

A blue rectangular box with white text is centered on a blurred background of a person's hands. The text reads: "SHIFTING GEARS UNDER PDPM" in large bold letters, "Changes and Considerations for Therapy" in smaller text below it, and "ON-DEMAND WEBINAR" in bold letters at the bottom, separated by a dotted line.

**SHIFTING GEARS UNDER PDPM**  
Changes and Considerations for Therapy  
.....  
**ON-DEMAND WEBINAR**

## Question and Answer

**Q:** From a payor standpoint, when do we expect to see a pricer/grouper?

**A:** The FY2019 PDPM unadjusted federal per diem base rates for each of the PDPM rate components can be found in Tables 12 and 13 in the FY2019 SNF PPS Final Rule. You may access it at the following link to the federal register: <https://www.federalregister.gov/documents/2018/08/08/2018-16570/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

The wage index adjustments should be applied to the per diem rates after all case-mix and variable per diem adjustments. The tables for the wage index adjustments can be found in Tables A and B in the FY2019 SNF PPS Final Rule Correction. You may access those tables at the following link to the federal register:

<https://www.federalregister.gov/documents/2018/10/03/2018-21499/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

Note: These rates will continue to be updated annually and posted on the federal register.

**Q:** How will this effect RNP financially? Is it true the reimbursement rate will change with the accountability of RNP's completion?

**A:** Restorative nursing program?

**Q:** If a swallowing problem is resolved with a change in diet consistency, would we mark swallow difficulty even if not specifically noted during 7 days?

**A:** In v1.17.1 of the MDS, the 5day assessment requires you to indicate whether the resident has signs/symptoms of a possible swallowing disorder and whether the resident has received a mechanically altered diet. You would indicate the signs and symptoms of a possible swallowing disorder in item set K0100 Swallowing Disorder and you would indicate whether the resident has been on a mechanically altered diet within the 7-day lookback period in item set K0510 Nutritional Approaches.

**Q:** Do the changes apply to a CAH?

**A:** These changes apply to all facilities subject to PPS assessments and reimbursement.

**Q:** We are at a facility who does not do group/concurrent. Do you have any recommended resources to start a group therapy program? i.e. group therapy toolkits by diagnostic group?

**A:** \*\*\*\*\*

**Q:** Do you have any recommendations for a "coding competency" for therapists?

**A:** I recommend that therapists become familiar with the ICD-10 Mapping Tool that was published by CMS to determine the appropriate ICD-10 codes to determine the clinical categories for residents, the SLP-related comorbidities that will impact reimbursement under the SLP per diem rate, and the additional comorbidities that will impact reimbursement under the NTA rate component.

The tool can be found at the following link: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSPDPM.html>.

**Q:** Can you explain MDS for those of us who are coders but new to SNF coding?

**A:** The Minimum Data Set (MDS) is a standardized assessment for nursing facility residents used as a data collection tool for the purposes of classification and reimbursement for nursing home residents. It is the basis for SNF PPS reimbursement and contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status.

For more information on the MDS, you may access the IOM 100-07 State Operations Manual Appendix R and the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>).

**Q:** Does HCPro offer webinars on SNF coding?

**A:** HCPro offers the ICD-10 Coding and Documentation for Long-Term Care on-demand webinar that can be accessed at the following link: <http://hcmarketplace.com/icd-10-coding-and-documentation-for-long-term-care>.

Additional tools are being developed and may be found in the HCPro Store at: <http://hcmarketplace.com/subject/long-term-care> as well as the HCPro Long-Term Care Resources page at <https://interactive.hcpro.com/LTCsolutions>.

**Q:** What would you do if there is a discrepancy in the BIMS assessment between the speech therapist and the social worker?

**A:** The BIMS assessment should be completed by one personnel (i.e. the social worker). If the assessment differs with an assessment completed by a therapist, then I would recommend that the facility analyze the discrepancy using their Quality Assurance and Performance Improvement (QAPI) process.

**Q:** Is it critical to have therapy evaluations completed on the day of the resident's admission?

**A:** The ARD for the 5-day assessment must be set between days 1-8. While it is not required for evaluations to be completed on the day of admission, the earlier that the interdisciplinary team completes all assessments, the more time they have to collaborate and determine feasible goals for the resident before the 5-day assessment is completed. It is, therefore, critical that therapy evaluations are completed as soon as possible after the resident admits to the SNF for a Medicare Part A stay.

