-10-CM MAPPING



1. (c) PDPM Cognitive Scoring

- Under PDPM, a patient's cognitive status is assessed in exactly the same way as under RUG-IV (i.e., via the BIMS or Staff Assessment)
- Scoring the patient's cognitive status, for purposes of classification, is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment



C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*
B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*
C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

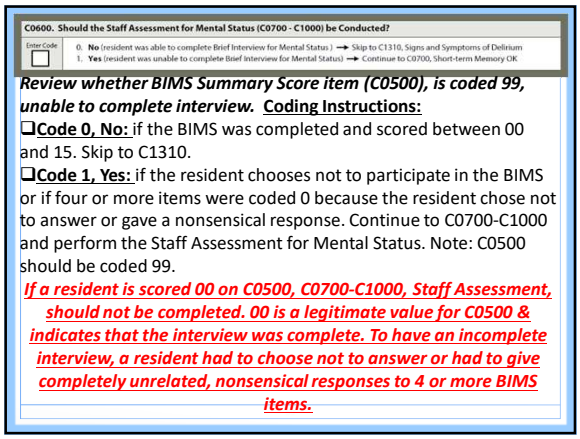
A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score ☐☐ **Add scores** for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview



C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

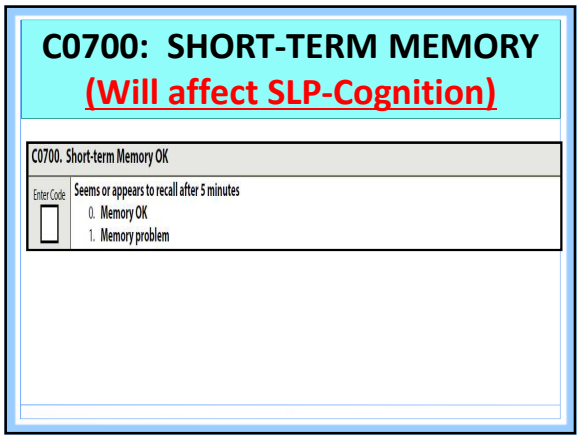
Enter Code ☐
0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Review whether BIMS Summary Score item (C0500), is coded 99, unable to complete interview. **Coding Instructions:**

❑**Code 0, No:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.

❑**Code 1, Yes:** if the resident chooses not to participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be coded 99.

If a resident is scored 00 on C0500, C0700-C1000, Staff Assessment, should not be completed. 00 is a legitimate value for C0500 & indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to 4 or more BIMS items.

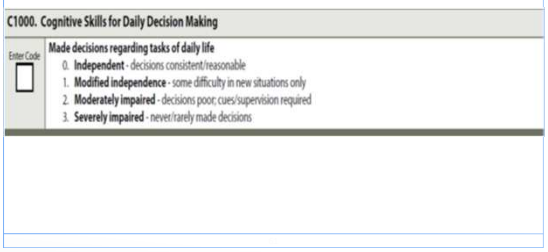


C0700: SHORT-TERM MEMORY
(Will affect SLP-Cognition)

C0700. Short-term Memory OK

Enter Code ☐
Seems or appears to recall after 5 minutes
0. Memory OK
1. Memory problem

C1000: COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Will affect SLP-Cognition)

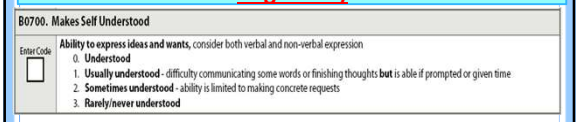


C1000. Cognitive Skills for Daily Decision Making

Enter Code

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

B0700: Makes Self Understood (Will affect SLP-Cognition)



B0700. Makes Self Understood

Enter Code

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

MAKES SELF UNDERSTOOD

- ❑ Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

PDPM Cognitive Scoring

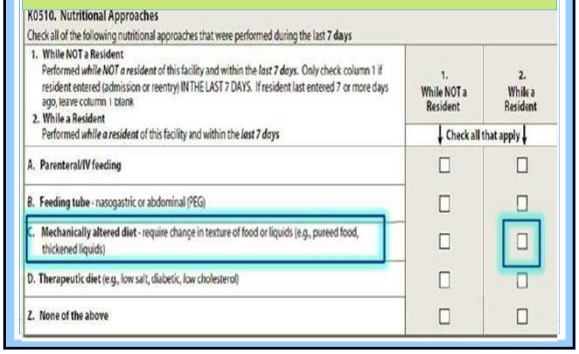
- ❑ *Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such,* ***only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS.*** *In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status. (RAI 2019, C-2)*

PDPM Cognitive Score: Methodology

PDPM Cognitive Measure Classification Methodology

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13 – 15	0
Mildly Impaired	8 – 12	1 – 2
Moderately Impaired	0 – 7	3 – 4
Severely Impaired	-	5 – 6

2. (a) MECHANICALLY ALTERED DIET: K0510C



K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days

1. While NOT a Resident
   Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. While a Resident
   Performed *while a resident* of this facility and within the *last 7 days*

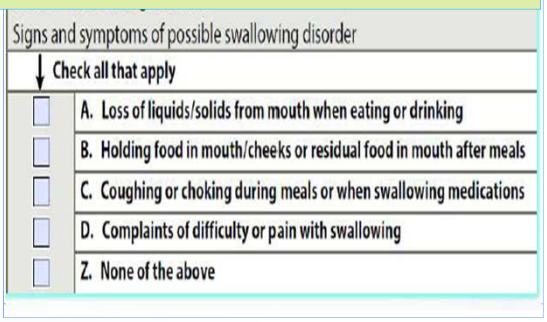
	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

K0510: Nutritional Approaches

MECHANICALLY ALTERED DIET

A diet specifically prepared to alter the texture or consistency of food **to facilitate oral intake**. Examples include soft solids, puréed foods, ground meat, and **thickened liquids**. A mechanically altered diet should not automatically be considered a therapeutic diet.

