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Harmony Healthcare INTERNATIONAL

PATIENT DRIVEN PAYMENT MODEL

Question and Answers

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Patient Driven Payment Model: Question and Answers

1. Is there an actual table of rates that we can access?

Yes, per the Federal Register / Vol. 83, No. 153 Final Rule

Rate component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Urban Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63
Rural Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

2. Is the 25% group and concurrent therapy cap based on total therapy or are PT and OT evaluated separately?

To capture therapy delivery information over the course of a patient's entire Part A stay, as it relates to the concurrent and group therapy limit under PDPM, CMS added Items **O0425A1 – O0425C5** which will be added to Section O of the MDS.

Using a lookback period of the entire PPS stay, providers will report, by **each discipline** and **mode of therapy**, the **amount of therapy** (in minutes) received by the patient.

Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

- **Step 1:** Total Therapy Minutes, **by discipline** (O0425X1 + O0425X2 + O0425X3)
- **Step 2:** Total Concurrent and Group Therapy Minutes, by discipline (O0425X2+O0425X3)
- **Step 3:** C/G Ratio (Step 2 result/Step 1 result)
- **Step 4:** If Step 3 result is greater than 0.25, then the provider is non-compliant.

There will be **no penalty** for exceeding the 25% combined concurrent and group therapy limit. However, providers will receive a **warning edit** on their assessment validation report that will inform them that they have **exceeded the 25% limit**.

The warning edit will read as follows: "The total number of group and/or concurrent minutes **for one or more therapy disciplines** exceeds the 25 percent limit on concurrent and group therapy. **Consistent violation of this limit may result in your facility being flagged for additional medical review."**

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CMS will also monitor therapy provision under PDPM to identify facilities that exceed the limit, in order to determine if additional administrative or policy action would be necessary.

3. Will there still be a 3-day hospital admission required for coverage?

Yes, under Traditional FFS Medicare, eligibility, entitlement, benefit periods and skilled coverage criteria do not change under PDPM.

4. NAC struggle with Section G. How do suggest they will do with GG?

Review your process now. Many facilities have Rehabilitation Services code Section GG on the MDS, and it is often based on only the evaluation. The evaluation may occur on day one. The assessment is based on the usual performance over first 3 days of the stay. Many facilities cut the assessment time for the assessment.

The Interdisciplinary Team should review their observations, documentation, speak with resident/family and direct caregivers. Section GG is scored based on the patient's usual performance, therefore the Interdisciplinary approach is critical.

5. With PDPM, what will be the best way for a facility team to measure therapy involvement/utilization to ensure appropriate levels of utilization are occurring and supported for our residents?

CMS expects that there is no significant change in the way care is provided to the SNF patient. This will be monitored and assessed via the discharge MDS that reports all therapy days and minutes since the start of the stay to the end of skilled stay.

Measure progress towards goals, functional outcomes, patient and family satisfaction to validate that clinically appropriate reasonable and necessary care is provided.

6. How will ST frequency impact payment/scores?

You do not need to deliver ST for the SLP Component. In fact, all patients have a PT, OT, SLP, NTA, Nursing and non-Case Mix component/rate. The 5-Day MDS does not code therapy involvement the way you code now.

The SLP component is based on Speech-Language Pathology-Related Comorbidities, Acute Neurologic Clinical Category, Swallowing Disorder using items K0100A through K0100D, and Mechanically Altered Diet (while a resident) and Cognitive Impairment.

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7. Will there be 2 sections/columns in GG to distinguish between nursing and therapy functional scores?

No, Section GG will be completed as it is now. There will be **6 GG Items** for calculating the PT/OT Functional Score and **4 GG Items** used for the Nursing Functional Score. Some Self-Care and Mobility tasks are averaged. Under Section GG, increasing score means increasing independence. Max Scores: PT/OT: 6 items x max 4 points = maximum of 24 for the PT/OT Functional Score. Nursing: 4 items x max 4 points = maximum of 16 for a Functional Score.

PT/OT Functional Score:

1. Self-care: Eating
2. Self-care: Oral Hygiene
3. Self-care: Toileting Hygiene
4. Average of following 2 items:
   - Mobility: Sit to lying
   - Mobility: Lying to sitting on side of bed
5. Average of following 3 items:
   - Mobility: Sit to stand
   - Mobility: Chair/bed-to-chair transfer
   - Mobility: Toilet transfer
6. Average of following 2 items:
   - Mobility: Walk 50 feet with 2 turns
   - Mobility: Walk 150 feet

Nursing Function Score:

1. Self-care: Eating
2. Self-care: Toileting Hygiene
3. Average of following 2 items:
   - Mobility: Sit to lying
   - Mobility: Lying to sitting on side of bed
4. Average of following 3 items:
   - Mobility: Sit to stand
   - Mobility: Chair/bed-to-chair transfer
   - Mobility: Toilet transfer

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8. Who is responsible for doing the cognitive assessment? I see there is a component under SLP, what if SLP is NOT involved in the patient care?

The cognitive assessment may be done by a qualified clinician. A qualified clinician is defined as a healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

The cognitive assessment and scoring are based on MDS coding of the BIMS or the CPS. Either a BIMS score or CPS score is necessary to classify the patient under the SLP component. The BIMS is completed by interview. The Cognitive Performance Scale (CPS) is based on the responses to the Staff Assessment.

Any degree of cognitive impairment contributes to the SLP Component.

- BIMS: ≤ 12
- CPS Score: ≥ 1

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

9. If rehab is not providing services who will complete rehab section GG. Sill Nursing?

Yes, nursing will complete the rehab portion of section GG if therapy has not observed, assessed or treated the patient (as they will not know the usual functional status). Nursing will observe, review documentation, interview patient, family and direct caregivers.