**Q:** Is there a required amount of minutes the patient needs to be treated by therapy under PDPM?

**A:** No, under PDPM, SNF PPS reimbursement is based on resident characteristics and not therapy utilization (minutes).

**Q:** Are bed holds considered in the length of stay?

**A:** Bed holds and resident leave of absences will continue to be counted as non-utilization days under PDPM, meaning that Medicare will not cover those days. The Medicare Part A length of stay is based on the number of utilization or Medicare Part A-covered days.

**Q:** How should the facility count days when a patient is outside of the facility for a leave of absence, a bed hold, or discharged and readmitted?

**A:** The new Interrupted Stay Policy is effective concurrent with implementation of the Patient Driven Payment Model (PDPM). CMS defines an "interrupted" SNF stay as one in which a patient is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the "interruption window").

Consistent with the interrupted stay policies used in the Inpatient Rehabilitation Facility (IRF) and Inpatient Hospital settings, the interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 12:00 am at the end of the third calendar day.

If both conditions are met, the subsequent stay is considered a continuation of the previous "interrupted" stay for the purposes of both the variable per diem schedule and the assessment schedule. The variable per diem schedule continues from the day of the previous discharge. For example, if the patient was discharged on Day 17, payment rates resume at Day 17 upon readmission. The assessment schedule also continues from the day of the previous discharge. Thus,

no new 5-day assessment is required upon the subsequent readmission, although the optional Interim Payment Assessment (IPA) may be completed at the provider's discretion.

If the patient is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the patient is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating a new 5-day assessment required.

Additional information on the Interrupted Stay Policy can be accessed at the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>

**Q:** Originally in the proposed rule, there was language that said the ARD for the IPA would be 14 days from the onset of the condition. Is that still the case?

**A:** The language in the proposed rule for the IPA has been updated. The IPA is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment. The ARD is the date that the facility chooses to complete the IPA is relative to the triggering event for the clinical change.

Additional information on the IPA can be accessed at the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>

**Q:** Please confirm PDPM only applies to the facility Part A billing - this does not apply to physician Part B billing correct?

**A:** Yes, PDPM is a new payment model for SNF PPS. This only applies to Medicare Part A and not Medicare Part B.

**Q:** When do you anticipate the final rule being available?

**A:** The FY2019 SNF PPS Final Rule included information for PDPM. It can be accessed on the federal register at the following link: <https://www.federalregister.gov/documents/2018/08/08/2018-16570/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

The proposed FY2020 SNF PPS Final Rule may be accessed on the federal register at the following link: <https://www.federalregister.gov/documents/2019/04/25/2019-08108/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>. The finalized FY2020 SNF PPS Final Rule will be published on the federal register in early August and effective on October 1, 2020.

**Q:** What happens with the patient Expires? Is the Discharge Assessment still filled out?

**A:** Yes, SNFs are required to complete the PPS Discharge assessment (and OBRA assessment) for a resident's expiration.

**Q:** Since the EOT assessment will no longer be applicable starting Oct. 1, has CMS given any guidance on what a facility should do if a resident on skilled services misses a day of therapy or 3 days in a row in combination with a weekend?

**A:** Under PDPM, there are not a required days of treatment per week (thus no EOT will be required); however, there is still a daily skilled care requirement for SNF Part A patients, as discussed in Chapter 8 of the Medicare Benefit Policy Manual, specifically section 30.6.

**Q:** One of the slides mentioned restorative nursing. Where does this fit in for reimbursement?

**A:** Facilities will indicate in the MDS (O0500) the number of days that the resident received restorative nursing for at least 15 minutes/day during the 7day lookback period. This input is used to assign the final PDPM Classification and reimbursement for the PDPM per diem nursing rate component.

**Q:** During the PDPM transition period, will we include PT/OT/SLP minutes provided prior to 10/1/2019 in the discharge assessment?

**A:** Yes, all therapy minutes provided during the Medicare Part A stay should be reported in the discharge assessments completed after 10/1/2019.

**Q:** Are Medicare Advantage plans required to change to payment methodology as well?

**A:** The Medicare Advantage plans will decide whether they will incorporate any aspects of PDPM into their payment system. Any questions regarding the impact of PDPM on Medicare Advantage plans should be directed to MA plan sponsors

**Q:** Are combinations of OBRA 5 day or IPA combos allowed?

**A:** The IPA cannot be combined with any other assessments, the 5-day assessment can be combined with an OBRA assessment and no PPS assessments can be combined.

**Q:** If a patient discharges from the SNF to the hospital and is gone for more than 24 hours does this require a new therapy evaluation under PDPM?

**A:** A new 5-day PPS assessment is not required after the interruption in the case of an interrupted stay that meets the criteria defined by the Interrupted Stay Policy (see previous question). Such a stay is considered a continuation of the previous stay. In this case, providers are not required to complete an evaluation for the purposes of PPS payment upon the patient's readmission after an interruption in a stay.