2. (b) K0100: SWALLOWING DISORDER



Signs and symptoms of possible swallowing disorder

Check all that apply

- ☐ A. Loss of liquids/solids from mouth when eating or drinking
- ☐ B. Holding food in mouth/cheeks or residual food in mouth after meals
- ☐ C. Coughing or choking during meals or when swallowing medications
- ☐ D. Complaints of difficulty or pain with swallowing
- ☐ Z. None of the above

K0100: SWALLOWING DISORDER

- ❑ Assess for signs and symptoms that suggest a swallowing disorder ***that has NOT been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.***

K0100: SWALLOWING DISORDER

- ❑ When necessary, the resident should be ***evaluated*** **by the physician, speech language pathologist and/or occupational therapist** to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- ❑ ***Care plan should be developed to assist resident to maintain safe and effective swallow using compensatory techniques, alteration in diet consistency, and positioning during and following meals.***

K0100: SWALLOWING DISORDER

CODING INSTRUCTIONS:

- ***Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.***

SLP Component: Payment Groups

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

FY 2020 PROPOSED RULE: BRONX, KINGS, NY, QUEENS, RICHMOND, WESTCHESTER

WAGE INDEX = 1.2639	SLP		
Acute Neuro, SLP Comorb, Cog Impairm	Mech diet OR Swall disord	RUG	RATE
None	Neither	SA	$18.42
None	Either	SB	$49.31
None	Both	SC	$72.35
Any One	Neither	SD	$39.56
Any One	Either	SE	$63.40
Any One	Both	SF	$80.74
Any Two	Neither	SG	$55.27
Any Two	Either	SH	$77.49
Any Two	Both	SI	$95.65
All Three	Neither	SJ	$81.02
All Three	Either	SK	$100.25
All Three	Both	SL	$114.07

NURSING COMPONENT

Nursing Component

- PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications.
  - Function score based on Section GG of the MDS 3.0
  - Collapsed functional groups, reducing the number of nursing groups from 43 to 25

NURSING CASE MIX CATEGORY

FUNCTIONAL SCORE

Scoring Response for Section GG Items		Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, refused, not attempted	0

Section GG items		Score
GG0130A1	Self-care: Eating	0–4
GG0130C1	Self-care: Toileting hygiene	0–4
GG0170B1	Mobility: Sit to lying	0–4 (avg. of 2 bed mobility items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0–4 (avg. of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to- chair transfer	
GG0170F1	Mobility: Toilet transfer	

Nursing Functional Score: GG Items

Section GG items included in the Nursing functional score

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	

Nursing Component

NURSING COMPONENT

EXTENSIVE SERVICES
SPECIAL CARE HIGH
SPECIAL CARE LOW
CLINICALLY COMPLEX

EXTENSIVE SERVICES

Extensive Service Conditions	PDPM Nursing Classification
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Isolation or quarantine for active infectious disease * **without** tracheostomy care* **without** ventilator/respirator*	ES1

*** WHILE A RESIDENT**

SPECIAL CARE HIGH

- ❑ B0100, GG ITEMS: ***Comatose and completely dependent or activity did not occur at admission***
- ❑ I2100: ***Septicemia***
- ❑ J2900, N0350A, B: ***Diabetes with both of the following:***
  - o ***Insulin injections (N0350A) for all 7 days***
  - o ***Insulin order changes on 2 or more days (N0350B)***
- ❑ I5100, NURSING FUNCTION SCORE: ***Quadriplegia with Nursing Function Score <= 11***
- ❑ I6200, J1100C: ***Chronic Obstructive Pulmonary Disease and Shortness of Breath when lying flat***

SPECIAL CARE HIGH

- ❑ J1550A, others: ***Fever and one of the*** *following;*
  - o *I2000* ***Pneumonia***
  - o *J1550B* ***Vomiting***
  - o *K0300* ***Weight loss (1 or 2)***
  - o *K0510B1 or K0510B2:* ***Feeding tube****
- ❑ **K0510A1 or K0510A2:** ***Parenteral/IV feedings***
- ❑ O0400D2: ***Respiratory therapy for all 7 days***

****Tube feeding classification requirements:***
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

SPECIAL CARE LOW

- ❑ *I4400, Nursing Function Score:* ***Cerebral palsy, with Nursing Function Score <=11***
- ❑ *I5200, Nursing Function Score:* ***Multiple sclerosis, with Nursing Function Score <=11***
- ❑ *I5300, Nursing Function Score:* ***Parkinson's disease, with Nursing Function Score <=11***
- ❑ *I6300, O0100C2:* ***Respiratory failure and oxygen therapy while a patient***
- ❑ *K0510B1 or K0510B2* ***Feeding tube****
- ❑ *M0300B1* ***Two or more stage 2 pressure ulcers with two or more selected skin treatments*****
- ❑ *M0300C1, D1, F1* ***Any stage 3 or 4 pressure ulcer with two or more selected skin treatments*****

SPECIAL CARE LOW

- ❑ *M1030* ***Two or more venous/arterial ulcers with two or more selected skin treatments*****
- ❑ *M0300B1, M1030* ***1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments*****
- ❑ *M1040A, B, C; M1200I* ***Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet***
- ❑ *O0100B2* ***Radiation treatment while a patient***
- ❑ *O0100J2* ***Dialysis treatment while a patient***