10. Can you group all other payor sources along with your Medicare A residents?

Reimbursement for group therapy varies based on practice setting and whether the services are covered under Part A (inpatient) or Part B (outpatient). Group therapy policies are further defined in local coverage determinations (LCDs) issued by Medicare Administrative Contractors (MACs).

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Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.

For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

11. Can OT address cognition or is it now going to be speech driven?

There is no change in clinical practice. The Cognitive impact is in the identification of the patient conditions to derive the SLP component. The cognitively impaired patient may not be receiving SLP services and the cognitive impairment contributes to the CMG for SLP.

12. I have heard that one organization has interpreted the PDPM information to mean that a SNF will receive the therapy components for rate whether or not therapy is involved. I realize there is not a minute threshold but does therapy at least have to be involved to receive therapy component part of the rate?

No, therapy doe s not need to be involved to receive the therapy component of the Part A rate. All Medicare A patients will classify into one of the 5 Case Mix Groups (CMGs) regardless of whether therapy is involved or not.

- PT
- OT
- SLP
- NTA
- Nursing

13. Just to clarify, the presence or absence of a therapy SOC date in Section O of the 5day assessment has no impact on the reimbursement categories for OT, PT, and ST, right?

Yes, Section O0425 will be added to the MDS Item Set and is specific to **Part A Therapies**. This section will be completed only if **A0310H = 1,** a **SNF Part A PPS Discharge Assessment.** Therefore, therapy is not recorded on the MDS until the SNF Part A PPS Discharge Assessment.

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The patient need not be receiving any or all 3 disciplines to qualify for the PT, OT and SLP Case Mix Groups (CMGs). Classification is based on primary medical reason for SNF care, functional score, Cognitive, Dysphagia, mechanically altered diet and other Comorbidities.

14. What dx will we put on the UB for billing? Of course, the primary but then what? The NTA? Then Therapy dx?

Continue to report relevant ICD-10 codes that support the skilled stay. There is one diagnosis that must be on the UB04 for reimbursement. HIV/AIDS code of B20 must be on the UB to trigger reimbursement. Rather than a 128 percent adjustment for the entire PPS per diem rate, the adjustment under PDPM is an increase of 18 percent in the nursing component of the per diem rate and a reclassification under the NTA component to a higher rate category.

Under the PDPM, the HIPPS code is structured differently. There are five Case Mix adjusted rate components under the revised model:

- The first position represents the Physical and Occupational Therapy Case Mix group.
- The second position represents the Speech-Language Pathology Case Mix group.
- The third character represents the nursing Case Mix group.
- The fourth character represents the Non-Therapy Ancillary Case Mix group.
- The fifth character represents the AI code.

15. Any idea how Case Mix states will handle this new classification system for Medicaid only facilities since section GG isn't done for these residents

For states that rely on the RUG-IV assessment schedule for calculating Case Mix group for NF patients, CMS has created an optional assessment so that Medicaid payments are not adversely impacted when PDPM is implemented as of October 1, 2019. States will have the ability to determine the policy associated with this assessment to meet your Medicaid payment needs. The optional assessment will be in place from October 1, 2019 through September 30, 2020.

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16. Do we know yet what will happen with patients who are evaluated prior to October first and already had MDS(s) done prior to the new system?

Yes, the transition between RUG-IV and PDPM will be a "hard" transition, meaning that the two systems will not run concurrently at any point. All days of service on or prior to September 30, 2019 will be billed under RUG-IV, while all days of service beginning October 1, 2019 will be billed under PDPM. To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to **complete an IPA with an ARD no later than October 7, 2019** for all SNF Part A patients.

October 1, 2019 will be considered Day 1 of the variable per diem schedule under PDPM, even if the patient began their stay prior to October 1, 2019. Any "transitional IPAs" with an **ARD after October 7, 2019 will be considered late and the late assessment penalty would apply.** The HIPPS code derived from the transitional IPA should be used to bill for dates of service beginning October 1, 2019.

17. Has your team been able to estimate therapy minutes per Case Mix group that would be financially efficient?

The Case Mix groups are not determined by minute or delivery of care. Delivery of therapy services is **resident centered and based on medical necessity.** The Case Mix Groups for PT, OT and SLP will be calculated for all patients regardless of therapy involvement.

18. Where is the mapping tool?

CMS PDPM Resources has the Clinical Mapping Tool, Comorbidities and Grouper at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html**

19. If re-skilling a patient within the 30-day window rule, what MDS assessment is required and how is the reimbursement calculated?

The Minimum Data Set (MDS) - Version 3.0 Resident Assessment and Care Screening Nursing Home PPS (Np) Item Set would be used for a standalone PPS Assessment. (MDS 3.0 NP PPS v1.12.0)

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20. If you are doing a new assessment starting Oct 1st for Med A patients, would you have to do a discharge PPS for all Med A patients on Sept 30th? If so, does the billing calendar reset?

No, a discharge PPS MDS is not done as the stay is not ending. The patient will have an Interim Payment Assessment. The patient will be credited for days used. The Variable Payment Adjustment will begin on October 1, 2019.

21. How does this impact States with Case Mix for Medicaid payment?

CMS has developed an Optional State Assessment (OSA) for use October 1, 2019 through September 30, 2020. CMS will continue to report the RUG-III and RUG-IV Health Insurance Prospective Payment System (HIPPS) codes, as requested by the state, until September 30, 2020 on the 5-day PPS, OBRA comprehensive and OBRA quarterly assessment types.

If a State requires the calculation of RUG-III or RUG-IV more frequently, the State may require its providers to submit the OSA at time points determined by the State.

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