If patient care needs have changed significantly, clinicians may complete an Interim Patient Assessment (IPA) at their discretion.

A new 5-day assessment is required if the interruption lasts longer than 3 days or if the beneficiary is readmitted to a different SNF, e.g. if the two stays do not meet the criteria of an interrupted stay.

**Q:** Has the definition of "skilled therapy" changed under the new model?

**A:** No, the definitions and skilled coverage criteria have not changed with PDPM.

**Q:** How do we decide RUG levels or minutes for patients? Is there a guideline?

**A:** Under PDPM, SNF PPS reimbursement is based on resident characteristics and not therapy utilization (minutes). RUGs will be discontinued with the effective date of PDPM on 10/1/19. CMS does not publish guidelines for therapy minutes. Rather, the expectation is that therapists will use sound clinical judgment to assess residents' characteristics and needs.

**Q:** Is there any change in reimbursement based on evaluation vs discharge scores?

**A:** No, however facilities will continue be subject to quality concern investigations during surveys and claim audits that may be triggered by poor outcomes.

**Q:** Are only the BIMs and CFS used to identify cognitive impairment? SLPs are experts in cognition and can often administer a more sensitive measure- can we use SLP cognitive assessments (i.e. RIPA-G, MOCA, etc.) to code cognitive impairment on the MDS?

**A:** No, only the BIMs and CFS are used to report cognitive impairment in the MDS. More information on why CMS has chosen this methodology can be found in the FY2019 SNF PPS Final Rule. You may access it at the following link to the federal register:

<https://www.federalregister.gov/documents/2018/08/08/2018-16570/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

**Q:** Am I understanding correctly that the IPA is optional? If so, why would staff complete it? Is it to guide the care plan to meet the new needs of the resident?

**A:** Yes, the IPA is optional. It would behoove facilities to opt to complete the IPA if a resident's characteristics have changed significantly since the completion of the 5-day assessment, resulting in a different clinical category and an opportunity for different (greater) reimbursement.

**Q:** Can you review the new skillable diagnoses that will be required with PDPM?

**A:** Residents are not eligible for Medicare Part A coverage based on diagnoses. You may access more information about skilled coverage determination requirements in Chapter 8 of the Medicare Benefit Policy Manual.

Once Medicare A eligibility and skilled coverage has been determined, facilities may use the CMS Mapping Tool to determine how thousands of ICD-10 codes are mapped to clinical reimbursement categories. The tool may be accessed at the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>.

**Q:** What is the payment impact of PDPM? Will there be a reduction in pay for most facilities?

**A:** CMS has published a provider-specific impact analysis file, which details the estimated impact of PDPM on Medicare Part A payments to each SNF in the country using provider and resident data for fiscal year 2017. You may access the following link to determine the impact of PDPM for your facility at the following link using your facility's CCN: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html>

**Q:** Would "finding additional comorbidities" that should have been coded on admission, and would positively impact reimbursement, be a justifiable reason to do an IPA?

**A:** No, the IPA is not to be used for corrections. It should be used when the resident's characteristics have changed since the 5-day assessment was completed.

**Q:** What happens if a resident discharges before the ARD for the 5d assessment?

**A:** Facilities may continue to use the short stay assessment for residents who expire or discharge from the SNF prior to day 8 of the Medicare A stay.

**Q:** Do you recommend to use coding professional to code for PDPM or therapists and train them to code?

**A:** Both therapists and MDS personnel should familiarize themselves with coding and reimbursement methodologies. Assigning codes should be a collaborative effort.

**Q:** Surgical Codes greater than 60-days old should not be used? Still true?

**A:** Major surgical procedures must have occurred during the inpatient hospital stay that immediately preceded the SNF admission, i.e., the qualifying hospital stay, in order to be captured in the MDS (Items J2100-J5000: Patient Surgical History).

To be eligible for Medicare Part A coverage, a resident must have had a qualifying hospital stay within 30 days prior to their SNF Medicare Part A admission.

**Q:** Is the CMI for OT, PT and SLP all different?

**A:** Yes, each PDPM per diem rate component has different base rates and CMI case-mix index adjustments.

**Q:** Has the Group Therapy definition changed to include 2-6 patients per group, instead of 2-4?

**A:** Currently under the SNF PPS, group therapy is defined as being one therapist working with four patients doing the same or similar activities. To better align the SNF PPS with other payment systems, specifically the inpatient rehabilitation PPS, CMS has proposed the adoption of a new definition to take effect this October if approved, which would be one therapist working with two to six patients doing the same or similar activities.

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