SPECIAL CARE LOW

**Tube feeding classification requirements:*
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories & K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
***Selected skin treatments:*

- ❑ *M1200A, B Pressure relieving chair and/or bed*
- ❑ *M1200CTurning/repositioning*
- ❑ *M1200D Nutrition or hydration intervention*
- ❑ *M1200E Pressure ulcer care*
- ❑ *M1200G Application of dressings (not to feet)*
- ❑ *M1200H Application of ointments (not to feet)*

CLINICALLY COMPLEX

MDS Item	Condition or Service
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D,E	Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatment* or surgical wounds
M1040F	Burns
O0100A2	Chemotherapy while a patient
O0100C2	Oxygen Therapy while a patient
O0100H2	IV Medications while a patient
O0100I2	Transfusions while a patient

**Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)*

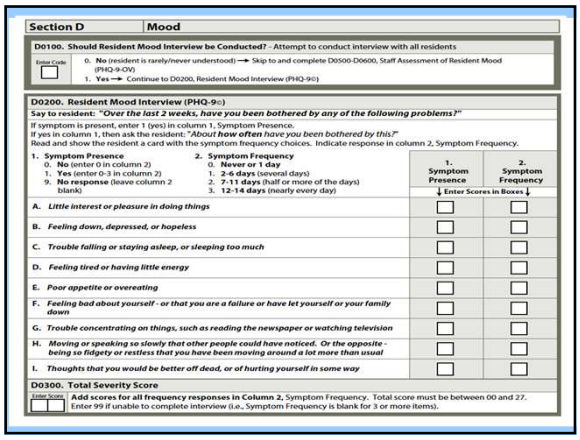
MOOD INDICATORS (NURSING COMPONENT DEPRESSION END-SPLIT FOR *SPECIAL CARE HIGH SPECIAL CARE LOW CLINICALLY COMPLEX)*

SECTION D

Intent: ***The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan.***

Section D: MOOD (NURSING DEPRESSION END-SPLIT FOR CLINICALLY COMPLEX; SPECIAL CARE HIGH & SPECIAL CARE LOW)

- ❑The resident mood interview is attempted with all residents, using either the PHQ-9 or the staff assessment, PHQ-9-OV.
- ❑If the resident seems unable to communicate, offer alternatives, such as writing, pointing, sign language, or cue cards. Utilizing the techniques in Appendix D of the *RAI User's Manual* as well as cue cards will enhance the resident interview.



Section D | **Mood**

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code
0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9®)

D0200. Resident Mood Interview (PHQ-9®)

Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

D0300. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2**, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Coding Instructions for Column 1 Symptom Presence

- ❑**Code 0, no:** if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- ❑**Code 1, yes:** if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- ❑**Code 9, no response:** if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

Coding Instructions for Column 2. Symptom Frequency

Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

- **Code 0, never or 1 day:** if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that he or she has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates that he or she has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates that he or she has experienced the symptom for 12-14 days.

D0300: TOTAL SEVERITY SCORE

D0300. Total Severity Score

Enter Score | **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

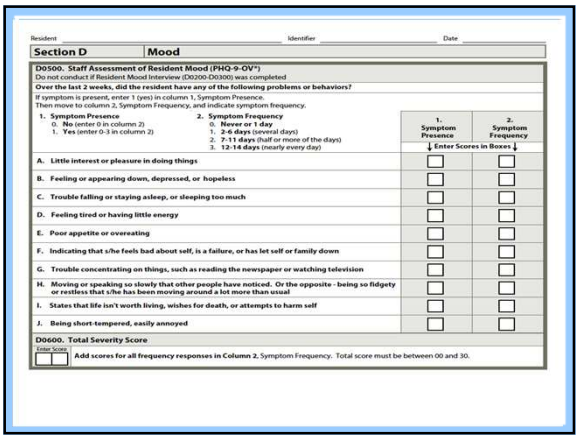
TOTAL SEVERITY SCORE

- **A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.**

After completing D0200 A-I:

1. **Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2.**
2. **The maximum resident score is 27 (3 x 9).**

- ***A SCORE OF 10 OR MORE WILL INCREASE THE NURSING COMPONENT CMI SCORE IF RUG SCORE IS CLINICALLY COMPLEX, SPECIAL CARE HIGH OR SPECIAL CARE LOW.***



Resident _____ Identifier _____ Date _____

Section D | **Mood**

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence: 0. No (enter 0 in column 2); 1. Yes (enter 0-3 in column 2)
2. Symptom Frequency: 0. Never or 1 day; 1. 2-6 days (several days); 2. 7-11 days (half or more of the days); 3. 12-14 days (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

Enter Score | **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 30.

D0600: TOTAL SEVERITY SCORE

D0600. Total Severity Score

Enter Score | Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

TOTAL SEVERITY SCORE

After completing items D0500 A-J:

1. Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2.
2. Maximum score is 30 (3 × 10).

❑***A SCORE OF 10 OR MORE WILL INCREASE THE NURSING COMPONENT CMI SCORE IF RUG SCORE IS CLINICALLY COMPLEX, SPECIAL CARE HIGH OR SPECIAL CARE LOW.***

****STAFF ASSESSMENT REQUIRES DOCUMENTATION DURING THE 14-DAY LOOK BACK PERIOD. (FREQUENCY OF OCCURRENCES)***

Section D: MOOD

Resident Interview (PHQ-9):

- ❑Items D02002A through D02002I
- ❑Requires no further documentation
- ❑RESIDENT responses on the MDS Item Set will be accepted as "Stand Alone" documentation.
- ❑***Must be completed on or before the ARD during the look back period.***

Staff Interview (PHQ-9-OV)

- ❑Items D05002A through J

Supporting Documentation Required

NURSING COMPONENT

IMPAIRED COGNITION

BEHAVIORS

PHYSICAL REDUCED

IMPAIRED COGNITION: SECTION C; B

❑**IMPAIRED COGNITION: BIMS < THAN 9**

❑**IF STAFF ASSESSMENT, CPS > 3**:

1. B0100 Coma (B0100 = 1) & Completely ADL Dependent or ADL did not occur
2. C1000 Severely Impaired Cognitive Skills (C1000 = 3)
3. B0700, C0700, C1000: Two or more of the following impairment indicators are present:
   - ❑**B0700 > 0:** ***Problem being understood***
   - ❑**C0700 = 1:** ***Short-term memory problem***
   - ❑**C1000 > 0:** ***Cognitive Skills Problem*** and 1 or more of the ff. severe impairment indicators are present:
     - oB0700 >= 2: *Severe problem being understood*
     - oC1000 >= 2: *Severe cognitive skills problem*

Section E: BEHAVIOR (NURSING COMPONENT – BEHAVIOR/COGNITION QUALIFIER)

Presence of Behavior(s): ***Need Documentation during the Look Back period to support Coding:***

- ❑**E0100A Hallucinations**
- ❑E0100B Delusions

Presence and Frequency of Behavior(s): *Need Daily Documentation during the Look Back period to support Coding:*

- ❑E0200A Physical Behaviors
- ❑E0200B Verbal Behaviors
- ❑E0200C Other Behaviors
- ❑E0800 Rejection of Care
- ❑E0900 Wandering

REDUCED PHYSICAL FUNCTION

❑Patients who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a PDPM Nursing Function Score less than 11, are placed in this category.

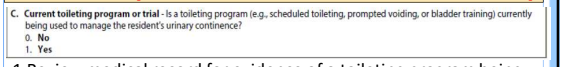
RESTORATIVE NURSING PROGRAMS
(NURSING COMPONENT END-SPLIT FOR BEHAVIORS, IMPAIRED COGNITION AND REDUCED PHYSICAL)

RESTORATIVE NURSING MODALITIES

- ❑ Urinary Toileting Program or Bowel Toileting Program
- ❑ Passive ROM
- ❑ Active ROM
- ❑ Splint or Brace Assistance
- ❑ Bed Mobility*
- ❑ Transfer
- ❑ Walking*
- ❑ Dressing or grooming
- ❑ Eating and swallowing
- ❑ Amputation/Prosthesis Care
- ❑ Communication

***Bed Mobility and walking are considered one program and minutes cannot be split between them.

Section H0200C: URINARY TOILETING PROGRAM (NURSING RESTORATIVE END-SPLIT)



C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
0. No
1. Yes

1.Review medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period.
Note the # of days during the look-back period that the toileting program was implemented or carried out.
2.Documentation in medical record **MUST SHOW 3 requirements:**

- ❑ Implemented an individualized, resident-specific toileting program – based on an assessment of resident's unique voiding pattern;
- ❑ Evidence that the individualized program was communicated to staff & resident verbally and through a care plan, flow records, and a written report;
- ❑ Notations of the resident's response to the toileting program and subsequent evaluations, as needed.

Section H0500: BOWEL TOILETING PROGRAM (NURSING RESTORATIVE END-SPLIT)

H0500. Bowel Toileting Program

Enter Code ☐ Is a toileting program currently being used to manage the resident's bowel continence?
0. No
1. Yes

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence **during the 7-day look-back period.**
2. Must meet **3 requirements** in medical records/documentation:

- ❑ Implementation of an **individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;**
- ❑ Evidence that the **individualized program was communicated to staff and the resident** (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
- ❑ Notations of the **resident's response to the toileting program and subsequent evaluations, as needed.**

Section O0500: RESTORATIVE NURSING (Affects Nursing Restorative End-Split for Impaired Cognition/Behaviors & Physical Reduced)

Resident Identifier Date

Section O	Special Treatments, Procedures, and Programs

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	**Training and Skill Practice In:**
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

Section O0500: RESTORATIVE NURSING

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record.

2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.

(Must be provided for **15 or more minutes a day for 6 or more of the last 7 days**)

3. The following criteria for restorative nursing programs must be met in order to code O0500:

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Section O0500: RESTORATIVE NURSING

a) *Measurable objectives and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process.*

b) *Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.*

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Section O0500: RESTORATIVE NURSING

c) ***Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.***

d) *A **registered nurse or a licensed practical (vocational) nurse** must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.*

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Section O0500: RESTORATIVE NURSING

*In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. **Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.***

*e) This category **does not include groups with more than four residents per supervising helper or caregiver.***

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NURSING CASE MIX CATEGORIES

NURSING COMPONENT	POINTS OR END-SPLITS	ADL SCORE	NURSING CASE MIX GROUP	CMI
EXTENSIVE SERVICES	TRACHEOSTOMY & VENTILATOR (3)	0-14	ES3	4.04
	TRACHEOSTOMY OR VENTILATOR (2)	0-14	ES2	3.06
	INFECTION ISOLATION (1)	0-14	ES1	2.91
SPECIAL CARE HIGH	DEPRESSED (2)	0-5	HDE2	2.39
	DEPRESSED (2)	6-14	HBC2	2.23
	NOT DEPRESSED (1)	0-5	HDE1	1.99
	NOT DEPRESSED (1)	6-14	HBC1	1.85
SPECIAL CARE LOW	DEPRESSED (2)	0-5	LDE2	2.07
	DEPRESSED (2)	6-14	LBC2	1.71
	NOT DEPRESSED (1)	0-5	LDE1	1.72
	NOT DEPRESSED (1)	6-14	LBC1	1.43

NURSING COMPONENT	POINTS OR END-SPLITS	ADL SCORE	NURSING CASE MIX GROUP	CMI
CLINICALLY COMPLEX	DEPRESSED (2)	0-5	CDE2	1.86
	DEPRESSED (2)	6-14	CBC2	1.54
	DEPRESSED (2)	15-16	CA2	1.08
	NOT DEPRESSED (1)	0-5	CDE1	1.62
	NOT DEPRESSED (1)	6-14	CBC1	1.34
	NOT DEPRESSED (1)	15-16	CA1	0.94
BEHAVIOR SYMPTOMS COGNITION	NURSING REHAB (2)	11-16	BAB2	1.04
	NO NURSING REHAB (1)	11-16	BAB1	0.99
REDUCED PHYSICAL FUNCTION	NURSING REHAB (2)	0-5	PDE2	1.57
	NURSING REHAB (2)	6-14	PBC2	1.21
	NURSING REHAB (2)	15-16	PA2	0.70
	NO NURSING REHAB (1)	0-5	PDE1	1.47
	NO NURSING REHAB (1)	6-14	PBC1	1.13
	NO NURSING REHAB (1)	15-16	PA1	0.66

FY 2020 PROPOSED RULE: BRONX, KINGS, NY, QUEENS, RICHMOND, WESTCHESTER WAGE INDEX = 1.2639

NURSING			
RUG	GG Score	End Split	RATE
ES3	0-14	Vent & Trach	$513.85
ES2	0-14	Vent or Trach	$388.55
ES1	0-14	Isolation	$370.83
HDE2	0-5	s/s Depress	$303.76
HDE1	0-5		$251.86
HBC2	6-14	s/s Depress	$283.51
HBC1	6-14		$235.41
LDE2	0-5	s/s Depress	$263.25
LDE1	0-5		$218.96
LBC2	6-14	s/s Depress	$217.69
LBC1	6-14		$180.99

FY 2020 PROPOSED RULE: BRONX, KINGS, NY, QUEENS, RICHMOND, WESTCHESTER WAGE INDEX = 1.2639

CDE2	0-5	s/s Depress	$236.68
CDE1	0-5		$205.03
CBC2	6-14	s/s Depress	$196.18
CA2	15-16	s/s Depress	$137.96
CBC1	6-14		$169.60
CA1	15-16		$118.97
BAB2	11-16	RNP	$131.63
BAB1	11-16		$125.30
PDE2	0-5	RNP	$198.71
PDE1	0-5		$186.05
PBC2	6-14	RNP	$154.41
PA2	15-16	RNP	$89.86
PBC1	6-14		$143.02
PA1	15-16		$83.53

NON-THERAPY ANCILLARY COMPONENT

NTA – Non Therapy Ancillary

- **6 RUG Categories Based on:**
  - Diagnoses, conditions, and services, etc.
- CMS has a list of conditions and assigned points to each condition (see list)
- Patients get points for each condition they have
- The higher the points, the higher the CMI, and the higher the rate

NTA COMPONENT

A. Based on certain comorbidities or use of certain extensive services: 50 categories; multiple codes within each category, except HIV/AIDS

B. Higher-point value = higher-cost to treat

- ❑8 - 1 Condition/Service (HIV/AIDS)
- ❑7 - 1 Condition/Service
- ❑6 - 0 Condition/Service
- ❑5 - 1 Condition/Service
- ❑4 - 1 Condition/Service
- ❑3 - 2 Condition/Service
- ❑2 - 9 Condition/Service
- ❑1 - 35 Condition/Service

NTA Component: Comorbidity Coding

- ❑ 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 the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/SNFPPS/PDPM.html
- ❑ One comorbidity (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV
  - o The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS

NTA Component: Condition Listing (1)

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
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
Diabetes Mellitus (DM) Code	MDS Item I2900	2

NTA Component: Condition Listing (2)

Condition/Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1

NTA Component: Condition Listing (3)

Condition/Extensive Service	Source	Points
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 Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Malnutrition Code	MDS Item I5600	1

NTA Component: Condition Listing (4)

Condition/Extensive Service	Source	Points
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

NTA Component: Payment Groups

NTA Score Range	NTA Case Mix Group	NTA Case Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

FY 2020 PROPOSED RULE: BRONX, KINGS, NY, QUEENS, RICHMOND, WESTCHESTER WAGE INDEX = 1.2639

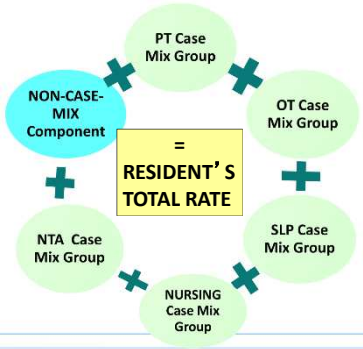
NTA		
Points	RUG	RATE
12+	NA	$309.36
9-11	NB	$241.57
6-8	NC	$175.69
3-5	ND	$126.99
1-2	NE	$91.66
0	NF	$68.75

NON-CASE MIX COMPONENT

Non- Case Mix

- Fixed rate for all patients
- Is not affected by patient characteristics – same rate for all patients
- Accounts for overhead, administrative costs, etc.

PATIENT-DRIVEN PAYMENT MODEL



Variable Per Diem Adjustment

PT & OT Components

Day in Stay	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

Day in Stay	Adjustment Factor
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

NTA Component

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

PDPM Variable Rate Adjustments

- **DAYS 1 – 3: NTA X 3 (HIGHEST RATE)**
- **DAYS 4 – 100: NO NTA ADJUSTMENT**
- **DAYS 21 – 100:**

PT AND OT DECLINE 2% EVERY 7 DAYS

PDPM HIPPS CODING

PDPM HIPPS Coding

- Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character Health Insurance Prospective Payment System (HIPPS) code.
- In order to accommodate the new payment groups, the **PDPM HIPPS algorithm is revised as follows:**
  - **Character 1: PT/OT Payment Group**
  - **Character 2: SLP Payment Group**
  - **Character 3: NURSING Payment Group**
  - **Character 4: NTA Payment Group**
  - **Character 5: Assessment Indicator**

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PDPM HIPPS Coding Crosswalk: PT, OT, NTA

PT/OT, SLP, NTA Payment Groups to HIPPS Translation

PT/OT Payment Group	SLP Payment Group	NTA Payment Group	HIPPS Character
TA	SA	NA	A
TB	SB	NB	B
TC	SC	NC	C
TD	SD	ND	D
TE	SE	NE	E
TF	SF	NF	F
TG	SG		G
TH	SH		H
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L
TM			M
TN			N
TO			O
TP			P

PDPM HIPPS Coding Crosswalk: Nursing

Nursing Payment Group to HIPPS Translation

Nursing Payment Group	HIPPS Character	Nursing Payment Group	HIPPS Character
ES3	A	CBC2	N
ES2	B	CA2	O
ES1	C	CBC1	P
HDE2	D	CA1	Q
HDE1	E	BAB2	R
HBC2	F	BAB1	S
HBC1	G	PDE2	T
LDE2	H	PDE1	U
LDE1	I	PBC2	V
LBC2	J	PA2	W
LBC1	K	PBC1	X
CDE2	L	PA1	Y
CDE1	M		

PDPM HIPPS Coding Crosswalk: AI

Assessment Indicator (AI) Crosswalk

HIPPS Character	Assessment Type
0	IPA
1	PPS 5-day
6	OBRA Assessment (not coded as a PPS Assessment)

PDPM HIPPS Coding: Examples

Example 1:

- ❑PT/OT Payment Group: **TN** = **N**
- ❑SLP Payment Group: **SH** = **H**
- ❑Nursing Payment Group: **CBC2** = **N**
- ❑NTA Payment Group: **NC** = **C**
- ❑Assessment Type: **5-day PPS Assessment** = **1**
- ❑**HIPPS Code = NHNC1**

PDPM HIPPS Coding: Examples

Example 2:

- ❑PT/OT Payment Group: **TC** = **C**
- ❑SLP Payment Group: **SD** = **D**
- ❑Nursing Payment Group: **PBC1**= **X**
- ❑NTA Payment Group: **NE** = **E**
- ❑Assessment Type: **5-day PPS Assessment** = **1**
- ❑**HIPPS Code = CDXE1**

BHFA1

PDPM RUG COMPONENTS PROPOSED for FY2020

(Bronx,Kings,New York,Orange,Queens,Richmond,Rockland,Westchester - Wage Index: 1.2639)

PT = TB $123.40

OT = TB $110.13

SLP = SH $77.49

NSG = HBC2 $283.51

NTA = NA $309.36 *(X 3 FOR DAYS 1, 2 & 3) = $928.08

NON-CASE MIX=$113.32

RATE FOR DAYS 1,2 &3 : = $1635.93

AFTER DAY 3 = $1017.21

PT/OT

Clinical Categ	GG Score	RUG	PT RATE	OT RATE	TOTAL RATE
Maj Jt Repl or Spinal Surg	0-5	TA	$111.06	$100.67	$211.73
	6-9	TB	$123.40	$110.13	$233.53
	10-23	TC	$136.46	$114.19	$250.65
	24	TD	$139.37	$103.38	$242.74
Other Orthoped	0-5	TE	$103.07	$95.27	$198.34
	6-9	TF	$116.87	$108.11	$224.97
	10-23	TG	$121.22	$110.81	$232.03
	24	TH	$84.20	$77.70	$161.90
Medical Management	0-5	TI	$82.02	$79.73	$161.75
	6-9	TJ	$103.07	$97.97	$201.05
	10-23	TK	$110.33	$104.05	$214.39
	24	TL	$79.12	$75.00	$154.12
NonOrthop Surg & Acute Neurologic	0-5	TM	$92.48	$87.84	$180.02
	6-9	TN	$107.43	$101.35	$208.78
	10-23	TO	$112.51	$104.73	$217.24
	24	TP	$78.39	$73.65	$152.04

SLP

Acute Neuro, SLP Comorb, Cog Impairm	Mech diet OR Swall disord	RUG	RATE
None	Neither	SA	$18.42
None	Either	SB	$49.31
None	Both	SC	$72.35
Any One	Neither	SD	$39.56
Any One	Either	SE	$63.40
Any One	Both	SF	$80.74
Any Two	Neither	SG	$55.27
Any Two	Either	SH	$77.49
Any Two	Both	SI	$95.65
All Three	Neither	SJ	$81.02
All Three	Either	SK	$100.25
All Three	Both	SL	$114.07

NTA

Points	RUG	RATE
12+	NA	$309.36
9-11	NB	$241.57
6-8	NC	$175.69

NTA VPD

Day	Adj
1-3	3.0
4-100	1.0

NURSING

RUG	GG Score	End Split	RATE
ES3	0-14	Vent & Trach	$513.85
ES2	0-14	Vent or Trach	$388.55
ES1	0-14	Isolation	$370.83
HDE2	0-5	s/s Depress	$303.76
HDE1	0-5		$251.86
HBC2	6-14	s/s Depress	$283.51
HBC1	6-14		$235.41

PDPM Policies

- MDS Related Changes:
  - o MDS Assessment Schedule
  - o New MDS Item Sets
  - o New MDS Items
- Concurrent & Group Therapy Limit
- Interrupted Stay Policy
- Administrative Presumption
- Payment for Patients with AIDS
- Revised HIPPS Coding
- RUG-IV – PDPM Transition

MDS Assessment Schedule CHANGES

RUG-IV Assessment Schedule

RUG-IV PPS Assessment Schedule

Scheduled Assessment			
Medicare MDS Assessment Schedule Type	**Assessment Reference Date**	**Assessment Reference Date Grace Days**	**Applicable Standard Medicare Payment Days**
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled Assessment			
Start of Therapy OMRA	5-7 days after	start of therapy	Date of the first day of therapy through the end of the standard payment period
End of Therapy OMRA	1-3 days after	end of therapy	First non-therapy day through the end of the standard payment period
Change of Therapy OMRA	Day 7 (last day) of	COT observation period	The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment
Significant Change in Status Assessment	No later than 14 days after	significant change identified	ARD of Assessment through the end of the standard payment period

PDPM Assessment Schedule

MEDICARE MDS ASSESSMENT	ARD	Applicable Standard Medicare Payment Days
5-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

PDPM SCHEDULE

- **LATE Assessments under PDPM:** The provider will bill the default **HIPPS code for the number of days out of compliance** and then the 5-day assessment HIPPS code for the remainder of the stay, unless an IPA is completed.
- **Caveat: The default billing will be assessed prior to the 5-day assessment HIPPS code,** in terms of counting days for the variable per diem.
  e.g. If a 5-day assessment is 2 days late, then Days 1 and 2 of the stay, with regard to the variable per diem adjustment, will be calculated using the default HIPPS code and then the 5-day assessment HIPPS code will control payment beginning on Day 3 of the variable per diem schedule.

NEW MDS ITEM SETS

IPA MDS ITEM SET: INTERIM PAYMENT ASSESSMENT

- The IPA has its own IPA item set. This item set contains merely payment items and demographic items, as necessary to attain a billing code under PDPM.
- Because the IPA is **completely optional,** there will be no late assessment penalties for that assessment.

OSA MDS ITEM SET: OPTIONAL STATE ASSESSMENT

For States that rely on on the RUG-IV assessment schedule for calculating case mix group for NF patients:

- As of October 1, 2019, all scheduled PPS assessments (except the 5- day) and all current unscheduled PPS assessments will be retired
- To fill this gap in assessments, CMS will introduce the **Optional State Assessment (OSA)**, which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules
- There is currently no definitive timeline for retiring the OSA. Once states are able to collect the data necessary to consider a transition to PDPM, CMS will evaluate the continued need for the OSA, in consultation with the states.

NEW & REVISED MDS ITEMS

MDS Changes: New & Revised Items

- **SNF Primary Diagnosis**
  - **Item I0020B (New Item)**
  - This item is for providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis
  - "What is the main reason this person is being admitted to the SNF?"
- **Patient Surgical History**
  - **Items J2100 – J5000 (New Items)**
  - These items are used to capture any ***major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?***

MDS Changes: New & Revised Items

- **Discharge Therapy Collection Items**
  - **Items 0425A1 – O0425C5 (New Items)**
  - Using a look-back of the entire PPS stay, providers report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient
  - If the total amount of group/concurrent minutes, combined, **comprises more than 25% of the total amount of therapy for that discipline, a warning message is issued on the final validation report**

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MDS Changes: New & Revised Items

- **Section GG Functional Items – Interim Performance**
  - On the IPA, Section GG items will be derived from a new column "5" which will capture the interim performance of the patient
  - The look-back for this new column will be the three-day window leading up to and including the ARD of the IPA (ARD and the 2 calendar days prior to the ARD)

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CONCURRENT AND GROUP THERAPY LIMIT

Concurrent & Group Therapy Limit

- Under RUG-IV, no more than 25% of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy.
- Definitions:
  - Concurrent Therapy: One therapist with two patients doing different activities
  - Group Therapy: One therapist with four patients doing the same or similar activities
- ***Under PDPM, a combined limit will be used for <u>both concurrent and group therapy</u> to be no more than 25% of the therapy received by SNF patients, for each therapy discipline.***

14

Concurrent & Group Therapy Limit

- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425).
  - Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay
  - If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the provider will receive a warning message on their final validation report

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INTERRUPTED STAY POLICY

Interrupted Stay Policy: Background

- Given the introduction, under PDPM, of the variable per diem adjustment, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay & then readmit the patient in order to reset the variable per diem schedule.
- Frequent patient readmissions and transfers represents a significant risk to patient care, as well as a potential administrative burden on providers from having to complete new patient assessments for each readmission.

Interrupted Stay Policy: Background

- To mitigate this potential incentive, PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window.
  - ***This type of policy also exists in other post-acute care settings (e.g., Inpatient Rehabilitation Facility (IRF) PPS).***

Interrupted Stay Policy: Background

- If a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay.
  - Assessment schedule continues from the point just prior to discharge
  - Variable per diem schedule continues from the point just prior to discharge
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay.
  - Assessment schedule and variable per diem schedule reset to day 1

INTERRUPTED STAY POLICY

- **Readmits to same SNF by 12:00am at the end of the third day**
  - Continuation of the previous stay
  - Source of readmission is not relevant
- **Readmits to same SNF after 3-day interruption window**
  - Considered a new stay
  - New 5-day assessment is required upon admission
- **Readmits to different SNF**
  - In any case where the resident is readmitted to a different SNF, the stay is considered a new stay
  - New 5-day assessment is required upon admission

Interrupted Stay Policy: EXAMPLES

Example 1: Patient A is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/25/19

- New stay
- Assessment Schedule: Reset; stay begins with new 5-day assessment
- Variable Per Diem: Reset: stay begins on Day 1 of VPD Schedule

Example 2: Patient B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to different SNF on 11/22/19

- New stay
- Assessment Schedule: Reset; stay begins with new 5-day assessment
- Variable Per Diem: Reset; stay begins on Day 1 of VPD Schedule

Example 3: Patient C is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/22/19

- Continuation of previous stay
- Assessment Schedule: No PPS assessments required, IPA optional
- Variable Per Diem: Continues from Day 14 (Day of Discharge)

ADMINISTRATIVE PRESUMPTION OF COVERAGE

Administrative Presumption: Background

- The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring an SNF level of care through the assessment reference date for that assessment.
- Those beneficiaries not assigned one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition, but instead receive an individual determination using the existing administrative criteria.

Administrative Presumption: CLASSIFIERS

- The following PDPM classifiers are designated under the presumption:
  - **Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;**
  - **PT & OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;**
  - **SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and**
  - **The NTA component's uppermost (12+) comorbidity group**

PAYMENT FOR SNF PATIENTS WITH AIDS (ICD-10-CM Code: B20)

PDPM Payments for SNF Patients with HIV/AIDS

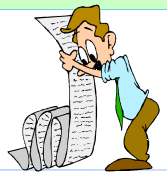
PDPM Payment for Residents with AIDS (B20):

*1)**8 POINTS in NTA component :** **Assigned the highest point value (8 points) of any condition or service for purposes of classification under the PDPM's NTA Component*

*2)**18% ADD-ON to the NURSING COMPONENT of the PDPM payment.***

**NOTE: As under the RUG-IV model, the presence of an AIDS diagnosis continues to be identified through the SNF's entry of ICD-10-CM code B20 on the claim.*

RUG-IV AND PDPM TRANSITION



RUG-IV & PDPM Transition

- As discussed in the FY 2019 SNF PPS Final Rule, there is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers & CMS.
  - RUG-IV billing ends September 30, 2019
  - PDPM billing begins October 1, 2019

RUG-IV & PDPM Transition

- To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A patients.
  - October 1, 2019 will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
  - Any "transitional IPAs" with an ARD after October 7, 2019 will be considered late & relevant penalty for late assessments would apply

STRATEGIES: HOW TO PREPARE

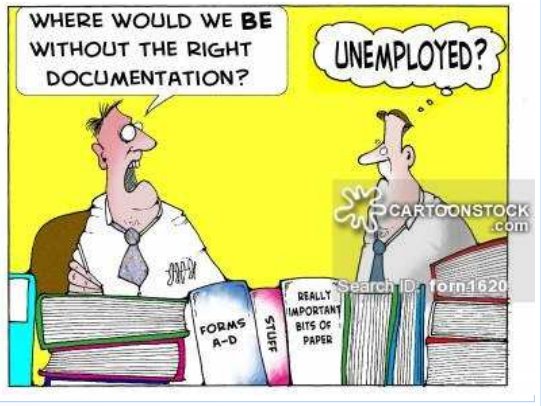


REMINDERS

- ❑5-day MDS can determine payment for entire stay
- ❑Accuracy of coding and **PROPER DOCUMENTATION TO SUPPORT THE 5-DAY ASSESSMENT is CRUCIAL**
- ❑ICD-10 accuracy is IMPERATIVE !
- ❑Skilled requirements did not change
- ❑ICD-10-CM training in LTC is a MUST!!!
- ❑MDS Accuracy
- ❑Quality of Charting
- ❑Restorative Program
- ❑Conducting Resident Interviews Properly

KEY TO PDPM SUCCESS

KEY: The establishment & implementation of efficient systems, processes and user-friendly tools, starting from "PRE-Admission Screening (Obtaining ALL Hospital Records); Conducting Comprehensive Admission Assessments to establish an individualized POC;
Active MD Involvement in Documentation & ICD-10 Coding; Individualized Case Management of each patient during the Medicare Stay (spearheaded by MDS Coordinator); Proactive IDCP Teamwork & Communication with Nursing to obtain the proper documentation - to ensure Accurate MDS Coding, ICD-10 Coding, UB-04 Coding & Documentation to support Daily Skilled Services rendered for Appropriate Clinical Reimbursement & ending with Submission of Clean Claims.



HOPE IS NEVER A STRATEGY

THANK YOU!

RESOURCES

- www.cms.gov
- www.ahca.org
- www.hcanj.org
- www.aanac.org
- www.oig.hhs.gov
- www.novitas-solutions.com
- www.ngsmedicare.com
- www.noridian.com
- www.wps.com
- Medicare Benefits Policy Manual Chapter 8
- Medicare Claims Processing Manual Chapter 6
- Medicare Program Integrity Manual Chapter 3
- Medicare Program Integrity manual Chapter 6